

Ministry of Health

Annual Report

for the year ended 30 June 2020

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

Citation: Ministry of Health. 2020. *Annual Report for the Year Ended 30 June 2020: Ministry of Health*. Wellington: Ministry of Health.

Published in November 2020 by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-1-99-002942-4 (print)
ISBN 978-1-99-002943-1 (online)
HP 7474

This document is available at health.govt.nz



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A message from the Director-General

Kia ora koutou katoa.

It gives me great pleasure to present the Ministry of Health's 2019/20 Annual Report.

Our health and disability system has undoubtedly faced its greatest challenge of our lifetimes during the second half of this financial year.

It has been my absolute honour to work alongside dedicated and talented people within the Ministry, across the health and disability sector, the Government and the general public, to support our nation's COVID-19 elimination strategy.

The Government called on all of New Zealand to protect the health and wellbeing of whānau, friends and communities. I am profoundly grateful for, and impressed with, the way people joined together for our pandemic response. It has taken courage and sacrifice, and its impact will be felt for many years to come.

During the past year, New Zealand – like many countries internationally – has tackled a measles outbreak. This highly infectious disease stretched our health sector, but once again we worked collectively to end the outbreak.

The tragic volcanic eruption on Whakaari/ White Island in December last year also tested our nation's emergency and health services in



carrying for so many critically injured people from a single event.

Our hard work in the last couple of years towards building the Ministry's role as kaitiaki (guardian) of our health and disability system put us in a strong position to face these unprecedented challenges.

Health sector leadership is about convening and

collaborating and that has been a critical part of our COVID-19 response. Strong relationships have underpinned our work and will continue to do so. We've learned many lessons in the past year that we are embracing for the future, such as how to harness digital technology to support contact tracing and the critical value of clear public communications to ensure best health outcomes.

During the past year, we've also continued working on our key priorities so that the current system delivers for all New Zealanders. Budget 2019 invested \$1.9 billion to support New Zealanders' mental wellbeing, which included a significant increase in Vote Health funding for mental health and addiction services. This investment has supported implementation of the Government's response to the recommendations in *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga)*.

We've been working hard on this significant and long-term work programme. It includes rolling out expanded services and support



across New Zealand for people experiencing mild to moderate mental health issues. We've also set up a Suicide Prevention Office to lead and coordinate nationwide actions to prevent suicide. It's work is being guided by *Every Life Matters – He Tapu te Oranga o ia Tangata: The Suicide Prevention Strategy 2019–2029 and Action Plan 2019–2024 for Aotearoa New Zealand*.

The Initial Mental Health and Wellbeing Commission, which was set up last year to monitor the Government's progress towards meeting *He Ara Oranga* recommendations, will be replaced by an independent Mental Health and Wellbeing Commission by February next year.

Budget 2020 focused on Rebuilding Together, which included significant additional funding to support our COVID-19 response. But our greatest challenge remains ensuring our health and disability system is fair to all people – that there is equitable access to, experience of and outcomes from care.

While progress has been made, we know that inequities persist for some groups, particularly for Māori. *The Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575)* has been hearing claims concerning

grievances relating to health services and outcomes of national significance for Māori. It's stage one report into primary health care was released in July last year, which highlighted the urgent need to improve Māori health and wellbeing by more effectively working with Māori communities through collaboration and partnership.

Achieving equity in outcomes was also highlighted in the *Health and Disability System Review*, which was released in June this year. We must work in partnership with our Treaty of Waitangi partners to find solutions and this is something the Ministry has been working hard to progress.

I'm confident the Ministry is in a strong position to achieve the Government's aspirations to improve the health and wellbeing of all New Zealanders.

*Pae tū, pae hinga
We stand and fall together. We stand together
along pathways to healthy futures.*

Ngā mihi

Dr Ashley Bloomfield
Director-General of Health
Te Tumu Whakarae mō te Hauora



He pānui nā te Tumuaki

Kia ora koutou katoa.

Tēnei te tāpae i tā te Manatū Hauora Pūrongo ā-Tau mō te tau 2019/20 i runga i te pārekareka.

Kāore e kore kua tatū ki te aroaro o tō tātou pūnaha mō te hauora me te hauātanga tōna raruraru nui katoa i ō tātou ao i te roanga o te haurua tuarua o te tau pūtea kua hori.



Nōku te hōnore nui rawa atu nei ki te mahi tahi me te hunga e tōngakingaki ana, e whai pūkenga ana anō hoki o roto i te Manatū, puta noa i te rāngai o te hauora me te hauātanga, i te Kāwanatanga me te marea, ki te tautoko i tā te motu rautaki whakakore i a KOWHEORI-19.

I rere te kara a te Kāwanatanga ki a Aotearoa whānui ki te tiaki i te hauora me te oranga o ngā whānau, o ngā hoa me ngā hāpori. Tēnei te whakamānawa rawa atu, tēnei hoki te whakamānaro atu ki te āhua o te piri tahi a te tangata i tā tātou urupare ki te mate urutā. I mahia i runga i te māia me te whakamātāmuri i ētahi kaupapa kē, ā, ko ōna pānga ka rangona i ngā tau tini haere ake nei.

I te roanga o te tau kua hori, kua pāngia a Aotearoa – pērā i ētahi whenua maha o te ao – e te urutā mihara. Nā tēnei mate kaha whakapoke i whakamātautau tō tātou rāngai hauora, heoi, ko taua āhua tonu rā, i mahi tahi tātou ki te whakakore i te urutā.

I whakamātautauria hoki ngā ratonga whawhati tata me ngā ratonga hauora o tō tātou whenua i te aituā o te pahūnga o Whakaari i a Tīhema i tērā tau, i te

haumanutanga i te tini tūroro i whara rā i taua tūāhuatanga kotahi.

Nā te whakapetonga ngoi i ngā tau ruarua kua hori e whakapakari ana i te tū a te Manatū hei kaitiaki mō tō tātou pūnaha mō te hauora me te hauātanga i mārō ai te tuarā ki te waha i ēnei whakataranga kātahi anō ka pā mai.

Ko te whakahuihui me te mahi tahi te pūtake

o te kaiārahitanga, ā, koirā tētahi o ngā wāhanga mātuatua o tā tātou urupare ki a KOWHEORI-19. Kua noho ngā hononga pakari hei tūāpapa mō ā mātou mahi, ā, ka pērā tonu haere ake. He nui ā mātou akoranga i te tau kua hori e mānawatia nei e mātou mō anamata, pērā i te whakamahi i ngā hangarau tahiko hei tautoko i te whakatewhatewha pānga me te uara mātuatua o te tuku pārongo e mārāma ana ki te marea e hua ai ngā putanga pai katoa o te hauora.

I te roanga o te tau kua hori, kua rere tonu tā mātou whakatutuki haere i ā mātou kaupapa mātāmua e whai hua ai ngā tāngata katoa o Aotearoa i te pūnaha o te wā nei. I haumitia e te Pūtea 2019 te \$1.9 piriona hei tautoko i te oranga ā-hinengaro o ngā tāngata o Aotearoa, i whai wāhi rā tētahi whakapikinga nui tonu i te pūtea mō te Hauora mō ngā ratonga e pā ana ki te oranga ā-hinengaro me ngā waranga. Nā tēnei haumitanga i tautoko te whakatinanatanga o tā te Kāwanatanga urupare ki ngā tūtohunga i roto o He Ara Oranga, i te pūrongo o tā te Kāwanatanga Pakirehua i te Oranga ā-Hinengaro me te Waranga.



Kua pukumahi mātou i tēnei hōtaka nui whakarahara ka rere i ngā tau roa. Kei roto i te hōtaka te tuku haeretanga o ngā ratonga kua whakawhānuitia, o te tautoko hoki puta noa i Aotearoa, mā te hunga e pāngia ana e ngā take e āhua māmā ana, e āhua kaha ana anō hoki e pā ana ki te oranga ā-hinengaro. Kua whakatūria hoki e mātou tētahi Tari Ārai i te Whakamomori ki te ārahi, ki te ruruku hoki i ngā mahi ā-motu hei ārai i te whakamomori. E arahina ana aua mahi e He Tapu te Oranga o ia Tangata 2019-2029 me te Mahere Mahi 2019-2024 mā Aotearoa.

Ka whakakapahia te Komihana Tuatahi mō te Oranga ā-Hinengaro me te Oranga Whānui, i whakatūria rā i tērā tau ki te aroturuki i te kokenga o te Kāwanatanga ki He Ara Oranga, ki tētahi Komihana motuhake mō te Oranga ā-Hinengaro me te Oranga Whānui i mua i a Pēpuere o te tau e tū mai nei.

I arotahi te Pūtea 2020 ki te Whakatū Ngātahi, i whai wāhi rā te āpitihanga o ētahi pūtea nui tonu hei tautoko i tā mātou urupare ki a KOWHEORI-19. Heoi, ko te whakataranga nui katoa kei mua tonu i te aroaro, ko te whakaū ake e tōkeke ana tā tātou pūnaha mō te hauora me te hauātanga mō ngā tāngata katoa, e taurite ai te wātea o te haumanutanga, te wheakotanga o te haumanutanga me ngā putanga i te haumanutanga.

Ahakoā ngā kaneketanga, e mōhio ana mātou tērā tonu ētahi āhuatanga e mau tonu ana kāore e taurite ana mō ētahi rōpū,

otirā mō te Māori. Kua kaha te whakarongo a te Whakatewhatewhatanga i ngā Ratonga Hauora me ngā Putanga a Te Rōpū Whakamana i te Tiriti o Waitangi mō ngā nawe e pā ana ki ngā ratonga hauora me ngā putanga ā-motu e whakahirahira ana ki te Māori. I whakaputaina te wāhanga tuatahi o tana pūrongo mō te haumanutanga ā-hauora e mātāmua ana i a Hūrae i tērā tau, i miramira rā te hiahia totoa ki te whakapai ake i te hauora me te oranga o te Māori mā te whai take ake o te mahi ki ngā hāpori Māori, mā te mahi tahi me te kōtuinga.

I miramira hoki te whakatutuki i te tauritenga i ngā putanga i te Arotake o te Pūnaha mō te Hauora me te Hauātanga i whakaputaina rā i a Hune o tēnei tau. Me mahi ngātahi mātou, i runga i te pātuinga, me ngā hoa o Te Tiriti o Waitangi e kitea ai he rongoā, ka mutu koinei tētahi āhuatanga kua whakapau kaha te Manatū kia koke.

E whakapono ana au kei tētahi wāhi e tika ana e tutuki ai i a mātou ngā tūmanako o te Kāwanatanga hei whakapai ake i te hauora me te oranga o ngā tāngata o Aotearoa.

Pai tū, pai hinga.

Ka tū tahi, ka hinga tahi tātou. Ka tū tahi tātou i ngā ara e ahu atu ana ki ngā anamata hauora.

Ngā mihi,
Dr Ashley Bloomfield
Te Tumu Whakarae mō te Hauora
Director-General of Health



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Our 2019/20 at a glance

He tirohanga ki ā mātau whakahaere i te tu 2019/20



More than
400,000
COVID-19 tests
completed



Over
1,000,000
calls, emails, texts
and webchats
answered



1.34 million
flu vaccines
distributed



1 in 10
New Zealanders
used National Telehealth
Services (Healthline)

Help us
find the
virus faster



Do your bit.
Get the app now.
Start using it today.



New Zealand Government

Unite
against
COVID-19

5 new
call centres
set up

500
people
attended
Health Forum 2019



585,000
registered users
of the COVID Tracer App
on 30 June 2020





32 Applications for a medicinal cannabis licence received

213

Ministry staff participated in Te Reo Māori classes

28,000

mental health and addiction sessions delivered for people experiencing distress

13

new full time staff

in youth forensic mental health services



500

Hauora Māori scholarships awarded to support students



Te Nikau, Grey Hospital and Health Centre build completed

\$1 Billion

Dunedin Hospital build started



46,000,000

items of PPE distributed



2,000

more places for Mental Health 101 and Addiction 101 programmes tripling the number of places available

50 years of the Newborn Metabolic Screening test celebrated



195,000 MMR vaccine

doses given out during the Measles Catch-up Campaign



the 1990s, the number of people in the world who are employed in the service sector has increased from 1.2 billion to 2.2 billion, and the number of people in the manufacturing sector has increased from 1.2 billion to 1.5 billion.

As a result of these changes, the world economy has become more service-oriented. The service sector now accounts for 60% of the world's GDP, up from 40% in 1990.

The service sector is also becoming more global. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more competitive. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more important. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more diverse. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more dynamic. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more innovative. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more flexible. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more resilient. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more sustainable. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more inclusive. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more transparent. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more accountable. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more ethical. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more responsible. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more trustworthy. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more reliable. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

The service sector is also becoming more secure. The number of people working in the service sector in the United States has increased from 1.2 billion in 1990 to 1.5 billion in 2000.

**Who we are and
what we do**

**Ko wai mātou,
he aha ā mātou
mahi**







The health and disability system

New Zealand Aotearoa's health and disability system is complex and cooperative with a uniquely New Zealand approach to biculturalism through Te Tiriti o Waitangi (the Treaty of Waitangi).

Vote Health

We are guided by the Government's priorities for our health and disability system. Vote Health is the primary source of funding for New Zealand's health and disability system, which includes the Ministry.

New Zealand's 20 district health boards (DHBs) carry out most of the day-to-day business of the system and administer nearly three-quarters of the Vote. In fulfilling their responsibilities, they plan, manage, provide and purchase health services for the population of their district, implement the Government's health and disability policy and ensure services are arranged efficiently and effectively for all New Zealanders. This includes funding for primary health care, hospital services, public health services, aged care services and services provided by other non-governmental health providers, including Māori and Pacific providers.

For the remaining part of the Vote, almost 20 percent goes towards delivering other health and disability services and almost 3 percent provides support, oversight, governance and development, with the aim of maintaining and

enhancing the quality of delivery of the sector. Just over 1 percent of the Vote is for Ministry operating costs.

The system extends beyond the Ministry and DHBs to ministerial advisory committees, the Accident Compensation Corporation and other health Crown entities, community based health and disability service providers, public health units (within some DHBs) and private providers (including Māori and Pacific providers). Professional and regulatory bodies for all health professionals are another part of the system. Many non-governmental organisations and consumer bodies also provide services and advocate for the interests of various groups.

The Health portfolio is led by a Minister and three Associate Ministers.

Health and disability policy choices are complex and challenging. The Ministry, as the lead advisor to the Government on health and disability issues, provides clear and expert clinical, technical and practical advice to the Minister of Health and Associate Ministers of Health, supported by strong, evidence-informed analysis.



Our kaitiaki responsibilities

As kaitiaki of the health and disability system, we have the role and responsibility of stewards to sustain, nurture, grow and develop the system.

- Sustain: We understand the strengths in the current environment and how to keep them going.
- Nurture: We identify the vulnerable areas that require more specific help and ensure that help is provided.
- Grow: We manage and provide for innovation to address rising demand and expectations for high-quality service.
- Develop: We understand and provide for the long-term future of the health environment.

As kaitiaki, we provide free and frank advice about effective interventions. We fund an array of national services (including disability support services and public health services) and provide clinical and sector leadership. We legislate and regulate, enforce, measure, monitor and evaluate as well as providing ongoing reviews of evidence about effective interventions. We set expectations and accountability requirements, fund national services and ensure that we meet New Zealand's international health and disability obligations.

We bring together the policies to improve, protect and promote the health of New Zealanders and to increase health equity. Our responsibilities traverse the whole lifespan of health and wellbeing – from maternity and childhood, through to palliative care and old age – and includes disability.

Our role as Manatū Hauora | Ministry of Health

We work collaboratively with our partners, which include DHBs, other Crown and government entities, community providers and non-governmental organisations. Collectively, we strive to improve health outcomes and increase health equities for the people of New Zealand Aotearoa.

We employ over 1,250 staff based across seven locations in Aotearoa New Zealand. Our people work on a wide range of activities – covering policy, regulation, operational matters, readiness and response, innovation, improvement and clinical development – to support New Zealand's health and disability sector.

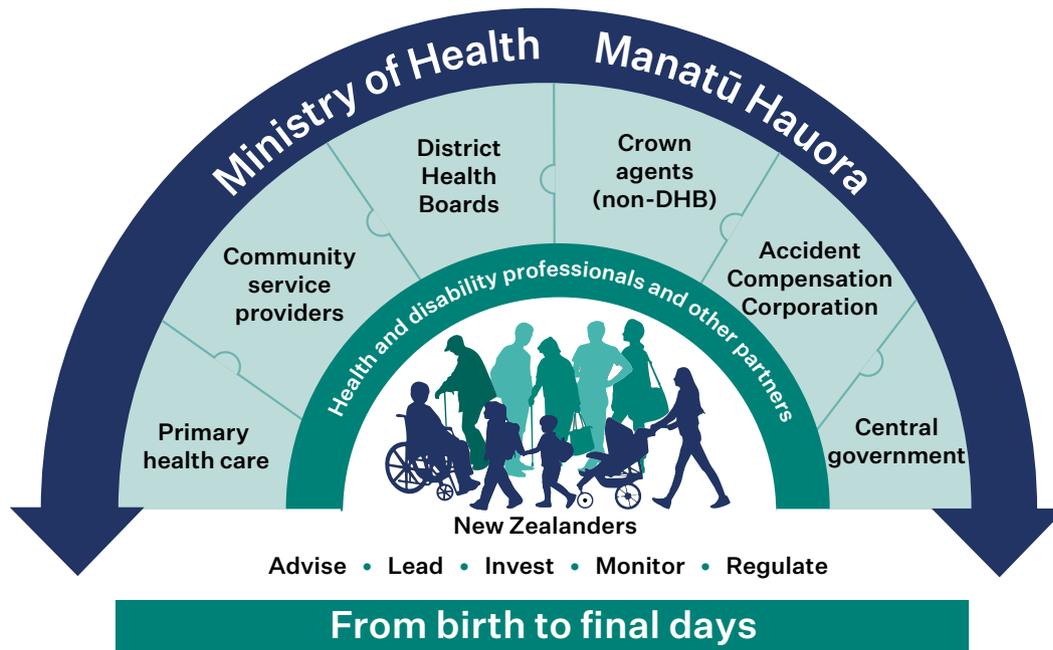
Our role is to improve, promote and protect the health and wellbeing of New Zealanders. We deliver key work programmes, to transform health and disability services, develop policy and schemes for health-related referendums, run major capital projects and put equity at the centre of our work.

Our 2019/20 year was momentous, seeing unexpected events arise for our nation that required us to pivot our attention and change the focus of our work. For example, COVID-19 saw new functions stand up overnight and others completely change.

Our people and those across the health and disability system have led with courage, tenacity, resilience and authenticity. We demonstrated our values and delivered on our commitment to a fair, effective and sustainable system that people trust.



Figure 1: Our role in the health and disability system





Health and Disability System Review

The Health and Disability System Review (the Review) was established in July 2018 and considered the overall function of the health and disability system with the aim of better balancing it towards wellness, access, equity and sustainability.

The outcome

Hauora Manaaki Ki Aotearoa Whānui Pūrongo Whakamutunga (Health and Disability System Review Final Report) was released in June 2020. The Review paints a broad and detailed picture of the future of the health and disability system. The focus of the analysis and recommendations in the report has been on the changes that have the potential to leverage the strengths of the current system to learn and evolve over the next 10 years.

What the Review's findings mean for the Ministry

The Ministry's role as kaitiaki of the health and disability system remains unchanged. We've done a great deal of work since the Review was commissioned and three immediate priority areas are well on their way to delivering:

- COVID-19 response and delivering the Government's elimination strategy
- improving DHB performance
- implementing the Government's response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*.

We have also identified seven priority focus areas based on the lessons learned from the COVID-19 response, which are the basis of the Ministry's work programme for 2020/21. These focus areas are:

- commissioning for better health outcomes for Māori and all New Zealanders
- strengthening system leadership
- strengthening public health services
- having a modern, digitally enabled health system
- improving delivery of primary care
- investing in intelligence and insights
- strengthening the focus on system quality and safety.

A Ministerial Group consisting of the Prime Minister, Ministers of Finance and Health and the Associate Minister of Health is being established, along with a Ministerial Advisory Group. The Department of the Prime Minister and Cabinet will lead the response and coordinate the change programme.

We will continue to support the Government through this process and provide advice as required.



Our core business

The Ministry is funded to provide the following core business functions as an agency within the health and disability system and as kaitiaki of the system.

Procurement of New Zealand's health and disability services

The Crown gives us the responsibility of procuring health and disability services from both Crown entities and other providers. We act on behalf of the Crown to enter into new or renewed contracts for services such as the National Screening Unit, disability support, ambulance, maternity, public and primary health services.

Payment services

Our payment services system administers and manages the agreements between health funding organisations and service providers. We track the entitlements that health care consumers access and we respond to queries and service requests from funders, providers and users of health care. In 2019/20, we received 399,063 telephone enquiries about payments.

Regulatory and enforcement services

We ensure health products, services and premises are safe and meet international and legal obligations. We issue licences and certifications. We coordinate public health protections and provide advice, manuals, training and guidelines to support the sector to comply with legislation. We appoint

members to statutory committees and regulatory authorities.

Sector planning and performance

We are responsible for funding and monitoring DHBs and other health Crown entities. While working with them so they can improve performance and meet deliverables, we also measure service levels and financial sustainability. We lead our sector responses to national health emergencies and work with other agencies to ensure our communities are safe and our key services can function in any situation.

Policy advice and ministerial servicing

We provide policy advice on a range of issues impacting the health and disability sector and the health of our populations. We prepare draft correspondence and briefings for Ministers and responses to parliamentary questions and Official Information Act 1982 requests.

Capital expenditure

We manage the renewal, upgrade and redesign of digital and physical assets used in the delivery of core functions and responsibilities.

Health sector information systems

We are responsible for the technology and digital services that underpin the national data collections and systems used across the health and disability system.



Our Strategy | Tā Tātou Rautaki

Our mission as kaitiaki of the health and disability system in New Zealand Aotearoa is to ensure that the health and disability system is fair, effective, sustainable and trusted by New Zealanders.

To achieve our mission, we set four strategic objectives we want to reach over the next five

years. This report sets out our performance in Year One (2019/20) against these. We also identified six objectives that will ensure we have the organisational capability to deliver the strategy.

Our five-year organisational strategy gives us direction to ensure we fulfil our role in achieving **pae ora – healthy futures**.



Our values | Ngā Ūaratanga

Our culture is guided by our values and informed by our rich history, our current context and our experience of how we work together to solve problems and deliver on **Tā Tātou Rautaki | Our Strategy**.

This year, we worked with our people to develop new organisational values that will support us to deliver our strategy, help shape our culture and reflect our organisational identity.

Our people are diverse, innovative, talented and dedicated, with a wide range of skills and experience. Our values guide how we work together within the Ministry, across the health and disability system, across the broader state sector and with communities to achieve Pae ora – healthy futures for all New Zealanders.

Our values guide us as we continue to respond to the COVID-19 pandemic and deliver key work programmes to ensure the health and disability system delivers for all New Zealanders.

Our Ministry values | Ngā Ūaratanga



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*



Responding to the COVID-19 pandemic

Mā tātau katoa e ārai atu te COVID-19

The response to the COVID-19 pandemic saw the rapid establishment of new teams, new responsibilities and significant changes to existing core functions in the Ministry of Health. Right from the beginning, we've been flexible and responsive, shaping our services and functions to meet the needs that each Alert Level created for New Zealand, always looking ahead to the longer-term response.

In New Zealand we've seen the impact of our significant public health measures and have adapted our workforce to meet changing needs.

We've supported New Zealanders on their journey home and managed isolation and quarantine facilities. We organised the procurement, storage and distribution of more than 46 million pieces of personal protective equipment (PPE) for the sector. Previously, we'd have managed just one million pieces of PPE a year.

We've created technological solutions to support the response in very short timeframes, using modern, agile, iterative methods. We've invested in data and surveillance and achieved record levels of investigation, contact tracing and testing.

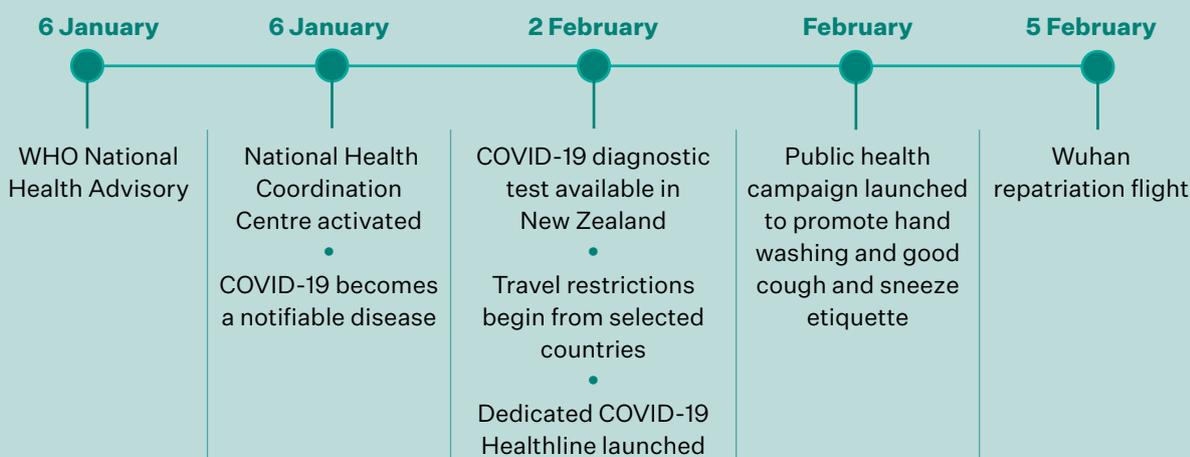
COVID-19 – the essential facts

Coronaviruses are a large and diverse family of viruses that cause illnesses such as the common cold, severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS)

COVID-19 is caused by a new type of coronavirus that can affect your lungs and airways.

The symptoms of COVID-19 are similar to common illnesses such as a cold or influenza. Symptoms can take up to 14 days to show after a person has been infected. Before the person knows they have it, they can pass on the virus to others – this can happen from up to two days before symptoms develop.

A range of community health services stepped up to work in extraordinary new ways. Community pharmacies remained open during levels 3 and 4 to ensure on-going access to essential medicines. General practice transformed virtually overnight to deliver online consultations in record numbers



and also moved to electronic prescription services.

The Ministry’s people worked hard to do whatever needed doing, working around the clock, across teams and agencies, sometimes in uncharted waters. We’ve found new ways of working at home and in the office and worked closely with our colleagues across the public sector.

We are all in the same boat He waka eke noa

After the World Health Organization (WHO) was advised of a mystery virus in China, within a week the Ministry of Health had issued a national health advisory, prepared Healthline to answer questions and started closely monitoring the situation.

By the end of January 2020, WHO had declared COVID-19 a public health emergency of international concern and we had activated the National Health Coordination Centre (NHCC). From January to May 2020, more than 250 people from across the Ministry and other agencies worked around the clock in the NHCC.

The NHCC carried out a range of functions:

- gathering intelligence and monitoring the situation overseas and in New Zealand
- coordinating border control

- coordinating internationally with the WHO and other countries
- providing advice and guidance to the health and disability sector
- enforcement
- supply chain logistics.

As at 30 June 2020



completed
402,000
COVID-19 tests



Grown lab capacity to conduct over
13,000 tests
per day



Distributed over
46 million
items of PPE to DHBs,
the wider health and disability system
and other essential services

28 February

First confirmed case of COVID-19 in New Zealand

29 February

Health staff begin to meet international arrivals at the border

9 March

COVID-19 becomes a quarantinable disease

12 March

All of Government National Crisis Management Centre activated

14 March

Cruise ships banned in New Zealand waters
• All arrivals from overseas required to self-isolate



We created new functions to support the response.

We supported New Zealanders to come home

Early in the response, we worked with the New Zealand Defence Force, New Zealand Police, Ministry of Foreign Affairs and Trade and the New Zealand Red Cross to repatriate 157 New Zealanders from Wuhan, China. The cross-agency team established a quarantine site at the military base in Whangaparaoa and housed the returnees in 200 campervans. The returnees received daily medical checks and regular needs assessments to identify pastoral, financial and post-stay requirements.

Later in the response, we worked with other agencies to establish managed isolation and quarantine facilities for all people arriving in New Zealand. All arrivals now complete two weeks of managed isolation in a hotel in Auckland, Hamilton, Rotorua, Wellington or Christchurch. Each arrival receives a COVID-19 test on day three and day twelve of their stay. The Ministry decides on the outcome of any applications for exemption from quarantine or managed isolation.

We established contact tracing

Effective contact tracing is an essential component of New Zealand's COVID-19 response. Contact tracing comprises

three distinct phases: case investigation (traditionally the work of public health units), contact tracing and follow-up of cases and close contacts. Our National Contact Tracing Service now links the work of all public health units. We worked with them to greatly increase our collective capacity for case investigation across the country.

Normally, it would take years to develop new technology platforms. We used an agile approach to develop a cloud-based contact tracing technology platform in just weeks. It enables all public health units to securely transfer case information to the contact tracing service and the contact tracing workforce can work remotely if necessary.

We now have 300 trained government agency staff who will be deployed if a significant spike in COVID-19 cases occurs that is beyond the capacity of the public health units to manage.

We developed the COVID Tracer app

NZ COVID Tracer is an app that allows you to create a digital diary of places you visit by scanning an official QR code as you enter. It helps contact tracers quickly identify and isolate anyone who may have been exposed to COVID-19. This app was also developed within weeks, using iterative approaches.



NZ COVID Tracer App had



**200,000
registered users**

**on the day it went live
(20 May 2020)**



**300,000
registered users**

by the end of the first week



**585,000
registered users**

by 30 June



**75,776
QR posters**
created by 30 June



**1,302,363
total poster scans**

by 30 June

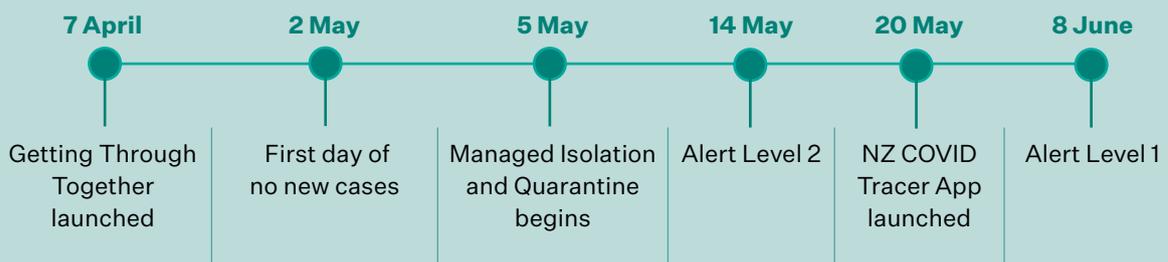
We managed the supply of personal protective equipment (PPE)

PPE is equipment such as face masks, eye protection and gloves that is worn to reduce everyday risks in the workplace. For a range of activities, wearing PPE in the correct way can reduce the risk of transmission of infection.

We manage the procurement and distribution of PPE for New Zealand's publicly funded health workers. With this approach, stocktaking and management of supplies occurs at a national level, so PPE can be available where it is needed. Usually, we'd invest around \$25 million a year in PPE. By 30 June 2020, we had invested around \$200 million to procure, store and distribute more than 46 million items of PPE, and had another 165 million items on hand.

We stood up Community Based Assessment Centres (CBACs)

CBACs are one of the services planned for responding to a national health emergency, especially when existing primary and home-based services are overwhelmed. Staff at CBACs provided clinical assessment, advice, triage and referrals to other services. They could provide prescriptions and a limited range of medicines to individuals. CBACs reduced the load on hospitals and protected other personnel from increased exposure to COVID-19.



We provided oversight and funding to ensure CBACs were set up, prepared and fit for purpose at each Alert Level, ensuring access to health care for vulnerable populations and reducing inequities.

We led the public health compliance framework

We led development of an all-of-government compliance framework as part of the Government's overall strategy of preventing the spread of COVID-19 and prioritising targeted enforcement and compliance activities. This framework covered matters like what activities could occur at each Alert Level.

We introduced new workforce initiatives

We established a portal to connect health and disability workers with sector employers who needed to employ extra workers during the COVID-19 response. More than 3,700 workers registered an interest to work and 25 employers used the service.

We funded training with Careerforce for the first 100 people who were interested in transitioning to a role as kaiāwhina (assistant, helper, contributor) during the COVID-19 response.

We created the Āwhina app to provide health and disability workers with the most up-to-date COVID-19 information. More than 4,000 people used the app. By September 2020 that number had risen to 15,000 health workers. In August over 83,000 health articles were viewed through the app.

We increased testing capacity

In the early response to COVID-19, our testing capacity was just a few hundred tests a day. Now, our laboratories can manage up

to 13,000 tests a day. More than 400,000 COVID-19 tests were completed in the year.

We provided advice and guidance

We provided advice and guidance to New Zealanders, the health and disability sector and the Government. We had public health experts from across the country and around the world supporting us and we repurposed our Technical Advisory Group to support our COVID-19 response.

We established a Māori Reference Group and Māori Monitoring Group to support and provide insights to the Ministry's COVID-19 response for Māori. Membership of these groups includes Māori academics, clinicians, providers, Tumu Whakarae and community members.

One in ten New Zealanders contacted our National Telehealth Service during the year. We provide telehealth services through phone, text, email and web chat, which this year received more than a million inbound contacts.

New telehealth services were established to respond to the surge in demand that COVID-19 generated. Some of these services handled inbound enquiries from the public, while others made outbound calls to check on people self-isolating. We also created a dedicated call centre to provide additional advice and support to community health providers and clinical workers.

We provided advice and guidance to the sector on a range of matters related to COVID-19 and updated infection prevention control guidelines for various health and disability settings. We continue to evolve these guidelines with our sector partners.



**New Zealanders
made more than
1 million
inbound contacts
to us in the year**

**Those contacts came from
556,933 people
(1 in 10 people in New Zealand)**

**We also made
215,000
outbound contacts**

**207,325
COVID-19 contacts
were answered in the
four months between
1 February and 30 June 2020**

The National Telehealth Service also provided a local targeted response in December 2019 following the Whakaari/ White Island volcanic eruption. Telehealth services worked with local iwi, the Bay of Plenty community and tourists to provide health advice and support where needed, including in relation to paperless prescribing in primary care, community and outpatient settings.

Health and wellbeing during COVID-19

We developed a COVID-19 Health and Wellbeing Survey, which started collecting information about people's health and wellbeing on 30 March 2020, just four days after New Zealand moved to Alert Level 4. It asked 300 respondents a day to rate their current health and wellbeing, along with their understanding of and compliance with the Alert Level rules.

Key results from the COVID-19 Health and Wellbeing survey

over the period
30 March to 14 June 2020
(covering Alert Levels 4 and 3),
the proportion of respondents
who:

•
**reported being in good health
remained stable, rising slightly
from 89 to 94 percent**

•
**reported meeting sleep duration
recommendations
remained stable, rising slightly
from 68 to 74 percent**

•
**reported experiencing
anxiety or depression symptoms
decreased from
13 to 6 percent**

•
**felt lonely or isolated
decreased from a high of
38 percent
during the week ending 19 April to
18 percent
during the week ending 14 June**

•
**were worried about the risk
of getting COVID-19
decreased from
39 to 14 percent**

The results were used to understand what additional support and information New Zealanders needed around COVID-19.

In May 2020 we published *Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Recovery Plan*. The plan provides a framework for collective actions across sectors to support whānau and



communities to adapt and thrive over the next 12 to 18 months. It draws on the directions for mental wellbeing set by the Government's response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*.

Our response to COVID-19 continues

Responding to COVID-19 has become a long-term function for the Ministry of Health. We have created a new directorate within our structure to lead the ongoing response, which will include contact tracing, supply chain, border control, managed isolation and quarantine and New Zealand's elimination strategy.

We are part of the Access to COVID-19 Tools (ACT) Accelerator, the global platform dedicated to finding a vaccine. We will advocate for equitable distribution of the vaccine and ensure our neighbours in the Pacific are able to access it when needed.

We are also enhancing our national immunisation programmes and technology so that we can effectively roll out COVID-19 vaccinations when they are available, including free online vaccinator training to support a larger workforce for a COVID-19 vaccination campaign.



**Our
performance
outcomes**

**Ā mātou
putanga ā-mahi**







Tā Tātou Rautaki | Our Strategy represents a shift in delivering the Government’s wellbeing approach and partnering with others to promote equity, sustainability, safety and innovation for all people in the health and disability system.

We have used the new strategy framework to structure our 2019/20 Annual Report, enabling us to tell our performance story in the context of our new objectives.

We have reported on some of the indicators outlined in the *Statement of Strategic*

Intentions 2017–2021 within the new framework and in Appendices 1 and 2. Over the next year, we will establish a new set of indicators aligned to our new strategic direction.



Improved equity in health outcomes and independence for Māori and all other people

Te tauritenga kua pai ake, i ngā putanga hauora me te motuhaketanga ki te Māori me ērā atu tāngata katoa

People have differences in health and independence that are not only avoidable but also unfair and unjust. We will understand where people face inequities and create innovative approaches to address them. This involves prioritising the health and independence of Māori and other groups experiencing inequity and working together to address the social, economic and behavioural determinants of health.

Health equity means ensuring that everyone can access the health system and achieve good health outcomes. Health equity is focused on supporting fair access, fair chances and fair resource distribution to alleviate any disadvantage people experience.

It is about everyone in the community having the necessary knowledge, skills and resources to achieve and maintain good health and wellbeing. It is about having the right services provided in the right ways and in the right places for different groups so they can have good outcomes. It is about ensuring that no social, economic or behavioural barriers stop individuals and communities from being able to improve their health and wellbeing.

In Aotearoa New Zealand:

the burden of health loss falls inequitably on Māori, in terms of poor health, disability and premature death. Differences in the determinants of health and wellbeing, differential access to health care and differences in the quality of care in health

outcomes for Māori contribute to this inequity. (Walsh and Greg 2019)

This year, to improve health equity . . .

we progressed the Waitangi Tribunal Wai 2575 process

Initiated in November 2016, the Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575) will hear all claims concerning grievances relating to health services and outcomes of national significance for Māori.

As of June 2020, approximately 220 claims were seeking to participate in the Health Services and Outcomes Kaupapa Inquiry. The claims cover both historical and contemporary concerns over a range of issues relating to the health system, specific health services and outcomes including health equity, primary health care, disability services and mental health and alcohol, tobacco and substance use.

The outcome of the Wai 2575 inquiry will have a significant impact on the provision, funding and accountability of health and disability services for Māori.

we reduced general practice fees

As at June 2020, over 97 percent of Community Service Card (CSC) holders and their dependants were enrolled with a general practice offering low-cost visits (less than \$20 for a standard visit). Among enrolled CSC holders who are Māori, Pacific or considered



high-needs, 99 percent now benefit from low-cost visits to their general practice. Enrolment rates are similar among children aged under 14 years.

We are now doing further work to find ways of improving accessibility for those who are eligible but are not automatically issued a Community Services Card.

we supported Generation 2040

The Ministry supports the Generation 2040 programme, led by the National Hauora Coalition. Generation 2040 is a whānau-centred strategy to give tamariki Māori the best start in life by providing comprehensive access to high-quality services as a way of achieving equity of outcomes for māmā (mums) and pēpi Māori (babies).

The Best Start Pregnancy Assessment tool was developed to support clinicians to provide a thorough assessment and referral process early in a woman's pregnancy so that she is connected with the range of services to which she is entitled. A crucial part of this process is supporting the woman to engage with a lead maternity carer as soon as possible in her pregnancy.

we developed an action plan for Pacific health

Pacific health has been a priority for the New Zealand health system since we published the first Pacific Health and Disability Action Plan in 2002. During the year, we held talanoa (community discussions) around New Zealand, as a way of engaging with more than 500 Pacific church and community leaders, local community groups and academics and Pacific representatives from local government, the health and disability sector and other government agencies.

From there, we developed and launched *Ola Manuia: Pacific Health and Wellbeing Action*

Plan 2020–2025. It sets out the following priority outcomes and accompanying actions for the next five years, through which Pacific peoples:

- lead independent and resilient lives – which we achieve by strengthening the health knowledge and skills of Pacific people to make informed choices about their health and wellbeing
- live longer in good health – which we achieve by changing the health and disability system to deliver more responsive, more accessible and high-quality services for Pacific families
- have equitable health outcomes – which we achieve by strengthening actions with government and across sectors to create environments that improve health equity for Pacific communities.

We will use these outcomes in planning, prioritising and delivering action to improve health equity for Pacific peoples.

we led part of the Mahi Aroha: Carers' Strategy Action Plan

Mahi Aroha: Carers' Strategy Action Plan 2019–2023 is a cross-government action plan to support carers. The Ministry of Health leads or co-leads the actions of:

- identifying and assessing best-practice options for supporting people and their carers with managing continence
- strengthening navigation across all parts of the care and support system to ensure that carers know about and can access available assistance for themselves and those they care for
- improving the quality, accessibility and equity of services so carers can take breaks.





Whakamaua

The Māori Health Action Plan 2020–2025

Whakamaua has been developed alongside Māori academics and researchers, health and disability professionals, iwi and rangatahi leaders.

Whakamaua means ‘to secure, to grasp, to take hold of, to wear’. It is also widely associated with the whakatauki used in this plan ‘ko te pae tawhiti, whaia kia tata. Ko te pae tata, whakamaua kia tina’ – seek out the distant horizons, while cherishing those achievements at hand.

Whakamaua focuses on four high-level outcomes.

1. Iwi, hapu, whanau and Māori communities can exercise their authority to improve their health and wellbeing.
2. The health and disability system is fair and sustainable and delivers more equitable outcomes for Māori.
3. The health and disability system addresses racism and discrimination in all its forms.
4. The inclusion and protection of matauranga Māori throughout the health and disability system.

Whakamaua emphasises the shared responsibility for Māori health and wellbeing. The vision of He Korowai Oranga and the objectives of Whakamaua will be achieved through action across the whole health and disability sector, government and communities.

Whakamaua will be a living document with the ability to evolve to ensure it meets existing and emerging needs. The Ministry of Health will measure and report progress regularly as the plan moves forward, using both quantitative and evaluative measures.



we delivered the influenza immunisation programme

Influenza is a significant public health issue in New Zealand, affecting between 10 and 20 percent of New Zealanders each year. Some people become so ill they need hospital care and a small number die. Influenza can have ongoing negative health impacts for those at highest risk and creates significant pressure on hospital resources every winter.

During the 2019 influenza immunisation programme (1 April 2019 – 31 December 2019), 1.34 million vaccines were distributed. This was an increase of 20,000 vaccines from 2018. Immunisation coverage for Māori, Pacific peoples and people aged 65 and over was higher than in the previous year.

We will report the results of the 2020 influenza immunisation programme in the 2020/21 annual report.

we engaged with the disability community

During September and October 2019, we travelled to 10 regions, held 20 community conversations, hosted a nationwide livestream event and engaged with more than 1,000 people to better understand the issues the disability community faces and the impact of disability support services.

We joined the cross-government Disability Action Plan 2019–2023, which was co-designed by disabled people, their representative organisations and government agencies. The Ministry of Health leads or co-leads six of the 25 Disability Action Plan work programmes, which focus on:

- transforming the disability support system
- repealing and replacing the Mental Health (Compulsory Assessment and Treatment) Act 1992

- improving access to high-quality health care and improving the health outcomes of that care
- exploring the framework that protects bodily integrity
- Funded Family Care
- reducing the use of seclusion and restraint (with the Department of Corrections).

we implemented Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan

We continued to work with te ao Māori leaders to develop initiatives to create a liberating environment that enables tāngata whaikaha (people who identify as having a disability) to shape the direction of their own lives.

This work has promoted participative decision-making with tāngata whaikaha in health care planning, funding and delivery. As a result, it has modified the effects of being vulnerable and marginalised on this community by protecting their rights to participate in and partner on solutions for tāngata whaikaha.

we supported programmes through Te Ao Innovation Fund

This year, Te Ao Auahatanga Hauora Māori: the Māori Health Innovation Fund allowed us to support 18 diverse Māori health innovation programmes throughout Aotearoa New Zealand. Programmes, which are in the testing and implementation stages, include whānau ora approaches to service delivery across:

- alcohol and other drugs
- youth suicide prevention
- youth mental health
- child and parent wellbeing improvement in holistic care through whānau ora approaches for Māori.



we have been active in Enabling Good Lives

As kaitiaki of the disability system, we continue to transform the way that we support disabled people and their families and whānau, to give them greater choice and control over their lives and their supports. Applying the vision and principles of Enabling Good Lives, we have:

- piloted transformation programmes in the MidCentral, Waikato and Canterbury DHB regions, including trials that support disabled people to take strong governance and leadership roles
- completed an evaluation of the outcomes of the MidCentral prototype (including a baseline study and implementation evaluation) to help us to understand what difference the new system has made for disabled people and their families and whānau over time.

Enabling Good Lives received the Leadership in Governance award in the public sector Spirit of Services Awards 2019.

The Enabling Good Lives vision, principles and approach focus on creating a system that:

- puts disabled people in control of their lives
- invests early in people's lives
- is person-centred
- promotes ordinary life outcomes
- supports people to access mainstream services
- is mana enhancing
- is easy to use
- builds relationships.

we expanded access to and choice of primary mental health and addiction support

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction called for an increased focus on early intervention, particularly for those with mild to moderate mental health and wellbeing needs. In line with this vision, the Ministry is rolling out new primary mental health and addiction services across New Zealand over five years. This work has different streams to make support available in a range of settings, including general practices, kaupapa Māori services and Pacific and youth settings.

This year saw the first new front-line primary mental health and addiction services roll out across general practices throughout New Zealand. In their first year of operating, these services together delivered nearly 28,000 sessions for people experiencing distress.

As part of our focus on engaging with communities, we held five regional roadshows, a series of hui attended by over 700 Māori whānau from across the country, and 14 Pacific fono. This engagement has delivered valuable insights that have informed our decisions about the core elements of new kaupapa Māori and Pacific primary mental health and addiction services. While COVID-19 has inevitably led to delays, the new kaupapa Māori, Pacific and youth services are now being established in a number of places across the country.

We continue to expand these services and to build new early intervention options to ensure that New Zealanders can access responsive mental wellbeing support, when and where they need it.



we enhanced specialist, crisis and forensic mental health services

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction was also clear that we continue to have a special responsibility to New Zealanders with the highest mental health needs.

In response, the Ministry is delivering a number of initiatives to strengthen our specialist mental health services. One focus is on improving mental health crisis responses across all 20 DHBs in New Zealand. Another involves exploring new approaches to supporting people who are acutely distressed or experiencing a mental health crisis, by using integrated models of community support that include clinical, peer and iwi health workers.

The Ministry has also invested in DHBs to strengthen forensic mental health services for youth and adults, resulting in:

- 13 new full-time staff in youth forensic mental health services
- 10.75 new full-time staff in adult forensic mental health services
- additional support available for prison in-reach services provided by the five Regional Forensic Mental Health Services.

we developed the resilience, diversity and skills of the mental health and addiction workforce

The development of a resilient, diverse and skilled workforce is crucial to delivering the Government's response to He Ara Oranga. We have increased the number of registered nurses, social workers and occupational therapists practising in mental health and addiction and increased the number of funded psychology interns.

We are increasing the scholarships and bursaries for Māori and Pacific students who are pursuing a career in mental health.

We are funding more than 100 new training places for postgraduate study in specialist practice areas, including in clinical leadership, cognitive behavioural therapy, infant, child and adolescent mental health and addiction, co-existing substance use and mental health and forensic youth and adult mental health.

We increased the number of places available for primary care nurses to achieve credentials in mental health and addiction and we more than tripled the number of people who can undertake the Mental Health 101 and Addiction 101 programmes, making more than 2,000 extra places available in 2020. We have more than doubled the capacity of cultural competency programmes, with over 800 new places on offer in 2020, to ensure Māori and Pacific peoples receive culturally-appropriate support when they need it.

we supported the Māori Provider Development Scheme

This year we supported 95 Māori providers in their individual areas of development including strategy, governance, service design, information technology and financial management. Providers have until December 2020 to complete their targeted development.

A review of the Māori Provider Development Scheme completed this year confirmed that while the funding for each individual provider was not significant, it often was the only funding source available to them for undertaking development activities to improve their capability and capacity and therefore it is a highly valued contribution. We plan to do further work to refine the scheme so that it keeps up with changes and matches the current needs of the sector in today's environment.



we worked towards minimising alcohol, drug and gambling addiction harm

While we continue to focus on increasing capacity for specialist alcohol and other drug services, *He Ara Oranga* called for strengthening community services, ensuring sustainability and policy and legislative reform.

The next four years will see us focus on residential care, managed withdrawal (detox) and continuing care to support sustainability for non-governmental organisations.

This year we have invested in a number of initiatives to address addiction, including:

- an alcohol and other drug peer support service in Taranaki DHB
- Odyssey House Auckland, to continue Haven, an after-hours drop-in support space
- additional new specialist alcohol and other drug services.

For more information, see our review: *Mental Health and Wellbeing: Year one – building foundations and momentum*
[health.govt.nz](https://www.health.govt.nz)

we collaborated on Healthy Active Learning

Children's nutrition and physical activity is linked to academic achievement and improved physical and mental health.

Sport NZ has 34 people working in schools to provide teacher professional development, supporting them to implement the health curriculum.

The Ministry of Health has 30 full-time staff helping schools and early learning centres to introduce a healthy food and drink policy.

we updated the Healthy Ageing Strategy priority actions

The Healthy Ageing Strategy 2019–2022 presents a strategic direction for change and a set of actions to improve the health of older people into and throughout their later years. This year we have implemented a nationwide programme of falls and fracture prevention and treatment initiatives. We have also increased pay equity funding in aged residential care by 11 percent between 2018 and 2020.

The *National Framework for Home Care Support Services* was approved in November 2019. By July 2022, this framework will see all DHBs delivering these services as consistently as possible, with regional specifications removed. It will also establish a nationally consistent method for resource allocation, greatly reducing the regional variation in care and support of older people.

In the future we will establish measuring and monitoring processes, with a focus on improving wellbeing and social connectedness in the community, developing quality and sustainability models of care and improving support for carers.

we supported the Joint Venture on Family Violence and Sexual Violence

Our work contributes to the cross-agency programme to prevent family violence and sexual violence, reduce the harm it causes and break the cycle of re-victimisation and re-offending.

This year, we have:

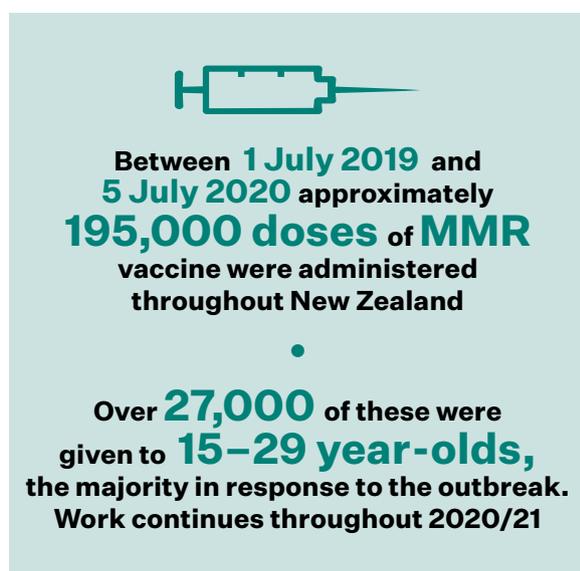
- developed *Information Sharing Guidance for Health Professionals*. The Ministry worked with the Accident Compensation Corporation, Ministry of Justice and Oranga Tamariki on distribution lists to ensure all health providers would receive this guidance and other updated information



- implemented funding increases for the Violence Intervention Programme
- introduced a pre-training module, 'Understanding the dynamics of family violence', for health professionals engaged in the Violence Intervention Programme
- scoped work on a response to family violence in primary care settings
- supported reorienting the Joint Venture's priorities and response in relation to COVID-19.

we launched a Measles Catch-up Campaign

The measles outbreak of 2019 infected more than 2,000 people in New Zealand Aotearoa. Samoa also had an outbreak during which, sadly, 80 people – mostly young children – died. In New Zealand Aotearoa, measles disproportionately affected Māori and Pacific young people in the Auckland region.



Between 1 July 2019 and 5 July 2020 approximately 195,000 doses of MMR vaccine were administered throughout New Zealand

Over 27,000 of these were given to 15–29 year-olds, the majority in response to the outbreak. Work continues throughout 2020/21

The National Measles Immunisation Campaign aims to equitably improve measles immunity for those aged 15–29 years, reduce the risk of future outbreaks and strengthen our immunisation system. Having more widespread immunity among the population

will help reduce the transmission of measles in the community and prevent future outbreaks.

we reviewed the Well Child / Tamariki Ora programme

In reviewing the Well Child / Tamariki Ora programme this year, we have identified ways of improving both the infrastructure and the delivery of the programme. These improvements will support the continuity of services and a more equitable, responsive programme for children and whānau.

we strengthened road and air ambulance services

This year we have worked with our emergency road and air ambulance providers to ensure that essential services continued to be available to New Zealanders throughout the COVID-19 lockdown.

We made safety improvements to the air ambulance fleet with the removal of the last single-engine helicopter from service in November 2019. This has also improved equity because, no matter where people are in New Zealand Aotearoa, they will be able to receive comprehensive clinical care in-flight. In addition, planning for phase two of the 10-year reconfiguration of the air ambulance service has begun, with a focus on modernising the national fleet.

Since the introduction of data collection and reporting to the sector, performance is now more visible, while the introduction of performance measures has brought continuous quality improvement to the sector. The proportion of those reaching performance targets for day activation times within 10 minutes has improved from 76 percent to 81 percent this year, while the achievement of night activation times of 20 minutes has improved from 85 percent to 90 percent.





Mental Health and Wellbeing Commission

Aim

The Government is establishing an independent Mental Health and Wellbeing Commission as part of its response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*.

The Commission will provide system-level oversight of mental health and wellbeing in New Zealand. It will hold the government of the day and other decision-makers to account for the mental health and wellbeing of people in New Zealand Aotearoa.

The Initial Mental Health and Wellbeing Commission

While the permanent Commission is being established as an independent Crown entity, the Initial Mental Health and Wellbeing Commission (the initial Commission) will undertake some, but not all, of the functions of the permanent Commission. In September 2019 the members of the initial Commission were announced and began their functions.

What this initiative means for New Zealanders

This new independent Crown entity will contribute to better and equitable mental health and wellbeing for people in New Zealand Aotearoa. The initial Commission is laying the groundwork for the permanent Mental Health and Wellbeing Commission, which will begin operating in February 2021, following legislation and establishment work to set up the Crown entity.

The initial Commission will:

- provide independent scrutiny of the Government's progress in improving New Zealand's mental health and wellbeing
- promote collaboration between mental health and wellbeing entities
- develop advice for the permanent Mental Health and Wellbeing Commission, including a work programme, outcomes and a monitoring framework, so it can make swift progress once it has been established.



Sustainable and safe health and disability services

He ratonga mō te hauora me te hauātanga ka mauroa, ka haumaru anō hoki

To meet current and future needs, the Ministry will prioritise services' clinical and financial sustainability, along with their quality and safety. We promote trust in the system by assuring the quality, safety and coverage of health and disability services. We will also adopt a long-term view that future-proofs our infrastructure, assets and facilities.

Having sustainable and safe services means our health and disability services have clinical and financial sustainability and robust quality and safety standards, so that they are delivered in a way that benefits all New Zealanders. We use our resources wisely to preserve the quality of safe health and disability services for future generations.

This year, to achieve sustainable and safe health and disability services . . .

we strengthened DHB performance

We have worked with DHBs to realign and strengthen their operational and financial reporting. We have developed a four-quadrant balanced scorecard to measure DHB performance, which includes over 50 measures or data points.

The scorecard will help enhance voluntary reporting and compliance by making it easier for people to understand the rules and expectations and holding the sector to account through our performance processes.

we increased diversity in DHB appointments

Each of our 20 DHBs is governed by an

11-member Board. The Ministry appoints the Chair, Deputy Chair and three board members, while the other members are elected. This year, 37 of the 76 appointments were women and the proportion of Māori Chairs and Deputy Chairs matches the proportion of Māori in the New Zealand population.

we attracted and retained newly qualified health professionals

The Voluntary Bonding Scheme is targeted to new graduates in eligible professions (including general practitioner trainees) to incentivise them to work in hard-to-staff professions, communities and specialties and increase representation of Māori and Pacific peoples within the health workforce. It also helps with retaining staff and spreading workforces through the country more equitably.



In 2020 the intake accepted

418

registrants (a record number)

A record number of mental health nurses (164)

Graduate midwives (86)

Rural and non-urban general practice trainees (35)

More Māori (80) and Pacific (44) registrants than ever before



We have also added some eligible professions and communities to the upcoming 2021 intake. These include public sector radiation therapists, medical physicists and midwives.

Analysis of historical workforce data indicates that nurses on the scheme have up to 27 percent higher retention after five years in hard-to-staff specialties compared with nurses not on the scheme.

we planned for a sustainable rural health workforce

Rural communities face many health challenges, including difficulties in accessing health services and poorer health outcomes (particularly for rural Māori, disabled people and people with mental health problems). Recruiting and retaining the health workforce in rural locations is also difficult.

We have been working closely with stakeholders from across the sector to develop solutions for rural health workforce issues. Extensive engagement in the last 12 months has involved key sector groups such as Rural Health Alliance Aotearoa New Zealand and the National Rural Health Advisory Group.

We have developed a work programme to strengthen the rural health workforce pipeline, from attracting people into health careers through to professional development. Another focus of the programme is on rural interprofessional learning and we are scoping interprofessional learning hubs. We began this programme of work in June 2020 and will continue throughout the coming year.

we improved environmental sustainability

This year, we developed guidelines that encourage and support the sector to incorporate environmentally friendly principles and reduce greenhouse gas emissions. Our *Sustainability and the Health Sector: Guidelines for DHBs* were published in July 2019.

we established the Health Infrastructure Unit

In late 2019 we established our Health Infrastructure Unit to support and oversee DHB capital projects.

With the construction of Dunedin Hospital, we are embarking on the largest hospital building project in New Zealand, valued at more than \$1 billion. We have also completed the Acute Services Building (Christchurch Hospital Hagley), and in July 2020 we opened Te Nikau, Grey Hospital and Health Centre in Greymouth.

National Asset Management Programme

Our National Asset Management Programme (NAMP) is part of a government-wide focus to improve capital funding decisions, capital investment plans and asset management and to ensure investments deliver the best value for New Zealanders.

The current state assessment of DHB assets, published in June 2020, is the first consistent nationwide report on the condition and clinical fitness-for-purpose state of DHB facilities and buildings, with a focus on main hospital campuses and acute care facilities. It gives a good foundation for understanding the pressure points.

The NAMP will enable the Government to make more informed and equitable investment decisions. It's important for future investment decisions to be based on good information that is valid for at least 10 years ahead so that funding is directed to where it will be most effective.

The Government approved a \$300 million Health Infrastructure Package as part of the New Zealand Upgrade Programme. The package starts to address issues identified in the NAMP, focusing on four areas of investment that support the Government's wider wellbeing priorities:

- maternity and child health



- mental health and addiction
- regional and rural services
- remediation and compliance.

we supported district health board bargaining

The Ministry continues to support DHBs with their bargaining processes to deliver outcomes that reflect the current economic environment and to minimise the implications of industrial action. In late 2019 the Employment Relations Governance Group, comprising senior Ministry and DHB officials and chaired by the Director-General of Health, was established to strengthen stewardship of employment relations across the DHB sector. The Ministry has also increased the support for DHBs during bargaining by engaging independent observers to participate in the bargaining processes.

The New Zealand Nurses Organisation bargaining is the first DHB national bargaining, as well as the first significant multi-employer collective agreement to be negotiated in the public sector since the COVID-19 pandemic began. The agreement covers 26,006 full-time equivalent staff at a current baseline cost of \$2.3 billion.

we found greater compliance with our drinking-water standards

In June 2020 we published our *Annual Report on Drinking-water Quality 2018–2019*. It

showed that thousands more New Zealanders have better drinking-water than the previous year.

The report covers supplies that serve populations of more than 100 people, which together provide drinking-water to 4,077,000 people across New Zealand.

Supplies that met all standards for drinking-water quality increased to 76.2 percent of the report population (3,107,000 people). This was up by 3.6 percent compared with the previous year.

Two large suppliers provided most of the water supplies that did not meet the drinking-water standards; these suppliers had their secure bore-water status withheld after the Havelock North Inquiry. Both water suppliers are actively working on new drinking-water safety plans to address non-compliance.

Suppliers that complied with their duties under the Health Act 1956, such as by having water safety plans, monitoring drinking-water and protecting drinking-water sources, increased 5.9 percent from the previous year to 97.1 percent (3,960,000 people).





Establishing Te Aho o Te Kahu, the Cancer Control Agency

Cancer is the leading cause of death in New Zealand Aotearoa. Each year, around 23,000 people are diagnosed with cancer and 10,000 die from it. The New Zealand Cancer Action Plan 2019–2029 provides a pathway to improve cancer outcomes for all New Zealanders. In December 2019 we established Te Aho o te Kahu, the Cancer Control Agency, to lead the implementation of this plan.

We established a transitional team to provide additional support within the Agency on communication, contracting and relationship management. An interagency agreement between the Ministry of Health and the Agency has been in place since December 2019.

Te Aho o te Kahu, the Cancer Control Agency, as a departmental agency hosted by the Ministry of Health, will provide strong national leadership for, and oversight of, cancer control in New Zealand Aotearoa. Its initial team of 18 people will focus on the following priority work as outlined in the Cancer Action Plan:

- equity
- treatment quality and standardisation
- data, monitoring and reporting
- person-centred care
- prioritisation, innovation and research.

What this initiative means for New Zealanders

The Agency will drive the implementation of the Cancer Action Plan 2019–2029, which focuses on equity and delivering nationally consistent services for all New Zealanders, no matter who they are or where they live.

Key priorities for the Agency include providing strong accountability, coordinating agencies involved in cancer and working to implement the plan. The Agency is working closely with people impacted by cancer, including not only people with cancer but also their family, whānau and health care professionals.

The Agency is also actively working with Māori and Pacific leaders to ensure that they inform the work of the Agency on how to best engage with them to meet their needs.

Te Aho o Te Kahu, the Cancer Control Agency is a departmental agency as defined by section 2 of the Public Finance Act 1989 and is hosted by the Ministry of Health. For performance information on Te Aho o Te Kahu, the Cancer Control Agency, see their Annual Report which is in Appendix 6 of this report.



An integrated, collaborative and innovative health and disability system

He pūnaha mō te hauora me te hauātanga e kōmitimiti ana, e ngātahi ana, e auaha ana hoki

The Ministry builds the connections needed to provide an integrated, collaborative and innovative health and disability system. To do this, we build effective relationships, advance collaborative ways of working and enable secure, timely, joined-up information to flow through the system.

We want a collaborative system where services are joined up to meet the needs of the person rather than having different professions providing those services in silos. In this system, organisations and sectors should continuously adapt, responding to opportunities to improve health outcomes and service quality and preparing to respond to any changes in health needs in the future.

This year, to shift towards an integrated, collaborative and innovative health and disability system . . .

we scoped a National Health Information Platform

In November 2019, more than 1,750 people from across the health and disability system attended the Health Informatics New Zealand Conference, the largest digital health event in the country. Here participants heard about chatbots, big data, virtual consultations, eMental Health, cyber security, artificial intelligence, digital transformation and more.

At this event, we also found significant interest in and support for our proposed National Health Information Platform (nHIP). Instead of building a single electronic health record, nHIP would assemble a virtual

electronic record on an ‘as required’ basis from multiple trusted sources.

In March 2020 we submitted a business case to Cabinet seeking support to progress nHIP. While the COVID-19 response has paused this work, ultimately nHIP will be a key tool that enables real-time clinical decision support and data-driven health care, empowering patients to manage their health and wellbeing.

we expanded the New Zealand ePrescription service

The New Zealand ePrescription service significantly improves patient safety by making prescriptions easier to read and more precise, reducing the risk of fraud and establishing a platform for pharmacies and community prescribers to be more efficient. Moving to the ePrescription service was essential to support virtual care during the COVID-19 response. This year we have enabled safer, more efficient medication management in the community by transitioning 80 percent of general practices and 50 percent of community prescribers to the ePrescription service.

we progressed the Maternity Action Plan

To give children the best possible chance of good health, we start our focus before birth with a commitment to support the maternity system. The Maternity Action Plan is strengthening and transforming local and national quality and safety programmes, supporting sustainability of the midwifery workforce and better supporting women and their families and whānau.





Our response to the Whakaari/White Island eruption

On 9 December 2019, the Whakaari/White Island volcano erupted, killing 21 people and injuring many more. A national and international response was activated, involving the Ministry of Health and many other government ministries and agencies.

Over the first few hours, the scale, complexity and severity of the casualties became apparent, but information about the extent and exact nature of the situation remained fluid. This event represented a significant challenge for the New Zealand health system.

Our role

Ministry personnel supported the response from a number of locations. Ministry liaison officers in the National Crisis Management Centre worked closely with New Zealand Police and the Ministry of Civil Defence and Emergency Management as part of the national response. Regional emergency management advisors, who were embedded in the Counties Manukau DHB Emergency Operations Centre, provided crucial liaison, support and advice for the response.

We also provided public health advice and support to the Scientific and Technical Advisory Group, which Fire and Emergency New Zealand established. Our advice on environmental hazards, PPE and recovering and handling the deceased helped to inform responders going to Whakaari/White Island as they made decisions about the hazards and risk mitigation measures. The Ministry also played a key role in coordinating psycho-social support, delivered through DHBs, for impacted communities and people.

Having foreign nationals among the victims brought another challenging dimension to this incident, particularly because it was more difficult to identify casualties when they had no identification on them on arrival at a hospital facility. Within the first 24 hours of the response, discussions between the Ministry of Health, Ministry of Foreign Affairs and Trade and the Australian Department of Foreign Affairs and Trade focused on the early repatriation of Australian citizens. Clinicians, defence force staff and government representatives from both Australia and New Zealand –Aotearoa worked on plans for medical retrieval flights to repatriate Australian nationals who had been severely burnt and injured by the eruption.

The Ministry's involvement contributed to the recovery of casualties, the timely, efficient and safe repatriation of foreign nationals and the recovery of deceased victims from Whakaari/White Island. Following this event, the Ministry is leading the review of the National Burns Plan in collaboration with other stakeholders, including the National Burns Unit.

Our thoughts are with those affected by this tragedy and their families.



We completed several projects of the Maternity Action Plan in 2019/20. With a focus on the quality and safety of care for women navigating the maternity sector, we:

- implemented the New Zealand Obstetric Ultrasound Guidelines to improve the quality and accessibility of primary maternity ultrasounds
- developed the Health Information Standards Organisation (HISO) Maternity Care Summary Standard, which defines the information that must be recorded to support high-quality maternity care to women and their babies, and to provide structured and coded information for reporting and analytics.

we supported practitioners to better detect and manage endometriosis

Endometriosis affects 1 in 10 women and girls. Delayed diagnosis is a significant problem for those with endometriosis as it leads to delays in appropriate management.

To address this problem, in March 2020 we published *Diagnosis and Management of Endometriosis in New Zealand*, which provides best-practice principles agreed by an Endometriosis Taskforce. This publication is intended to inform local clinical pathways and referral guidelines to improve the quality and consistency of clinical practice and improve early recognition and management of symptoms that suggest endometriosis may be the cause.

we progressed the Therapeutic Products Bill

The Therapeutic Products Bill will repeal and replace the outdated Medicines Act 1981 to provide comprehensive coverage for all therapeutic products under a modern regulatory scheme. This scheme is designed to ensure the safety, quality and efficacy of medicines, medical devices and cell tissue products and to bring the regulation of these therapeutic products up to international standards.

A key output this year was our analysis of 442 public submissions on the draft Bill, which has helped inform further development of the Bill.

we established the Medicinal Cannabis Scheme

Following changes to the Misuse of Drugs Act 1975 and associated regulations, we have been able to act on our commitment to improving access to high-quality, affordable medicinal cannabis products in New Zealand. The Medicinal Cannabis Scheme, which operationalised the new regulations (passed in December 2019) and is the regulator for medicinal cannabis, went live on 1 April 2020.

The Ministry also made changes to prescribing requirements to improve patient access to the medicinal cannabis product Sativex, a consented medicine. Making medicinal cannabis products more accessible will improve patients' wellbeing by helping them to manage symptoms associated with certain chronic conditions and health conditions needing palliative care.



In the first three months of operation
(April to June 2020)
the Ministry received
32
applications
for a
medicinal cannabis licence
covering cultivation,
manufacture and supply
of medicinal cannabis products



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

He ratonga, he tautoko, he kupu ārahi hoki e aro ana ki te tangata, e ngata ai ngā hiahia o te katoa

We harness the lived experience and expertise in the wider system to improve health outcomes and the quality of life of New Zealanders. We work collectively with people and communities to make smart, informed and transparent decisions about the design and delivery of services.

New Zealand's population is growing, ageing and diversifying. These trends create new challenges and opportunities for the health and disability system and amplify the need to continually evolve. During public consultations and inquiries (such as *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* and *Hauora Manaaki Ki Aotearoa Whānui: Health and Disability System Review*), we continue to hear from consumers that they expect more choice in the way services and support are delivered.

As we see it, people-centred health services, support and advice represent an approach to care that consciously adopts the perspectives of individuals, families and communities. In this approach, people are participants in, as well as beneficiaries of, a trusted health system that responds to their needs and preferences in humane and holistic ways.

We acknowledge that for people-centred care to succeed, people need to have appropriate education and support to be able to make decisions and participate in their own care. It is organised around the health needs and expectations of people rather than around their conditions.

To make people-centred care happen, we work with people and communities to make smart, informed and transparent decisions about the design and delivery of services.

This year, to promote people-centred services, support and advice . . .

we advanced abortion law reform

In 2019, we produced a report that provided a basis for the Government's review of the abortion legislation.

The Abortion Legislation Bill was introduced to decriminalise abortion, better align the regulation of abortion services with other health services and modernise the legal framework for abortion services in New Zealand. Officials from the Ministries of Health and Justice acted as advisors to a specially formed select committee that considered this Bill.

Passed into law in March 2020, the Abortion Legislation Act removes the regulation of abortion from the Crimes Act 1961 and treats it as a health matter. It has also made the Ministry responsible for oversight and monitoring of abortion services. The Ministry has worked alongside the sector to support the reorientation of abortion services under a health care framework. This included developing a high-level care pathway to guide service delivery, an information helpline and webpage (health.govt.nz/abortion) to provide information for consumers and an online notifications system for abortion



service providers. We also published interim standards for abortion care.

we made Funded Family Care fairer

Funded Family Care allows the Ministry and DHBs to pay people to care for family members with needs related to disability, long-term chronic health conditions, mental health or addiction or older age.

Since Funded Family Care began in 2013, aspects of the scheme have been criticised as discriminatory and unfair. Particular concerns have included the eligibility criteria, pay rates and Part 4A of the New Zealand Public Health and Disability Act 2000.

Changing Funded Family Care is one of the priorities in both the Disability Action Plan and Carers' Strategy Action Plan. A Bill to repeal Part 4A of the New Zealand Public Health and Disability Act 2000 was introduced this year and a range of policy changes has been agreed and is being implemented, starting in April 2020. These changes involve raising pay rates for family carers, providing choice on employment arrangements, lowering the minimum age of carers from 18 to 16 years, extending eligibility for payment to partners and spouses and removing discriminatory provisions from legislation that go against human rights.

we addressed low pay and gender-based discrimination

Over the last three years, pay rates for most front-line workers have increased by an average of 3 percent per year. The Ministry and DHBs prioritised this investment to narrow the gap between the highest and lowest earners and to give the same remuneration to workers doing the same job.

The Ministry is supporting DHBs to progress seven pay equity claims, which cover an estimated 85 percent of the DHB workforce. We have reviewed key decisions, conclusions

and outcomes and actively supported the DHBs in milestone reporting to the State Sector Pay Equity Governance Group.

This significant work will eliminate gender-based undervaluation across the predominantly female DHB workforce. We expect pay equity settlements will be reached from October 2020, beginning with the DHB clerical and administration workforce.

we established the Suicide Prevention Office

As *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* recommended, we moved quickly this year to establish the Suicide Prevention Office. This Office provides leadership on suicide prevention and strengthens efforts and collaboration across the sector.

Since opening, the Office has been engaging regularly with stakeholders at all levels – including national, regional and community-based groups, as well as individuals and whānau – to better understand community needs and challenges. An expert Māori advisory panel (chaired by Ta Mason Durie) has also been formed to give guidance to the Office.

To date the Suicide Prevention Office has:

- developed a national suicide bereavement response service
- extended DHB postvention services, which provide support after the loss of a loved one from suicide
- established Māori and Pacific suicide prevention community funds
- enhanced information services for whānau and the media.





Supporting advice on public referenda

New Zealanders will vote on two referenda in the 2020 General Election. The Ministry of Health has supported the development of evidence-based, impartial advice to the public about both of them.

Referendum on the End of Life Choice Act 2019

The End of Life Choice Act 2019 gives people with a terminal illness the option of requesting medically assisted dying. It establishes a system of assuring that a person meets eligibility criteria, reviewing decisions, providing guidance and oversight to the system and creating a process to request medically assisted dying from health practitioners. Under the Act, health practitioners are not allowed to suggest medically assisted dying and are allowed to conscientiously object to providing medically assisted dying.

The End of Life Choice Act was a Member's Bill, so the Ministry's role – alongside the Ministry of Justice – was to provide legal and technical advice to the select committee and to support committee processes such as submissions. Ongoing work includes preparing to implement the Act if the referendum produces a 'yes' vote.

Cannabis Legalisation and Control referendum

The Cannabis Legalisation and Control referendum will give the public the opportunity to vote on whether the recreational use of cannabis should become legal, based on the proposed Cannabis Legalisation and Control Bill. The proposed Bill sets out a way for the Government to control and regulate cannabis. This regulatory model covers how people can produce, supply or consume cannabis. The Bill's main purpose is to reduce cannabis-related harm to individuals, families, whānau and communities.

Based on its drugs and addiction expertise, the Ministry of Health provided health advice to the Ministry of Justice on ways to reduce harm from cannabis use in a regulated and controlled system. We provided coordinated input from policy, clinical advice, mental health and addiction experts, as well as from the interface with existing medicinal cannabis and hemp regimes. Our role included reviewing and contributing to Ministry of Justice briefings, Cabinet papers and the final Cannabis Legalisation and Control Bill.

The Ministry of Health continues to work closely with the Ministry of Justice on post-referendum planning and implementation issues that will arise if the referendum leads to a 'yes' vote.

Neither the Ministry nor the Government has a position for or against either referendum.



Some stakeholders have expressed concern that the suicide rate may increase as a result of COVID-19. The Suicide Prevention Office is working closely with the Chief Coroner and her office in monitoring the number of suspected suicides reported to coroners. In May 2020, the Chief Coroner released a statement confirming that reports of an increase in the suicide rate during the COVID-19 lockdown were incorrect.

we rolled out the National Bowel Screening Programme

Bowel cancer is New Zealand's second most common cancer, which causes about 1,200 deaths per year. The National Bowel Screening Programme aims to detect and treat cancers at an early stage.

From July 2017, the programme is being rolled out gradually and is expected to be operating nationwide by December 2021. It has so far detected bowel cancer in 694 people.

We have also developed the National Screening Solution (the new Bowel Screening Register). This cloud-based system will support bowel screening in Hauora Tairāwhiti first. Once it is rolled out nationally, we expect the programme will detect 500 to 700 more bowel cancers in its early years, helping to reduce early mortality and to improve quality of life.

we supported students with Hauora Māori Scholarships 2020

Through Hauora Māori Scholarships, we provide financial assistance to students who are undertaking or completing a New Zealand Qualifications Authority accredited course in health and disability studies (level seven or above at graduation) or health care worker training (level three or above) at a recognised tertiary provider.

The purpose of the scholarship programme is to increase the number of Māori participating in the health and disability workforce and to contribute to the delivery of high-quality health services for Māori.

Each year, we support more than 500 students through this scholarship programme. This year, interest in the programme has increased and we gave extra time to students to complete their applications because the COVID-19 pandemic interrupted timeframes for many universities.

we supported rongoā Māori – traditional healing services

Rongoā Māori is informed by a body of knowledge that at its core enhances Māori wellbeing. In this way, rongoā Māori differs from a Western medical paradigm, which focuses principally on the absence of health and wellbeing and on treatments or interventions that return the person to a state of health.

Rongoā is formulated in a Māori cultural context, using a range of culturally bound responses to address the understanding of events leading to ill health and its impacts. These responses include rākau rongoā (native flora herbal preparations), mirimiri (massage) and karakia (prayer).

This year, we extended contracts so rongoā providers could continue to serve their communities and manage delivery of services during the COVID-19 pandemic.

we rolled out a cervical screening campaign

Our cervical screening campaign encourages more women, particularly young Māori and Pacific women, to engage with cervical screening. The 'Give your cervix some screen time' campaign is about normalising the screening process (depicted as a woman looking after herself, her future and her whakapapa).



After running for only five weeks (before COVID-19 Alert Level 4), the campaign resulted in more than 350,000 views of the video, nearly 14,000 website visits and more than 17,500 views of other related informational videos.

we celebrated the 50th anniversary of Newborn Metabolic Screening (heel prick test)

The Newborn Metabolic Screening Programme diagnoses metabolic conditions in babies before they become unwell. This means treatment can start straight away before life-threatening illness or developmental delays occur.

We made a series of videos showcasing the work of the Newborn Metabolic Screening Programme, which turned 50 years old this year.

Around 64,000 babies a year are tested. In 2018, the lives of 67 babies were saved or enhanced thanks to the detection of a

metabolic condition. Parents and caregivers also received information and support through the programme.

we led a restorative justice process for those impacted by surgical mesh

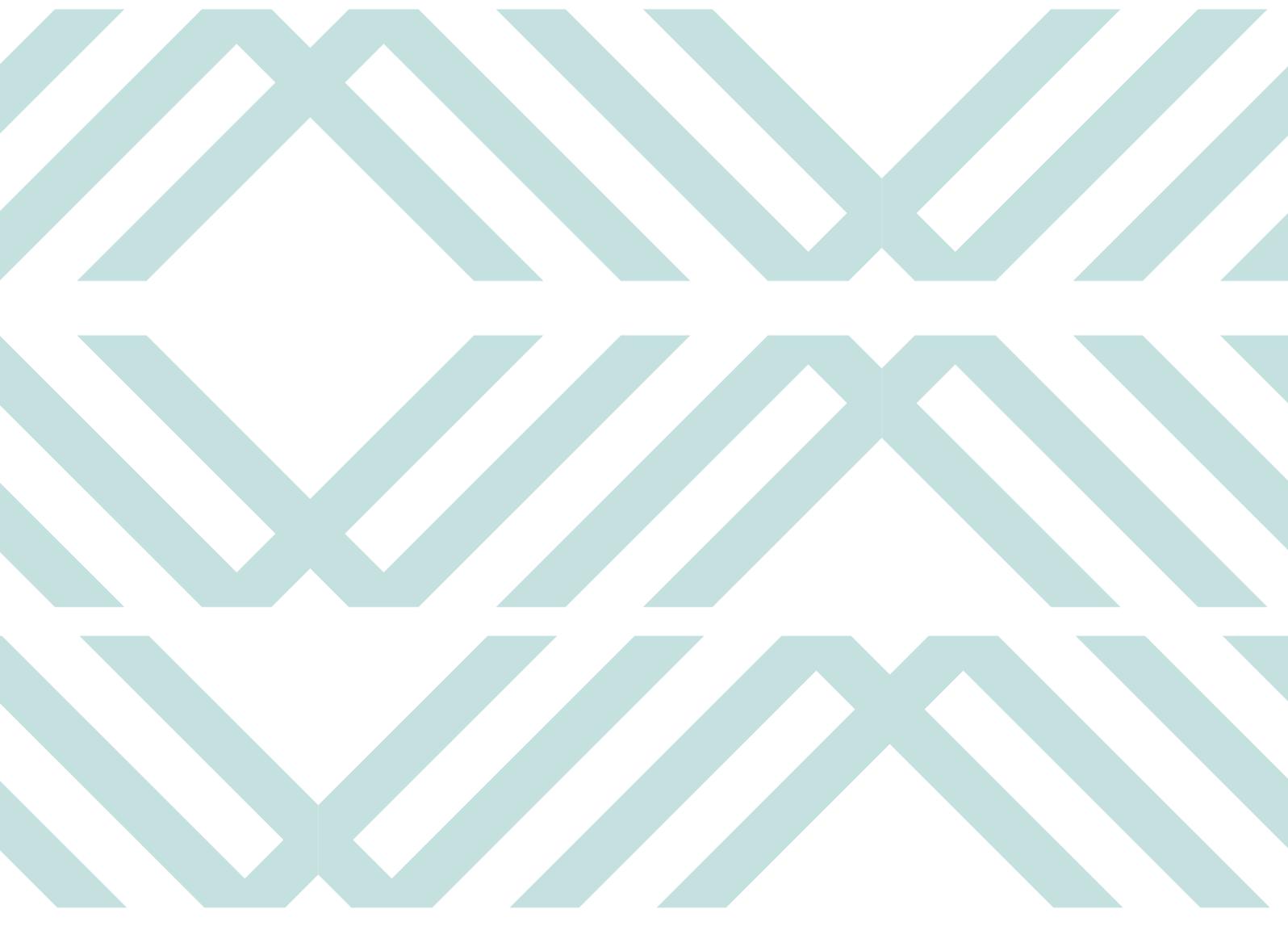
The use of surgical mesh, especially in urogynaecology procedures, has been a matter of local and international concern for some years. During 2019/20, we led a restorative process as an opportunity for New Zealand men and women who have been affected by surgical mesh to be heard and share their lived experience.

This process resulted in the report *Hearing and Responding to the Stories of Survivors of Surgical Mesh: Ngā kōrero a ngā mōrehu – he urupare*, which was released in December 2019. We are evaluating the restorative approach to identify learning that we can use when replicating the restorative approach across the wider health and disability system.



**Enhancing how
we operate**

**Te whakapakari
i ā mātou mahi**







Tā Tāku Rautaki/Our Strategy sets out six organisational capability objectives that will ensure we are well positioned to achieve our strategic direction.

This section reports on our progress towards these objectives and includes information on our workforce, equal employment opportunities and diversity and inclusion



Building our capability to meaningfully engage with Māori

We want to improve health equity and independence for Māori. To achieve this, we will further develop both our understanding of te ao Māori and our ability to build authentic and effective relationships with Māori.

This year we have supported our people to learn te reo Māori, grow their understanding of te ao Māori and further develop their Māori stakeholder engagement skills. As part of this process:

- 213 staff participated in te reo Māori classes
- Te Arawhiti (the office for Māori Crown Relations) delivered training on Māori stakeholder engagement
- we held Ministry-wide events to recognise Matariki and Te Wiki o Te Reo Māori (Māori Language Week)
- our new staff orientation programme included the Māori Health Strategy and a tour of the He Tohu exhibition at the National Library
- we focused on our commitment to Te Tiriti o Waitangi in our new leaders induction programme.

Working with our stakeholders to achieve our goals

We will strengthen relationships and work with people, communities, iwi, our system partners and other government agencies to achieve shared goals.

This year we hosted the Health Sector Forum 2019. This event brought more than 500 people together to discuss the future of the health and disability sector, with input from over 40 presenters and facilitators.

We have continued to strengthen our long-standing relationship with the WHO and are often invited to lend technical expertise on a range of areas. As kaitiaki of the health and disability system, we lead New Zealand's progress towards Sustainable Development Goal 3 – ensuring healthy lives and promoting wellbeing for everyone at all ages.

The Ministry's three core objectives for global engagement are to:

- contribute towards the achievement of the global and regional health agenda
- learn from the experience of others
- meet international obligations.

We strive to achieve these objectives by engaging with multiple multilateral forums, particularly the WHO, and by working closely and in partnership with Pacific Island countries and territories.

Supporting our people to succeed

We will ensure our people have the skills, capabilities, tools and support they need to succeed.

Building capability

To progress this objective, we have focused on building leadership capability in the Ministry through:

- Ngā Kete Mātauranga | Baskets of Knowledge – an online toolkit for people leaders to support management of people and business processes like recruitment, performance and development, wellbeing, flexible working, leave management, procurement and leading the delivery of Tā Tātou Rautaki | Our Strategy
- leadership development programmes, including new manager induction, coaching and feedback, mental wellbeing training and change leadership training



- keeping our leaders informed and engaged during the COVID-19 response through online meetings and forums
- improving the recruitment and selection process by aligning it with the Leadership Success Profile, weighting leadership attributes over technical skills in selection decisions and introducing psychometric testing for leadership roles.

We want the Ministry to be a place that supports the career aspirations of our people so they can grow and develop. Our people often gain these opportunities through the exposure and experiences they have on the job, or by taking up the low-cost but high-impact training options we provide.

The organisational change programme, the COVID-19 response and the stand-up of new Ministry functions and agencies have provided many opportunities for career development. In 2019/20 the Ministry supported:

- 97 secondments
- 51 acting opportunities
- 152 lateral and vertical movements.

In-house training programmes that we offer to our people throughout the year include orientation day, manager induction, leadership development, te reo Māori classes, Māori stakeholder engagement training, change leadership development, CV and interview skills training, remote working webinars and mental wellbeing. Our internal learning management system, LearningSpace, offers modules including resilience, mental wellbeing, project management, procurement, remote working, machinery of government and business writing, along with toolkits that support the upgrade of Ministry technology.

Kua tawhiti kē to haerenga mai, kia kore e haere tonu. He nui rawa o mahi, kia kore e mahi tonu

You have come too far not to go further, you have done too much not to do more.

Sir James Henare

Organisational change programme

The final decisions on the second phase of the changes to the Ministry structure, *Delivering on the Ministry's role as sector leader and kaitiaki*, were announced in July 2019. We stood up the new structure on 3 October 2019.

This was a significant change programme that followed the restructure of the Executive Leadership Team in 2018. We reorganised the Ministry so that the right people are in the right places to deliver on our substantial work programme, our Māori health and equity responsibilities under Te Tiriti o Waitangi and our role as kaitiaki of the health and disability system.

In total, the restructure involved disestablishing 133 roles and creating 326 new roles. Another 1,171 roles were carried over, many with minor changes to the role and/or reporting lines. Throughout the change programme, we provided change leadership development, resilience and CV and interview skills training, along with employee assistance.

Ensuring data insights and evidence drive our decisions

We will improve data quality and provide easier and quicker access to reliable, consistent and comparable information so we can use relevant insights to make better decisions.



This year we developed governance and a work programme to implement our new Analytics Operating Model to deliver high-quality data analysis and analytics. We also began work on the Data and Information Management Strategy for Health, which sets the direction for the management and use of data and information for the Ministry and across the system. In a devolved system, the way we work together to solve common problems is very important and the strategy will help individual organisations and the system work more effectively.

Geospatial analysis provides location-focused insights to support evidence-based decision-making. This year, geospatial analysis supported the Abortion Legislation Bill, to ensure that access to emergency contraception is available anywhere in New Zealand within 48 hours of someone requesting it. During the COVID-19 pandemic, geospatial analysis enabled spatial variation in laboratory testing rates and changes in the rates of active cases over time at a local scale.

We also started work on a Māori data governance and sovereignty approach for the health and disability system in partnership with Māori. This is a deliverable under *Whakamaua: The Māori Health Action Plan 2020–2025*.

Investing in robust and functional technology

We will continue to improve our information and communications (ICT) infrastructure to support our people to succeed.

ICT is a fundamental driver and enabler of change in the delivery of health and disability services. This year we developed the Ministry's Information Systems Strategic Plan that sets out a programme to build a digitally enabled Ministry that effectively manages

its business functions, collaborates with the sector, delivers value for money from our ICT investment and mitigates risk in our existing ICT systems. During Alert Levels 3 and 4, staff were equipped to work from home effectively.

This year we rolled out improvements to our business ICT systems and upgraded the Health Emergency Management Information System.

Making the Ministry a great place to work

We want to be an employer of choice and a great place to work. To achieve this, we will focus on building a value-driven, inclusive culture where we respect the ideas, perspectives and experiences of our people.

This year we worked across the Ministry to co-create Ngā Uaratanga | Our Values. All of our people in all locations had multiple opportunities to shape this work, led by 40 'culture champions' from all levels of the organisation. We are now embedding the values into our people and business processes. They anchor and guide how we work with each other and the wider sector as we navigate to the future.

Supporting the wellbeing of our people has remained a priority, particularly throughout the organisational change programme and at the peak of the COVID-19 pandemic. We continued to implement the Ministry's Wellbeing roadmap, based on Te Whare Tapa Whā – the Māori health model. In addition to the leadership and capability development activities noted above, we:

- provided resilience and mental wellbeing training and e-learning for our people
- developed a 'Supporting Wellbeing' online toolkit for people leaders, so they know what's expected of them and how they can best support the wellbeing of their teams



- incorporated 'building grit and resilience' into the Ministry's emerging leaders programme
- ran events to recognise Mental Health Awareness Week
- continued to provide Employee Assistance Programme support to our people.

Diversity and inclusion

We are committed to promoting a culture where our people feel safe and included, and can bring their whole selves to work regardless of age, gender, ethnicity or sexual orientation. This year, our diversity and inclusion work has included:

- implementing our Diversity and Inclusion Strategy, Gender Pay Action Plan and Accessibility Tick Action Plan
- launching a Rainbow Network and celebrating Pride Week
- supporting Women's Network events
- celebrating Matariki, Te Wiki o Te Reo Māori and International Day of People with Disabilities
- holding regular Accessibility Working Group meetings and supporting the Disabled Persons Network
- supporting and embedding all-of-government diversity and inclusion initiatives, including the Accessibility Charter, WeCount survey and Lead Toolkit.



126,631
followers on Facebook



23,654
followers on Twitter



13,240
followers on LinkedIn



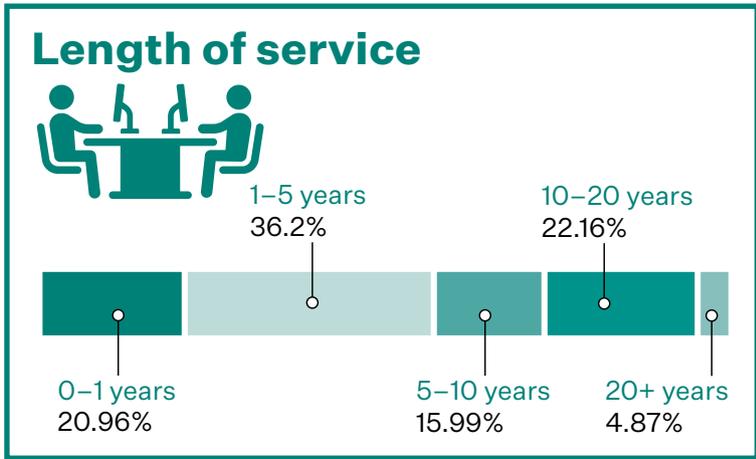
12,965
subscribers on YouTube



Our workforce profile Ō tātou tangata

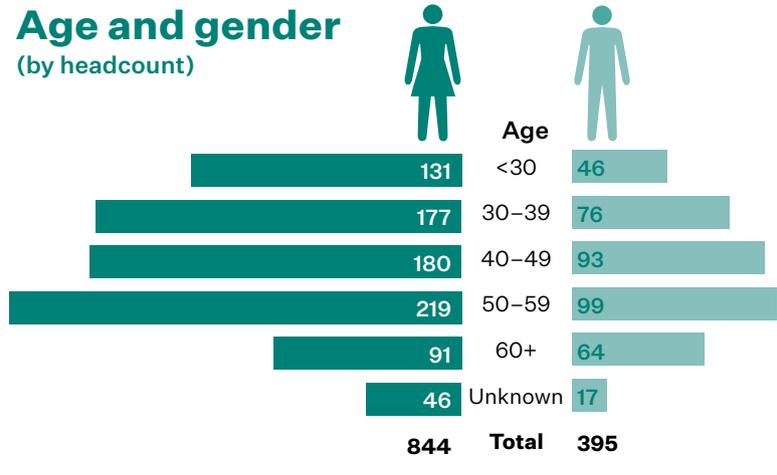
A snapshot as at 30 June 2020

1,239
People
work for the
Ministry of Health
(+34 from 2018/19)



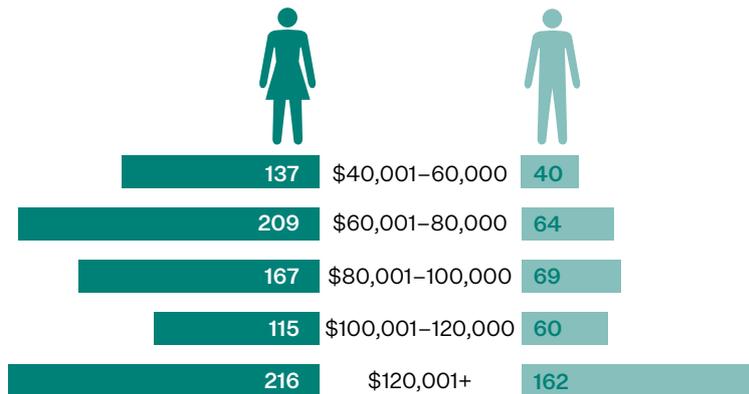


Age and gender (by headcount)



2019/20	68.1%	31.9%
2018/19	68.4%	31.6%

Gender and remuneration



Average salary
\$105,167
(+4.7% from 2018/19)

45.4%
Staff paid over
\$100,000
(41.5% 2018/19)

Gender pay gap

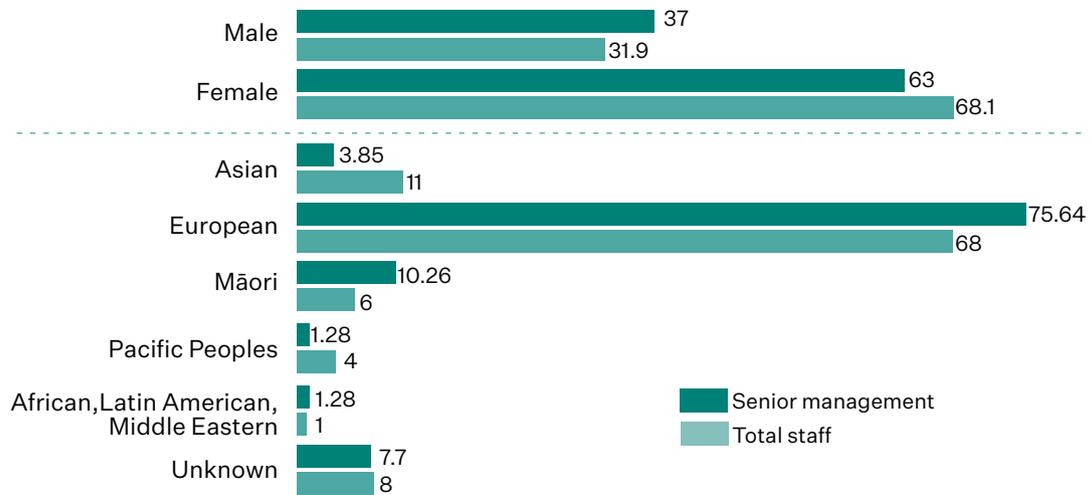
14.0% as at 30 June 2020
11.3% as at 30 June 2019
18% as at 30 June 2017

We are attributing this increase from last year mainly to the rapid recruitment of specialists during the COVID-19 outbreak. Our recruitment has continued to be at pace and we are monitoring our gender pay gap on a monthly basis. Our GPG action plan can be found at [health.govt.nz/about-ministry/careers/working-ministry-health/gender-pay-gap-action-plan](https://www.health.govt.nz/about-ministry/careers/working-ministry-health/gender-pay-gap-action-plan)





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



The Ministry of Health is an **equal employment opportunity employer**. The Ministry's remuneration policy ensures that all roles in the Ministry are evaluated using a recognised methodology and that salary bands are set accordingly, ensuring all employees, regardless of their age, gender or ethnicity, are rewarded on an appropriate salary scale.



**Our
performance**

Te kiko



 MINISTRY OF
HEALTH
MANATŪ HAUORA

133

 MINISTRY OF
HEALTH

MANATŪ HAUORA



This section outlines our performance against the outputs that are specified in the Vote Health – Main Estimates of Appropriation 2019/20¹ and, where updated, 2019/20 Vote Health – Supplementary Estimates of Appropriation² and 2019/20 Vote Health – Addition to the Supplementary Estimates of Appropriation.³

Performance information for selected non-departmental appropriations for the year ended 30 June 2020 is available in a separate Vote Health Report.

1 <https://treasury.govt.nz/publications/estimates/vote-health-health-sector-estimates-2019-20>

2 <https://treasury.govt.nz/publications/supplementary-estimates/vote-health-supplementary-estimates-2019-20>

3 <https://treasury.govt.nz/publications/supplementary-estimates/vote-health-addition-supplementary-estimates-2019-20-html>



Health sector information systems

This appropriation is limited to providing information technology services and publishing data and information derived from these services to the health and disability system. The intention is to provide information technology services and infrastructure to support the operation of New Zealand's health services.

Performance assessment

Performance measure	Actual	Budget standard	Actual
	2018/19	2019/20	2019/20
Client insight and analytics			
Percentage of published Tier 1 statistics meet Statistics New Zealand standards within agreed timetable	100%	100%	100%
Respondent satisfaction with how the Health Survey is conducted is greater than	98%	90%	98%
National infrastructure and Ministry information systems			
The percentage of time for which key sector- and public-facing systems are available (note 1)	99.9%	99%	99.85%
Number of security breach incidents (note 2)	0	0	1

Note 1: Key sector- and public-facing systems are National Health Index, National Immunisation Register, Online Pharmacy, Special Authorities, Oracle Financials and the Ministry of Health website.

Note 2: One health sector information system had a security breach in July 2019. The vendor informed the Ministry that its systems were compromised.

Financial performance

Health sector information systems	Actual	Main estimates	Voted appropriation	Actual
	2018/19 \$000	2019/20 \$000	2019/20 \$000	2019/20 \$000
Crown revenue (note 1)	51,118	58,618	61,886	61,886
Third party revenue	-	-	-	-
Total revenue	51,118	58,618	61,886	61,886
Total expenses (note 2)	51,050	58,618	61,886	56,931
Net surplus (deficit)	68	-	-	4,955

Note 1: New Crown funding was received in 2019/20 for this output class mainly for supporting the response to the measles outbreak and strengthening the immunisation system; and a fiscally neutral transfer from the National Health Information Systems appropriation for the initiative Transforming Access to and Use of Health Information to Improve the Wellbeing of New Zealanders.

Note 2: The underspend was mainly due to timing of the implementation of the National Bowel Screening Programme, the National Immunisation Register and the National Health Information Platform. Cabinet has approved an expense transfer of the unspent funding to carry forward to 2020/21.



Managing the purchase of services

This appropriation is limited to purchasing services for the public and the health and disability system on behalf of the Crown, for those services where the Ministry has responsibility for the purchasing function (that is, where funding is not devolved to another entity). The intention is 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 *Statement of Strategic Intentions*).

Performance assessment

Performance measure	Actual	Budget standard	Actual
	2018/19	2019/20	2019/20
The Ministry procurement process is in line with government standards	Achieved	Achieved	Achieved
The ratio of departmental expenditure for the output class against relevant non-departmental expenditure (note 1)	1:73	1:107	1:76
The percentage of Ministry feedback to Crown funding agreement variation monitoring reports that are supplied to DHBs within agreed timeframes (note 2)	95%	95%	98.4%
The percentage of complaints in regards to disability support services (DSS) that receive either a resolution notification or a progress update within 20 days of DSS receiving the complaint (note 3)	92.7%	95%	92.8%

Note 1: The Ministry does not control the level of departmental or non-departmental expenditure available for the purchase of services each year.

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

Note 3: The impact of COVID-19, on both the Ministry of Health and DSS providers, resulted in revised expectations around the timeliness and resolution of complaints received.

Financial performance

Managing the purchase of services	Actual	Main estimates	Voted appropriation	Actual
	2018/19 \$000	2019/20 \$000	2019/20 \$000	2019/20 \$000
Crown revenue	49,374	42,441	57,427	57,427
Third party revenue	-	-	-	141
Total revenue	49,374	42,441	57,427	57,568
Total expenses	49,313	42,441	57,427	54,665
Net surplus (deficit)	61	-	-	2,903



Payment services

This appropriation is limited to administering and auditing contracts and payments on behalf of the Crown and Crown agencies. The intention is to provide for timely and accurate 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	Budget standard	Actual
	2018/19	2019/20	2019/20
The percentage of claims paid on time	99.8%	98%	100%
The percentage of claims processed accurately	98.6%	95%	98.9%
The percentage of draft agreements prepared for funders within target timeframes (note 1)	90.3%	95%	94.5%
The percentage of agreements prepared accurately (note 2)	100%	95%	100%
The percentage of calls to contact centres answered within service specifications for timeliness (20 seconds)	81.9%	80%	81.7%
The percentage of calls abandoned by callers prior to being answered by the contact centre is less than	2.6%	5%	3.2%
The percentage of enquiries resolved within 10 working days	95.1%	95%	95.7%
Court written decisions and findings relating to concluded Ministry of Health Audit & Compliance initiated prosecutions contain no adverse judicial comment in regard to the evidential basis of the prosecutions	0	0	0
The percentage of Health Integrity Line complaints that are evaluated within 10 working days of complaint being received is greater than or equal to	100%	95%	99%

Note 1: Contracting cycles fall in line with the financial year. June and July are high-demand periods for primary care contracts, making service levels during this period unachievable. Despite this, the Ministry's performance for 2019/20 improved on 2018/19.

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

Financial performance

Payment services	Actual	Main estimates	Voted appropriation	Actual
	2018/19 \$000	2019/20 \$000	2019/20 \$000	2019/20 \$000
Crown revenue	15,340	17,340	16,340	16,340
Third party revenue	0	-	-	-
Total revenue	15,340	17,340	16,340	16,340
Total expenses	15,331	17,340	16,340	15,871
Net surplus (deficit)	9	-	-	469



Regulatory and enforcement services

This appropriation is limited to implementing, enforcing and administering health- and disability-related legislation and regulations, providing regulatory advice to the sector and to Ministers and providing support services for committees established under statute or appointed by the Minister in line with legislation. The intention is to ensure that health and disability services are regulated so that appropriate standards are followed.

Performance assessment

Performance measure	Actual	Budget standard	Actual
	2018/19	2019/20	2019/20
The percentage of medium- and high-priority quality incident notifications relating to medicines and medical devices that undergo an initial review within 5 working days (note 1)	98%	90%	81%
The percentage of certificates issued to providers under the Health and Disability Services (Safety) Act 2001 within target timeframes	91%	90%	92%
The percentage of licences and authorities issued to providers under the Medicines Act 1981 and Misuse of Drugs Act 1975 within target timeframes	88%	90%	93%
The percentage of licences and consents issued to radiation users under the Radiation Safety Act 2016 within 10 working days of the receipt of all information and payment of the required fee	90%	90%	92%
The percentage of new medicines applications (for ministerial consent to market) that receive an initial assessment within 200 days	77%	80%	91%
The percentage of changed medicines notifications (for ministerial consent to market) responded to within 45 days	100%	100%	100%
Average rating for statutory committee satisfaction with secretariat services provided by the Ministry (note 2)	4	4 out of 5 or greater	3.75 out of 5

Note 1: This measure reflects the first step in evaluating and managing incidents – although initial review is the very first step in the process, acknowledging their receipt has been used as a convenient surrogate marker for this. A significant proportion of the incidents reported to the Ministry relate to medical devices and these made up the majority that missed the five working day timeframe for an initial review as measured by the acknowledge receipt timepoint. However, the Ministry has focused in recent years on managing the ‘whole of life’ timeliness of completing Medical Devices Incident Reports (MDIRs). For example the Ministry has been completing an increasing number of MDIRs with the following processed in recent calendar years: 176 in 2017, 300 in 2018, 886 in 2019 (dedicated resource used to close older events) and 253 events as of October 2020.

Note 2: Chairs of the Ministry’s ethics advisory committees commented that the secretariat is supportive and knowledgeable. However, the committees experienced resource constraints and noted that more overall support is needed throughout the year.



Financial performance

Regulatory and enforcement services	Actual 2018/19 \$000	Main estimates 2019/20 \$000	Voted appropriation 2019/20 \$000	Actual 2019/20 \$000
Crown revenue	12,735	11,188	12,550	12,285
Third party revenue	11,882	13,458	13,458	11,505
Total revenue	24,617	24,646	26,008	23,790
Total expenses	23,345	24,646	26,008	24,936
Net surplus (deficit)	1,272	-	-	-1,146



Sector planning and performance

This appropriation is limited to advising on and coordinating health sector planning and performance improvement; funding, monitoring and supporting the governance of health sector Crown entities; and sector coordination. This appropriation is intended to ensure health sector services are appropriately planned, funded and monitored; health sector Crown entities, agencies and companies are appropriately governed; and sector coordination is encouraged and assisted.

Performance assessment

Performance measure	Actual	Budget standard	Actual
	2018/19	2019/20	2019/20
Planning and funding advice for the financial year is provided to Crown entities by 31 December	Achieved	Achieved	Achieved
The Ministry provides the Minister with advice of all DHB annual plans by 30 June	Achieved	Achieved	Achieved
The percentage of monitoring feedback reports about performance supplied to DHBs within agreed timeframes (note 1)	100%	100%	99.2%
The percentage of quarterly and monthly monitoring reports about DHBs provided to the Minister within agreed timeframes (note 2)	5%	100%	0%
The percentage of quarterly and monthly monitoring reports about Crown entities (excluding DHBs) provided to the Minister within agreed timeframes	50%	100%	100%
Maintain the capability and capacity to respond to national emergencies and emerging health threats (note 3)	Achieved	Achieved	Not achieved
The percentage of appointments to DHBs and other health Crown entity boards where advice is presented to the Minister prior to the current appointee's term expiring (note 4)	100%	95%	93%

Note 1: The requirements for Q3 2019/20 were significantly reduced due to the demands of responding to COVID-19. The 2019/20 result includes the monitoring feedback reports prepared in the 2019/20 year on the following quarters – Q4 2018/19, Q1 2019/20, Q2 2019/20 and Q3 2019/20. We will include results for Q4 2019/20 in our 2020/21 Annual Report.

Note 2: Reports to the Minister about DHBs were delayed during the response to COVID-19. The Ministry is working to improve performance in this area. To ensure that the Minister receives financial information in a timely manner, we introduced a process of issuing a report to the Minister within five working days of DHBs making the results available.

Note 3: Capability and capacity to respond means the Ministry has the necessary systems, procedures, facilities and staffing in place to initiate and manage at the national level the health response to a national emergency or emerging health threat. Responding to emergencies such as the Whakaari/White Island volcanic eruption and COVID-19 has meant that the training for response volunteers has not occurred. We are progressing a plan to address this issue.

Note 4: This percentage does not include unexpected resignation or departure before the term expires. The presentation of advice to the Minister on appointments to the Health Research Council was delayed due to competing priorities in responding to COVID-19.



Financial performance

Sector planning and performance	Actual	Main	Voted	Actual
	2018/19 \$000	estimates 2019/20 \$000	appropriation 2019/20 \$000	2019/20 \$000
Crown revenue (note 1)	54,277	50,877	69,902	69,902
Third party revenue	2	149	149	-
Total revenue	54,279	51,026	70,051	69,902
Total expenses (note 2)	54,230	51,026	70,051	56,822
Net surplus (deficit)	49	-	-	13,080

Note 1: The Ministry received an additional \$19 million funding from the Crown in 2019/20 for this output class through the Supplementary Estimates process. The funding is mainly for:

- Budget 2019 initiative Improving the Financial Sustainability and Performance of District Health Boards (fiscally neutral transfer from the Health Services Funding appropriation)
- Budget 2020 initiative Enhancing the Ministry's Capacity and Capability to Lead and Support the Health and Disability System
- Supporting the implementation of the New Zealand Cancer Action Plan (fiscally neutral transfer from the National Personal Health Services appropriation)
- Budget 2019 initiative Establishing a New Mental Health and Wellbeing Commission.

Note 2: The underspend was mainly due to the phasing of the Ministry's work programmes as a result of the impact of COVID-19, in particular the work on Improving the Financial Sustainability and Performance of District Health Boards. Cabinet has approved an expense transfer of the unspent funding to carry forward to 2020/21.



Policy advice and ministerial servicing

The purpose of this appropriation is to provide policy advice and other support to Ministers in discharging their policy decision-making and other portfolio responsibilities, including ministerial servicing. In 2019/20 this included supporting the review of the health and disability system.

The intention of this appropriation is to support and advise Ministers so they can discharge their portfolio responsibilities.

Performance assessment

Performance measure	Actual	Budget standard	Actual
	2018/19	2019/20	2019/20
The percentage of responses provided to the Minister within agreed timeframes, for written parliamentary questions and ministerial letters	79.9%	95%	98.3%
The percentage of responses provided to the Minister within agreed timeframes, for requested briefings (note 1)	77.7%	95%	94%
The percentage of ministerial letters that required no substantive amendments	NA	95%	96%
The percentage of responses to Official Information Act 1982 requests provided to the Minister within the agreed timeframe (for requests made to the Minister) or to the requestor within the statutory timeframe, including where extended in line with the Act (for requests made to the Ministry)	96.6%	95%	95%
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	3.12 out of 5	Greater than 3.2 out of 5	3.63
The health and disability system review's key milestones are achieved	Achieved	Achieved	Achieved
The satisfaction of the Minister and Associate Ministers of Health with the policy advice service (note 2)	New measure	Equal to or greater than 4 out of 5	No result
The health and disability system review members are satisfied with the support services provided	Satisfied	Satisfied or better	Satisfied

Note 1: Requested briefings did not meet the agreed timeframes due to the increased demand for advice on responding to COVID-19. The Ministry is working to improve timeliness.

Note 2: The Minister of Health for the 2019/20 financial year, Hon Dr David Clark, resigned in early July 2020. The Ministry has decided not to request him to complete a ministerial satisfaction survey. The three Associate Ministers of Health for the 2019/20 financial year were not asked to complete ministerial satisfaction surveys as the Minister of Health was the primary customer for policy advice from the Ministry in 2019/20. The Ministry is still committed to the survey and will report on the measure in our 2020/21 Annual Report.



Financial performance

Policy advice and ministerial servicing	Actual 2018/19 \$000	Main estimates 2019/20 \$000	Voted appropriation 2019/20 \$000	Actual 2019/20 \$000
Ministerial servicing				
Crown revenue	4,702	4,702	5,702	5,702
Third party revenue	-	-	-	-
Total revenue	4,702	4,702	5,702	5,702
Total expenses	4,684	4,702	5,702	7,108
Net surplus (deficit)	18	-	-	-1,406
Policy advice				
Crown revenue	16,439	17,889	25,005	25,005
Third party revenue	1	-	-	-
Total revenue	16,440	17,889	25,005	25,005
Total expenses	16,404	17,889	25,005	19,895
Net surplus (deficit)	36	-	-	5,110
Supporting the review of the New Zealand health and disability system				
Crown revenue	5,260	4,304	6,897	6,897
Third party revenue	-	-	-	-
Total revenue	5,260	4,304	6,897	6,897
Total expenses	2,667	4,304	6,897	4,413
Net surplus (deficit)	2,593	-	-	2,484



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.

The intention of this appropriation is to renew, upgrade or redesign assets to support the delivery of the Ministry of Health’s core functions and responsibilities.

Performance assessment

Performance measure	Actual	Budget standard	Actual
	2018/19	2019/20	2019/20
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	Main estimates	Voted appropriation	Actual
	2018/19 \$000	2019/20 \$000	2019/20 \$000	2019/20 \$000
Total appropriation	12,781	16,000	23,000	11,977



**Taking care of
our funds**

**Te penapena
pūtea**





Statement of responsibility

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

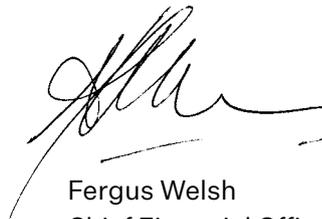
- the preparation of the Ministry's financial statements, and statements of expenses and capital expenditure, and for the judgements expressed in them
- having in place a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting
- ensuring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

In my opinion:

- the financial statements reflect the financial statements of the Ministry as at 30 June 2020 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 2021 and its operations for the year ending on that date.



Ashley Bloomfield
Director-General of Health
30 November 2020



Fergus Welsh
Chief Financial Officer
30 November 2020



Independent Auditor's Report
To the readers of the Ministry of Health's annual report
for the year ended 30 June 2020

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 73 to 102, that comprise the statement of financial position, statement of commitments, statement of contingent liabilities and contingent assets as at 30 June 2020, 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 2020 on pages 53 to 63 and 123 to 138;
- the statements of expenses and capital expenditure of the Ministry for the year ended 30 June 2020 on pages 112 to 115 and 119; and
- the schedules of non-departmental activities which are managed by the Ministry on behalf of the Crown on pages 103 to 111 and 116 to 118 that comprise:
 - the schedules of assets; liabilities; commitments; and contingent liabilities and assets as at 30 June 2020;
 - the schedules of expenses; and revenue for the year ended 30 June 2020; and
 - the notes to the schedules that include accounting policies and other explanatory information.

Opinions

Unmodified opinion on the financial statements, statements of expenses and capital expenditure and schedules of non-departmental activities (“the financial information”)

In our opinion:

- the financial statements of the Ministry on pages 73 to 102 :
 - present fairly, in all material respects:
 - its financial position as at 30 June 2020; and
 - its financial performance and cash flows for the year ended on that date; and
 - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Standards.
- the statements of expenses and capital expenditure of the Ministry on pages 112 to 115 and 119 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 103 to 111 and 116 to 118 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 2020; and
 - expenses; and revenue for the year ended 30 June 2020.

Qualified opinion on the performance information – the Ministry was unable to report on the satisfaction of the Minister with the policy advice service

In our opinion, except for the possible effects of the matter described in the Basis for our opinions section of our report, the performance information of the Ministry on pages 53 to 63 and 123 to 138:

- presents fairly, in all material respects, for the year ended 30 June 2020:
 - what has been achieved with the appropriation; and
 - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 30 November 2020. This is the date at which our unmodified opinion on the financial information and qualified opinion on the performance information are expressed.

The basis for our opinions is explained below, and we draw attention to the impact of Covid-19 on the Ministry and the activities it manages on behalf of the Crown. In addition, we outline the responsibilities of the Director-General of Health and our responsibilities relating to the information to be audited, we comment on other information, and we explain our independence.

Basis for our opinions

The provision of policy advice is one of the critical functions of the Ministry. One of the key measures to indicate the quality of that advice to the readers of the annual report is “the satisfaction of the Minister and Associate Ministers of Health with the policy advice service”.

As disclosed on page 61, the Minister of Health for the 2019/20 financial year, Hon Dr David Clark, resigned in early July 2020. The Ministry has decided not to request him to complete a ministerial satisfaction survey. Consequently, the Ministry has not reported a result for the above-mentioned performance measure. We were therefore unable to obtain sufficient appropriate evidence about whether the quality of the policy advice provided was to the satisfaction of the Minister.

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 opinions.

Emphasis of matter – Impact of Covid-19

Without further modifying our opinions, we draw attention to the disclosures about the impact of Covid-19 on the Ministry as set out in pages 101 to 102 and 116 to 118 of the financial statements and pages 55, 59 to 61 and 128 to 130 of the performance information.

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

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

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

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

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

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

Responsibilities of the auditor for the information to be audited

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

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General’s Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of the information we audited.



For the budget information reported in the information we audited, our procedures were limited to checking that the information agreed to the Ministry's Statement of Strategic Intentions 2017 to 2021, Estimates, Supplementary Estimates and Addition to the Supplementary Estimates of Appropriations 2019/20 and the 2019/20 forecast financial figures included in the Ministry's 2018/19 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 opinions. 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 on the financial information. 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 xi, 3 to 50, 67 and 139 to 159, but does not include the information we audited, and our auditor's report thereon.

Our opinions 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.

Other than in our capacity as auditor, we have no relationship with, or interests, in the Ministry.



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



Financial statements

Statement of comprehensive revenue and expense for the year ended 30 June 2020

Actual 2019		Note	Actual 2020	Unaudited budget 2020	Unaudited forecast 2021
\$000			\$000	\$000	\$000
Revenue					
209,245	Revenue Crown		255,444	207,359	235,264
11,885	Other revenue	2	11,646	13,607	14,668
221,130	Total revenue		267,090	220,966	249,932
Expenses					
124,965	Personnel costs*	3	134,648	123,976	141,541
7,418	Depreciation and amortisation expense	6,7	6,710	12,118	9,000
2,130	Capital charge	4	2,584	2,344	2,412
82,511	Other expenses	5	96,699	82,528	96,979
217,024	Total expenses		240,641	220,966	249,932
4,106	Surplus/(deficit)		26,449	-	-
Other comprehensive revenue and expense					
-	Item that will not be reclassified to net surplus/(deficit)		-	-	-
-	Total other comprehensive revenue and expense		-	-	-
4,106	Total comprehensive revenue and expense		26,449	-	-

* In budget 2020 and forecast 2021, ACC levy has been moved from other expenses to personnel costs to reflect the 2019 and 2020 actual classification.

Explanations of major variances against budget are detailed in note 17. The accompanying notes form part of these financial statements.



Statement of financial position as at 30 June 2020

Actual 2019 \$000		Note	Actual 2020 \$000	Unaudited budget 2020 \$000	Unaudited forecast 2021 \$000
Equity					
40,477	Taxpayers' funds		43,621	44,954	47,153
2,590	Property revaluation reserve		2,590	2,590	2,590
(2,857)	Memorandum accounts		(3,753)	(2,857)	(3,753)
40,210	Total equity	12	42,458	44,687	45,990
Represented by:					
Assets					
Current assets					
8,904	Cash and cash equivalents		6,180	7,000	7,000
2,067	Receivables		6,872	1,146	2,059
17,283	Crown debtor		34,663	4,085	12,619
32	Inventory		–	–	32
3,618	Prepayments		4,018	2,894	2,894
31,904	Total current assets		51,733	15,125	24,604
Non-current asset					
9,335	Property, plant and equipment	6	8,696	11,267	14,142
36,005	Intangible assets	7	47,501	41,981	37,692
45,340	Total non-current assets		56,197	53,248	51,834
77,244	Total assets		107,930	68,373	76,438
Liabilities					
Current liabilities					
19,972	Payables	8	24,596	11,773	18,980
5,442	Return of operating surplus	9	27,345	–	–
1,511	Provisions	10	214	2,372	1,600
8,442	Employee entitlements	11	11,591	8,168	8,168
35,367	Total current liabilities		63,746	22,313	28,748
Non-current liabilities					
1,667	Employee entitlements	11	1,726	1,373	1,700
1,667	Total non-current liabilities		1,726	1,373	1,700
37,034	Total liabilities		65,472	23,686	30,448
40,210	Net assets		42,458	44,687	45,990

Explanations of major variances against budget are detailed in note 17.
The accompanying notes form part of these financial statements.



Statement of changes in equity for the year ended 30 June 2020

Actual 2019 \$000	Note	Actual 2020 \$000	Unaudited budget 2020 \$000	Unaudited forecast 2021 \$000
31,454	Balance at 1 July	40,210	41,543	40,207
4,106	Total comprehensive revenue and expense	26,449	-	-
	Owner transactions			
(5,442)	Return of operating surplus to the Crown	(27,345)	-	-
10,092	Capital contribution – cash	3,144	3,144	5,783
40,210	Balance at 30 June	42,458	44,687	45,990

Explanations of major variances against budget are detailed in note 17. The accompanying notes form part of these financial statements.



Statement of cash flows for the year ended 30 June 2020

Actual 2019 \$000		Actual 2020 \$000	Unaudited budget 2020 \$000	Unaudited forecast 2021 \$000
Cash flows from operating activities				
199,380	Receipts from revenue Crown	238,064	215,462	227,712
10,962	Receipts from other revenue	6,762	13,607	14,668
(79,827)	Payments to suppliers	(102,704)	(87,949)	(98,342)
(123,696)	Payments to employees	(130,467)	(118,220)	(135,378)
(2,130)	Payments for capital charge	(2,561)	(2,344)	(2,412)
557	Goods and services tax (net)	2,457	–	–
5,246	Net cash flow from operating activities	11,551	20,556	6,248
Cash flows from investing activities				
144	Receipts from sale of property, plant and equipment	–	–	–
(195)	Purchase of property, plant and equipment	(111)	(1,163)	(6,213)
(12,586)	Purchase of intangible assets	(11,866)	(14,837)	(3,029)
(12,637)	Net cash flow from investing activities	(11,977)	(16,000)	(9,242)
Cash flows from financing activities				
10,092	Capital injection	3,144	3,144	5,783
–	Return of operating surplus	(5,442)	(7,700)	–
10,092	Net cash flow from financing activities	(2,298)	(4,556)	5,783
2,701	Net increase in cash held	(2,724)	–	2,789
6,203	Cash at the beginning of the year	8,904	7,000	4,211
8,904	Cash at the end of the year	6,180	7,000	7,000

Explanations of major variances against budget are detailed in note 17.
The accompanying notes form part of these financial statements.



Statement of cash flows for the year ended 30 June 2020 (continued)

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

Actual 2019 \$000		Actual 2020 \$000
4,106	Net surplus/(deficit)	26,449
	Add/(less) non-cash items:	
7,418	Depreciation and amortisation expense	6,710
–	– Impairment of work in progress intangibles	1,709
7,418	Total non-cash items	8,419
	Add/(less) items classified as investing or financing activities	
–	– (Gains)/losses on disposal of property, plant and equipment	8
–	Total items classified as investing or financing activities	8
	Add/(less) movements in working capital items:	
(854)	(Increase)/decrease in receivables	(4,805)
(9,865)	(Increase)/decrease in Crown debtor	(17,380)
(32)	(Increase)/decrease in inventory	32
(1,729)	(Increase)/decrease in prepayments	(400)
3,817	Increase/(decrease) in payables*	(2,683)
1,511	Increase/(decrease) in provisions	(1,297)
874	Increase/(decrease) in employee entitlements	3,208
(6,278)	Total movements in working capital items	(23,325)
5,246	Net cash flow from operating activities	11,551

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

Explanations of major variances against budget are detailed in note 17.
The accompanying notes form part of these financial statements.



Statement of commitments as at 30 June 2020

Capital commitments

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

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

Non-cancellable operating lease commitments

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

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

Actual 2019 \$000		Actual 2020 \$000
	Capital commitments	
422	Intangible assets*	236
422	Total capital commitments	236
	Operating leases as lessee	
	Future aggregate lease payments to be paid under non-cancellable operating leases are as follows:	
7,265	Not later than one year	9,569
37,729	Later than one year and not later than five years	37,716
65,898	Later than five years	54,425
110,892	Total non-cancellable operating lease commitments	101,710
111,314	Total commitments	101,946

* Last year's Intangible assets contractors' fees commitment was based on their fulfilling of the full contract (\$3.026 million). These have been restated as contractors' have a standard notice period of 10 days.

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



Statement of contingent liabilities and contingent assets as at 30 June 2020

The Ministry is defending legal disputes involving past employees for which a potential liability has not yet been quantified as at 30 June 2020. The Ministry had no other contingencies liabilities as at the balance date (2019: \$nil).

The Ministry had no contingent assets as at the balance date (2019: \$nil).

Statement of departmental capital injections for the year ended 30 June 2020

Actual capital injections 2019 \$000		Actual capital injections 2020 \$000	Approved appropriation 2020 \$000
Vote Public Issues			
10,092	Ministry of Health – Capital injection	3,144	3,144

Statement of departmental capital injections without, or in excess of, authority for the year ended 30 June 2020

The Ministry has not received any capital injections during the year without, or in excess, of authority.



Notes to the financial statements for the year ended 30 June 2020

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
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12. Equity
13. Memorandum accounts
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15. Departmental agency results – Cancer Control Agency
16. Events after the balance date
17. Explanations of major variances against budget

1 Statement of accounting policies

Reporting entity

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

The financial statements of the Ministry for the year ended 30 June 2020 are consolidated financial statements including both the Ministry and the Cancer Control Agency. The Cancer Control Agency (established 1 December 2019) is a departmental agency as defined by section 2 of the PFA and section 5 of the Public Service Act 2020, which is hosted within the Ministry. Unless explicitly stated, references to the Ministry cover both the Ministry and the Cancer Control Agency (see note 15). The Ministry's ultimate parent is the New Zealand Crown.

In addition, the Ministry has reported separately, in the non-departmental schedules, financial information on public funds managed by the Ministry, on behalf of the Crown.



The Ministry's primary objective is to provide services to the New Zealand public. The Ministry funds, administers and monitors the delivery of health services. The Ministry does not operate to make a financial return. In addition, the Ministry has reported on Crown activities and trust monies that it administers in the non-departmental statements and schedules on pages 103 to 119.

The financial statements are for the year ended 30 June 2020 and were approved for issue by the Director-General of Health on 30 November 2020.

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 Public Finance Act, which include the requirement to comply with New Zealand generally accepted accounting practice and Treasury Instructions.

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

Presentation currency and rounding

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

Changes in accounting policies

During the 2020 financial year, the Ministry adopted the amendment to the impairment of revalued assets, where a revalued asset can be impaired without having to revalue the entire class of asset of which the asset belongs.

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

Comparative figures

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

Standards issued, 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:

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires 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 flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The Ministry does not intend to early adopt the amendment.



PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although the Ministry has not assessed the effect of the new standard, the Ministry does not expect any significant changes as the requirements are similar to PBE IFRS 9 which the Ministry has early adopted for the 30 June 2019 financial year.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. The Ministry has not yet determined how application of PBE FRS 48 will affect its statement of performance.

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

Income tax

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

Budget and forecast figures

Basis of the budget figures

The 2019/20 budget figures are for the year ended 30 June 2020 and were published in the 2019 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 ending 2019/20.

Basis of the forecast figures

The 2020/21 forecast figures are for the year ending 30 June 2021, which are consistent with the best estimate at the time for financial forecast information submitted to the Treasury for the BEFU for the year ending 2020/21.

The forecast financial statements have been prepared as required by the PFA to communicate forecast financial information for accountability purposes. The 30 June 2021 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 Acting Chief Executive on 4 May 2020.

While the Ministry regularly updates its forecasts, updated forecast financial statements for the year ending 30 June 2021 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 2020/21 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 4 May 2020, were as follows:

- the Ministry's activities and output expectations will remain substantially the same as the previous year focusing on the Government's priorities
- personnel costs were based on current wages and salary costs adjusted for anticipated remuneration changes



- operating costs were based on historical experience and other factors that are believed to be reasonable in the circumstances and are the Ministry's best estimate of future costs that will be incurred
- estimated year-end information for 2019/20 was used as the opening position for the 2020/21 forecasts.

The actual financial results achieved for 30 June 2021 are likely to vary from the forecast information presented. Factors that may lead to a material difference between information in these forecast financial information statements and the actual reported results include changes to the budget through initiatives approved by Cabinet, technical adjustments to (including transfers between) financial years and timing of expenditure relating to significant programmes and projects.

At the time of signing the annual report, the Ministry received confirmation of a range of approved Cabinet and technical adjustment changes (approximately \$98 million) for 2020/21. These changes will likely cause a material difference between the reported forecast figures and actual results for 2020/21. At the time of completion of the annual report, the Ministry is reassessing its financial forecasts for 2020/21 considering the recently approved funding changes. 2020/21 funding changes will be reported as part of the Ministry's 2020/21 Annual Report and disclosed in the 2020/21 Supplementary Estimates.

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.

Supply of services

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



Breakdown of other revenue

Actual 2019 \$000		Actual 2020 \$000
9,080	Medicines registration	8,861
501	Service fees	342
2,288	Annual licence and registration fees	2,278
16	Other revenue	165
11,885	Total other revenue	11,646

3 Personnel costs

Accounting policy

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

Breakdown personnel costs

Actual 2019 \$000		Actual 2020 \$000
115,886	Salaries and wages	124,983
3,611	Employer contributions to defined contribution plans	3,798
875	Increase/(decrease) in employee entitlements	3,076
3,082	Other personnel costs	2,791
1,511	Cost of restructuring	–
124,965	Total personnel costs	134,648

4 Capital charge

Accounting policy

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

The Ministry pays a capital charge to the Crown on its equity (adjusted for memorandum accounts) as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2020 was 6.0% (2019: 6.0%).



5 Other expenses

Accounting policy

Operating leases

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

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

Other expenses

Other expenses are recognised as goods and services as received.

Breakdown of other expenses

Actual		Actual	Unaudited	Unaudited
2019		2020	Budget	Forecast
\$000		\$000	2020	2021
			\$000	\$000
427	Fees to Audit New Zealand for audit of financial statements	450	416	450
18,981	Contractors and consultants	25,410	19,471	16,206
26,149	Computer services	28,178	28,482	29,142
3,381	Travel	3,350	3,125	2,951
6,350	Communications and couriers	7,010	7,259	7,249
1,121	Printing and stationery	1,238	1,115	1,281
11,341	Operating lease payments	11,931	11,099	13,831
3,046	Occupancy costs other than leases	3,398	3,015	3,472
7,986	Professional specialist fees	9,631	4,870	9,839
1,571	Sector and public consultations	1,280	2,242	2,083
	– Impairment of Work in Progress Intangibles	1,709	–	–
	– Net loss on sale/disposal of property, plant and equipment	8	–	–
2,158	Other expenses	3,106	1,434	10,475
82,511	Total other expenses	96,699	82,528	96,979



6 Plant, property and equipment

Accounting policy

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

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

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

Depreciation

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

	Useful life	Depreciation rate
Buildings	40 years	2.5%
Motor vehicles	5 years	20%
Furniture, 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.

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

Disposals

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



Subsequent costs

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

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

Revaluations

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

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

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

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class-of-class asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus 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 assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

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

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

Breakdown of property, plant and equipment

The land at 108 Victoria Street, Christchurch was valued by Bayleys Valuations Limited, an independent valuer. The effective date of the evaluation is 30 June 2018. There has been no change to the value of this land.



	Land \$000	Buildings/ leasehold improvements \$000	Furniture plant and equipment \$000	Motor vehicles \$000	Computer hardware \$000	Total \$000
Cost or valuation						
Balance as at 1 July 2018	5,350	5,798	1,661	373	6,635	19,817
Additions	–	–	–	–	231	231
Disposals	–	–	(20)	–	(3,806)	(3,826)
Transfers/Reclassifications	–	11	–	–	14	25
Balance as at 30 June 2019	5,350	5,809	1,641	373	3,074	16,247
Balance as at 1 July 2019	5,350	5,809	1,641	373	3,074	16,247
Additions	–	–	23	–	65	88
Disposals	–	(538)	(42)	–	(39)	(619)
Balance as at 30 June 2020	5,350	5,271	1,622	373	3,100	15,716
Accumulated depreciation and impairment losses						
Balance as at 1 July 2018	–	1,898	1,088	298	6,485	9,769
Depreciation expense	–	545	129	–	134	808
Eliminate on disposal	–	–	(9)	–	(3,661)	(3,670)
Transfers/Reclassifications	–	–	3	–	2	5
Balance as at 30 June 2019	–	2,443	1,211	298	2,960	6,912
Balance as at 1 July 2019	–	2,443	1,211	298	2,960	6,912
Depreciation expense	–	528	118	–	68	714
Eliminate on disposal	–	(538)	(33)	–	(35)	(606)
Balance as at 30 June 2020	–	2,433	1,296	298	2,993	7,020
Total property, plant and equipment including WIP						
At 30 June 2018	5,350	3,900	573	75	150	10,048
At 30 June 2019	5,350	3,366	430	75	114	9,335
At 30 June 2020	5,350	2,838	326	75	107	8,696

Work in Progress

There is computer hardware on hand of \$0.03 million (2019: \$0.02 million) bought for use in specific IT projects to be capitalised when the project is completed. No other asset classes have assets to be capitalised.

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 development and maintenance of the Ministry's website are recognised as an expense when incurred.

Amortisation

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

	Useful life	Amortisation rate
Software – internally generated	3–10 years	14.3–33.3%
Software – other	3–10 years	14.3–33.3%

Impairment

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



Critical accounting estimates and assumptions

Useful lives of software

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

Breakdown of intangible assets

	Acquired software	Internally generated software	Total
	\$000	\$000	\$000
Cost			
Balance as at 1 July 2018	20,120	79,429	99,549
Additions	24	12,356	12,380
Disposals	–	–	–
Transfers	(25)	–	(25)
Balance as at 30 June 2019	20,119	91,785	111,904
Balance as at 1 July 2019	20,119	91,785	111,904
Additions	12	19,189	19,201
Disposals	–	(1,709)	(1,709)
Balance as at 30 June 2020	20,131	109,265	129,396
Accumulated amortisation and impairment losses			
Balance as at 1 July 2018	19,208	50,086	69,294
Amortisation expense	213	6,397	6,610
Transfers	(5)	–	(5)
Balance as at 30 June 2019	19,416	56,483	75,899
Balance as at 1 July 2019	19,416	56,483	75,899
Amortisation expense	213	5,783	5,996
Balance as at 30 June 2020	19,629	62,266	81,895
Total intangible assets including WIP			
At 30 June 2018	912	29,343	30,255
At 30 June 2019	703	35,302	36,005
At 30 June 2020	502	46,999	47,501

Work in Progress

The Ministry has numerous IT projects in progress resulting in work in progress of \$25.7 million (2019: \$19.9 million).

Restrictions

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



8 Payables

Accounting policy

Short-term payables are measured at amortised cost and recorded at the estimated obligation to pay less an allowance for credit losses per the requirements of PBE IFRS 9. As the estimated loss allowance is considered nil or trivial, no adjustment has been made.

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

Breakdown of payables

Actual 2019 \$000		Actual 2020 \$000
4,186	Creditors	4,011
2,251	Revenue in advance	2,169
11,375	Accrued expenses	13,806
2,160	GST payable	4,610
19,972	Total payables	24,596

9 Return of operating surplus

Actual 2019 \$000		Actual 2020 \$000
4,106	Net surplus/(deficit)	26,449
	Add:	
1,336	(Surplus)/deficit of memorandum accounts	896
5,442	Total operating surplus/(deficit)	27,345
5,442	Total return of operating surplus	27,345

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



10 Provisions

Accounting policy

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

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

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

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

Restructuring

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

In June 2019 the second phase of changes to the Ministry's structure was announced. A restructuring provision of \$1.511 million was established in 2018/19. Most of the change management process has been completed and the redundancy payments made accordingly. The provision balance as at 30 June 2020 represents the amount of expected redundancy payments to the remaining staff impacted by the restructure.

Breakdown of provisions

Actual 2019 \$000		Actual 2020 \$000
	Current portion	
1,511	Restructuring	214
1,511	Total current portion	214
1,511	Total provisions	214

Movement of provisions

	Restructuring \$000	Total \$000
Opening balance 1 July	1,511	1,511
Additional provision made	–	–
Amounts applied	(1,297)	(1,297)
Closing balance 30 June	214	214



11 Employee entitlements

Accounting policy

Short-term employee entitlements

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

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

Long-term employee entitlements

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

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

Presentation of employee entitlements

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

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

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

Expected future payments are discounted using discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash flows. A weighted average discount rate of 0.22% (2019: 1.23%) 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 \$11,226 higher/lower.

If the salary inflation rates were to differ by 1% from the Ministry's estimates, with all other factors held constant, the carrying amount of the total liability and the surplus or deficit would be an estimated \$24,281 higher/lower.



Breakdown of employee benefits

Actual 2019 \$000		Actual 2020 \$000
Current position		
6,419	Annual leave	8,677
1,099	Retirement and long service leave	768
924	Accrued salaries	2,146
8,442	Total current portion	11,591
Non-current position		
1,667	Retirement and long service leave	1,726
1,667	Total non-current portion	1,726
10,109	Total employee entitlements	13,317



12 Equity

Accounting policy

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

Memorandum accounts

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

Property revaluation reserves

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

Breakdown of equity

Actual 2019 \$000		Actual 2020 \$000
	Taxpayers' funds	
30,385	Balance at 1 July	40,477
4,106	Surplus/(deficit)	26,449
1,336	Transfer of memorandum account net deficit for the year	896
(5,442)	Return of operating surplus to the Crown	(27,345)
10,092	Capital injection	3,144
40,477	Balance at 30 June	43,621
	Property revaluation reserves	
2,590	Balance at 1 July	2,590
2,590	Balance at 30 June	2,590
	Memorandum accounts	
(1,521)	Balance at 1 July	(2,857)
(1,336)	Net memorandum account deficits for the year	(896)
(2,857)	Balance at 30 June	(3,753)
40,210	Total equity	42,458



13 Memorandum accounts

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

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

Action taken to address surpluses and deficits

To recover the deficit memorandum account balance from fees revenue in future years, the Ministry has commenced fees reviews to reassess the level of fees charged to achieve cost recovery.

Capital management

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

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

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



Memorandum accounts

Actual 2019 \$000		Actual 2020 \$000
	Opening balance	
(609)	Problem gambling	(707)
398	Office of radiation safety	(104)
(1,310)	Medsafe	(2,046)
(1,521)		(2,857)
	Revenue and appropriation	
990	Problem gambling appropriation	–
1,034	Office of radiation safety revenue	956
8,746	Medsafe revenue	8,400
–	Medicinal cannabis revenue	277
10,770		9,633
	Expenditure	
(1,088)	Problem gambling expenditure	–
(1,536)	Office of radiation safety expenditure	(1,527)
(9,482)	Medsafe expenditure	(8,839)
–	Medicinal cannabis expenditure	(163)
(12,106)		(10,529)
(1,336)	Total deficit for year	(896)
	Closing balance	
(707)	Problem gambling	(707)
(104)	Office of radiation safety	(675)
(2,046)	Medsafe	(2,485)
–	Medicinal cannabis	114
(2,857)		(3,753)



14 Related party transactions

The Ministry is a wholly owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and 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 2019 \$000		Actual 2020 \$000
	Leadership Team including the Director-General:	
5,489	Remuneration	5,485
14	Full-time equivalent staff	17

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

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.



15 Departmental agency results – Cancer Control Agency

On 28 August 2019, Cabinet approved the establishment of a new Cancer Control Agency as a departmental agency, hosted by the Ministry of Health.

The Order in Council also named the Cancer Control Agency as a department agency within the Ministry on Schedule 1A of the then State Sector Act 1988 with effect from 1 December 2019.

The nature of this arrangement means while this new 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.

As confirmed by Cabinet, the estimated cost of establishing a Cancer Control Agency is \$2.017 million in 2019/20, which was funded from within Vote Health baselines.

In summary its financial performance for the year was as follows:

	Actual 2020 \$000
Departmental activities	
Revenue	
Revenue Crown	2,251
Expenses	
Personnel costs	1,230
Other expenses	535
Total expenses	1,765
Surplus/(deficit)	486
Non-departmental activities	
Appropriation: National personal health services	8,947
Total non-departmental expenditure	8,947

16 Events after the balance date

There are no other significant events after the balance date.



17 Explanation of major variances against budget

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

Statement of Comprehensive Revenue and Expense

Revenue Crown

Revenue Crown was \$48 million higher than the budget mainly due to the Ministry receiving additional funding through the Supplementary and Additional Supplementary Estimates for:

- improving the Financial Sustainability and Performance of DHBs initiative (\$12.2 million, fiscally neutral transfer from non-departmental expenditure appropriation)
- COVID-19: Public Response package (\$10 million)
- enhancing the Ministry's Capacity and Capability to Lead and Support the Health and Disability System initiatives (\$10 million)
- responding to the Measles Outbreak and Strengthening the Immunisation System initiative (\$6.5 million)
- New Zealand Health and Disability System Review (\$2.6 million)
- COVID-19 Contact Tracing Action Plan implementation (\$2 million)
- NZ Cancer Action Plan implementation (\$2 million)
- establishing a new Mental Health and Wellbeing Commission (\$2 million, fiscally neutral transfer from non-departmental expenditure appropriation).

Personnel Costs

Personnel costs have increased by \$10.7 million due to cost pressures funding for enhancing the Ministry's capability, higher than anticipated leave balances as a result of the travel restrictions due to COVID-19 impacting on leave taken, additional resources required for the COVID-19 response, and the establishment of the new Cancer Control Agency.

Depreciation

Depreciation and amortisation costs were \$5.4 million lower than the budget due to the timing of the completion of some capital projects as the Ministry re-prioritised resources to the COVID-19 response.

Other Expenses

Other expenses were higher than the budget by \$14.2 million. The main reasons for this are higher fees paid to professional specialists (\$4.8 million), higher contractors and consultants expenditure mainly related to supporting the response to COVID-19 and other project work programmes (\$5.9 million), and an impairment of the Natural Health and Supplementary Products Database project due to legislation not progressing (\$1.7 million).



Statement of financial position

Current assets

Current assets were \$36.6 million higher than the budget. This is mainly due to a higher than budgeted debtor Crown as a result of not all revenue Crown being drawn down at 30 June 2020 (\$30.6 million), and higher receivables as a result of the invoicing for other revenue (\$5.7 million) being later than anticipated due to COVID-19.

The debtor Crown is offset by a higher than budgeted return of the operating surplus due to variances in cost incurred to deliver output.

Payables

Payables were \$12.8 million higher than the budget due to timing of GST (\$4.6 million) and PAYE (\$1.3 million) being paid in the following month, and higher accrued expenses which includes IT projects in progress (\$1.8 million) and information and communications technology costs (\$3.3 million).



Non-departmental statements and schedules for the year ended 30 June 2020

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



Statement of non-departmental expenses for the year ended 30 June 2020

Actual 2019 \$000		Actual 2020 \$000	Unaudited budget 2020 \$000	Revised budget 2020 \$000
14,886,847	Contracted services funding to DHBs (including devolved and non devolved funding)	16,004,117	15,778,837	15,861,975
23,488	Services from PHARMAC	28,126	23,488	32,367
18,029	Services from Institute of Environmental Research	19,642	14,971	17,498
16,774	Services from Health Promotion Agency	16,239	18,132	18,132
13,552	Services from Health Quality Safety Commission	13,342	13,476	13,476
13,370	Services from the Health and Disabilities Commissioner	13,370	12,870	12,870
190	Services from Other Crown Entities [#]	–	–	–
14,972,250	Total services from Crown Entities	16,094,836	15,861,774	15,956,318
72,585	Workforce training and development services	86,798	18,505	96,719
31,937	Mental Health services	63,118	8,350	85,615
1,218,846	Disability support services	1,469,359	1,156,098	1,501,007
176,967	Maternity services	185,627	183,417	185,692
–	– Covid-19 activities	271,198	–	860,946
467,273	Other services from third parties	274,719	708,172	384,478
–	– Impairment of inventory (PPE) (note 2.1)	71,519	–	–
1,967,608	Total services from third parties	2,422,338	2,074,542	3,114,457
16,939,858	Total services	18,517,174	17,936,316	19,070,775
2,735	Revaluation loss on property, plant and equipment	–	–	–
(755)	Net movement in residential care loans book value	1,318	–	–
22,588	Write off of Crown investments*	–	–	–
24,568	Total revaluation and impairment adjustments	1,318	–	–
16,964,426	Total non-departmental expenses	18,518,492	17,936,316	19,070,775
2,534,792	GST input expense	2,770,022	2,674,890	2,873,543
19,499,218	Total non-departmental expenses GST inclusive	21,288,514	20,611,206	21,944,318

[#] Tertiary educational institutes have been reclassified from Crown Entities to 3rd party entities.

* \$22.6 million was written off in 2018/19 for a one-off correction made to the accounting treatment for previous health related capital investments or expenditure that no longer considered as Crown investments.

Further details of non-departmental expenditure and appropriations by Vote are provided in the Statement of budgeted and actual expenses and capital expenditure incurred against appropriations for the year ended 30 June 2020 which cover both operating and capital expenditure.

The accompanying notes form part of these financial statements.

For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statements of the Government for the year ended 30 June 2020.



Schedule of non-departmental revenue and capital receipts for the year ended 30 June 2020

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 2019		Actual 2020	Unaudited budget 2020	Revised budget 2020
\$000		\$000	\$000	\$000
Revenue				
Reimbursement from the Accident Compensation Corporation (ACC)				
6,357	Reimbursement of complex burns costs	21,223	6,631	26,699
27,788	Reimbursement of work-related public hospital costs	29,272	28,986	29,272
328,563	Reimbursement of non-earners' account	346,106	342,721	346,106
106,434	Reimbursement of earners' non-work-related public hospital costs	112,118	111,022	112,118
51,541	Reimbursement of motor vehicle-related public hospital costs	54,294	53,763	54,294
3,113	Reimbursement of medical misadventure costs	3,280	3,248	3,280
6,471	Reimbursement of self-employed public hospital costs	6,816	6,750	6,817
530,267	Total ACC reimbursements	573,109	553,121	578,586
Other non-departmental revenue				
333,511	Payment of capital charge by DHB	302,267	374,875	401,937
-	Fines and Penalties	14	-	-
863,778	Total non-departmental revenue	875,390	927,996	980,523
Non-departmental capital receipts				
12,864	Repayment of residential care loans	13,558	15,000	20,000
-	Repayment of DHB debt	-	-	-
12,117	Equity repayments by DHB	12,580	12,499	12,499
24,981	Total non-departmental capital receipts	26,138	27,499	32,499
888,759	Total non-departmental revenue and capital receipts	901,528	955,495	1,013,022

The accompanying notes form part of these financial statements.

For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statements of the Government for the year ended 30 June 2020.



Schedule of non-departmental assets and liabilities as at 30 June 2020

Actual	Note	Actual	Unaudited budget	Revised budget
2019		2020	2020	2020
\$000		\$000	\$000	\$000
Assets				
Current assets				
356,580		343,822	95,000	88,630
8,507	2.1	92,470	17,000	8,507
Receivables:				
4,935		25,625	1,962	1,822
41,933		164,431	415	36,198
96		16,048	282	59
5,892		11,884	–	–
32,719		112,972	33,000	32,720
–	2.2	630,055	–	–
450,662		1,397,307	147,659	167,936
Non-current assets				
Advances:				
41,046		44,114	40,361	41,546
Investments:				
588,771	2.2	97,926	84,934	786,514
629,817		142,040	125,295	828,060
1,080,479		1,539,347	272,954	995,996
Liabilities				
Current liabilities				
Payables:				
12,141		35,755	–	–
15,586	2.3	19,984	–	–
Accrued liabilities and provisions:				
263,762		261,765	269,407	277,544
1,026		2,269	–	–
196,693		310,180	177,889	203,816
489,208		629,953	447,296	481,360

- In the 2018/19 comparatives, an Investment in Crown Entities of \$500,000 has been removed from Other Investments in accordance with Treasury Instructions section 6.2.1.2. Also, the property portfolio of land and buildings intended to be used for hospital redevelopment has been moved from Other Investments to Hospital rebuild projects.



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

Schedule of non-departmental commitments as at 30 June 2020

Breakdown of capital commitments

Actual 2019 \$000		Actual 2020 \$000
110,899	Property, plant and equipment	149,815
110,899	Total capital commitments	149,815

There are four projects in progress. Two are due to be completed within one year, one in year 2, and one in the outer years. All are related to hospital redevelopment.

Schedule of non-departmental contingent liabilities and contingent assets as at 30 June 2020

Breakdown of contingent liabilities

Actual 2019 \$000		Actual 2020 \$000
46,010	Legal proceedings and disputes	46,610
46,010	Total contingent liabilities	46,610

Legal proceedings and disputes

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

Contingent assets

The Ministry had no contingent assets as at the balance date (2019: \$nil).

The accompanying notes form part of these financial statements.

For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statements of the Government for the year ended 30 June 2020.



Problem Gambling Revenue Report for the year ended 30 June 2020

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

Actual		Non-departmental actual	Departmental actual	Total actual
2019		2020	2020	2020
\$000		\$000	\$000	\$000
Problem Gambling non-departmental expenditure				
7,403	Balance at 1 July	11,813	(707)	11,106
20,294	Revenue	13,794	–	13,794
(15,884)	Expenses	(17,076)	–	(17,076)
11,813	Balance at 30 June	8,531	(707)	7,824

Revenue is actual levies collected by IRD 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 Statements of the Government for the year ended 30 June 2020.



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 2020

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 2020.

Basis of preparation

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

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

Statement of compliance

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

The financial statements have been prepared in accordance with and comply with PBE accounting standards.

Presentation currency and rounding

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

Changes in accounting policies

During the 2020 financial year, the Ministry adopted the amendment to the impairment of revalued assets, where a revalued asset can be impaired without having to revalue the entire class of asset to which the asset belongs.

There have been no other 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

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although the Ministry has not assessed the effect of the new standard, the Ministry does not expect any significant changes as the requirements are similar to PBE IFRS 9 which the Ministry has early adopted for the 30 June 2019 financial year.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. The Ministry has not yet determined how application of PBE FRS 48 will affect its statement of performance.

Summary of significant accounting policies

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

Revenue and receipts

Revenue from ACC recoveries and capital charges from DHBs is recognised when earned and is reported in the financial period to which it relates.

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 May 2020.

Inventory

Inventories held for consumption in the provision for services are recorded at the lower of cost or current replacement cost. Any write-down from cost to replacement cost is recognised in the Statement of Non-Departmental Expenses and Capital Expenditure against appropriations.



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 recognized as a separate expense and eliminated against GST revenue on consolidation of the financial statements of the Government.

Commitments

Future expenses and liabilities to be incurred on contracts that have been entered into as at the balance date are disclosed as commitments to the extent that there are equally unperformed obligations.

Budget figures

The budget figures are consistent with the financial information in the Mains Estimates. In addition, these financial statements also present the updated budget information about the Supplementary Estimates (Revised budget).

Payables and provisions

Payables and provisions are measured at amortised cost and are recorded at the estimated obligation to pay less an allowance for credit losses per the requirements of PBE IFRS 9. As the estimated loss allowance is considered to be nil or trivial, no adjustment has been made.

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

There are no significant events after the balance date.



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 2020. 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 2020

Actual expenditure 2019 \$000	Appropriation title	Note	Actual expenditure 2020 \$000	Unaudited budget 2020 \$000	Revised budget* 2020 \$000	Location of end-of-year performance information ^
Departmental output expenses						
49,313	Managing the purchase of services		54,665	42,441	57,427	1
23,346	Regulatory and enforcement services		24,936	24,646	26,008	1
54,229	Sector planning and performance		56,822	51,026	70,051	1
51,050	Health sector information systems		56,931	58,618	61,886	1
15,331	Payment services		15,871	17,340	16,340	1
193,269	Total departmental output expenses		209,225	194,071	231,712	
Multi-category expenses						
4,684	Ministerial servicing		7,108	4,702	5,702	1
16,404	Policy advice		19,895	17,889	25,005	1
2,667	Review of Health & Disability Support Services		4,413	4,304	6,897	1
23,755	Total multi-category expenses		31,416	26,895	37,604	
217,024	Total departmental and multi-category output expenses		240,641	220,966	269,316	
Departmental capital expenditure						
12,781	Ministry of Health - permanent legislative authority		11,977	16,000	23,000	1
12,781	Total departmental capital expenditure		11,977	16,000	23,000	



229,805	Total departmental output appropriations		252,618	236,966	292,316	
	Non-departmental output expenses					
	Health/disability support services for district health boards (DHB)					
603,894	Northland		646,528	632,077	646,992	2
1,541,545	Waitematā		1,655,318	1,622,080	1,656,458	2
1,330,186	Auckland		1,424,527	1,391,484	1,425,479	2
1,447,122	Counties Manukau		1,557,372	1,524,353	1,558,472	2
1,206,300	Waikato		1,296,190	1,262,909	1,297,088	2
327,560	Lakes		351,120	340,415	351,370	2
728,951	Bay of Plenty		783,960	762,449	784,521	2
166,213	Tairāwhiti		175,629	171,979	175,757	2
349,768	Taranaki		371,857	362,111	372,119	2
501,129	Hawke's Bay		538,967	524,166	539,352	2
226,848	Whanganui		241,407	234,337	241,571	2
515,380	MidCentral		556,666	540,792	557,068	2
401,750	Hutt Valley		425,931	416,836	426,228	2
778,511	Capital & Coast		834,385	817,679	834,955	2
140,647	Wairarapa		153,557	149,112	153,667	2
442,100	Nelson-Marlborough		476,831	462,233	477,171	2
132,026	West Coast		139,154	137,668	141,161	2
1,431,953	Canterbury		1,556,180	1,510,695	1,574,557	2
182,426	South Canterbury		195,765	190,066	195,905	2
884,024	Southern		953,173	926,825	953,849	2
13,338,333	Total health/disability support services for DHBs	2.4	14,334,517	13,980,266	14,363,740	
	National services					
1,358,397	National disability support services	2.5	1,598,936	1,344,646	1,624,640	3
390,239	Public health service purchasing	2.6	811,062	440,302	1,173,390	3
92,432	National child health services		105,549	112,980	107,332	3
356,968	National planned care services		373,998	396,085	401,749	3
120,252	National emergency services		156,025	150,319	161,586	3
3,105	National Māori health services		17,061	6,828	19,328	3



180,628	National maternity services		192,121	188,492	193,972	3
76,685	National mental health services		132,321	141,296	159,917	3
23,488	National contracted services - other		23,488	23,488	23,488	5
29,468	Monitoring and protecting health and disability consumer interests		26,346	31,546	26,346	3
15,884	Problem gambling services		17,076	18,698	19,079	3
184,748	Health workforce training and development		205,323	211,641	215,691	3
262,607	Primary health care strategy		340,896	330,533	359,533	3
70,005	National personal health services	2.7	118,727	67,005	132,848	3
4,803	National health information systems		9,377	8,382	13,382	3
6,923	Health sector projects operating expenses		11,115	–	11,385	3
30	Auckland health projects integrated investment plan		591	–	1,340	4
362,527	Supporting Equitable Pay	2.8	–	413,636	–	4
–	Health services funding		–	23,681	11,500	3
36,107	Supporting Safe Working Conditions for Nurses		9,584	–	9,586	4
3,575,296	Total national services		4,149,596	3,909,558	4,666,092	
16,913,629	Total non-departmental output expenses		18,484,113	17,889,824	19,029,832	



	Non-departmental other expenses					
1,863	International health organisations	2,081	2,030	2,100	4	
3,038	Legal expenses	1,034	1,028	2,678	4	
21,328	Provider development	29,946	43,434	36,165	3	
26,229	Total non-departmental other expenses	33,061	46,492	40,943		
	Non-departmental revaluation and impairment adjustments					
2,735	Revaluation loss on property, plant and equipment	–	–	–		
(755)	Net movement in residential care loans book value	1,318	–	–	4	
22,588	Write off of Crown investments	–	–	–		
24,568	Total non-departmental revaluation and impairment adjustments	1,318	–	–		
16,964,426	Total non-departmental expenses	18,518,492	17,936,316	19,070,775		
	Non-departmental capital contributions to other persons or organisations					
234,211	Equity support for DHB deficit	430,000	134,211	430,000	2	
91,515	Equity for capital projects for DHBs and Health Sector Crown Agencies	2.9	128,840	1,507,470	354,836	3
158,432	Health sector projects	2.10	139,210	40,600	197,743	3
14,910	Residential care loans - payments		18,003	15,000	20,000	4
499,068	Total non-departmental capital contributions to other persons or organisations	716,053	1,697,281	1,002,579		
17,463,494	Total non-departmental appropriations	19,234,545	19,633,597	20,073,354		
17,693,299	Total Vote: Health	19,487,163	19,870,563	20,365,670		

* These are the total approved appropriations from the Supplementary Estimates.

^ 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 annual reports.



- 3 The Vote Health Report in relation to selected non-departmental appropriations for the year ended 30 June 2020.
- 4 Exemptions granted under section 15D of the Public Finance Act 1989.
- 5 PHARMAC'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

2.1 Inventory

The total value of inventory on hand at balance date and not expensed during the year was \$92.5 million, \$75.5 million higher than the budget. The increase relates to the purchases the Ministry has made as a result of the Covid-19 pandemic that includes personal protective equipment (\$80.2 million) and swab tests (\$5.9 million).

With fluctuating prices and implications of the evolving understanding of Covid-19 on safety standards, at year end the Ministry performed an assessment on the value of stock on hand. As a result, in accordance with PBE IPSAS 12, the value of the stock was written down by \$71.5 million to reflect the estimated market value of the stock as at balance date, and this is included in the Statement of non-departmental expenses.

2.2 Hospital rebuild projects

The hospital projects are \$643 million higher than the budget. This is due to:

- the later than anticipated completion and hand over of the Canterbury and West Coast Hospital redevelopment to the DHBs originally forecast to occur this year
- the reclassification of property held for future hospital redevelopment.

Costs of \$728 million remain in the work in progress account at year end, with projects currently valued at \$630 million due to be completed next year.

Schedule of non-departmental liabilities

2.3 Other payables

Other payables were not provided for in the Main Estimates.

Schedule of non-departmental expenses and capital expenditure against appropriations

2.4 Health and disability support services for DHBs

A net increase of \$354.3 million actual expenditure against the budget across the DHBs reflects several increases during the year as outlined in the 2019/20 Supplementary and Additional Supplementary Estimates. Main changes include:

- allocation of devolved Pay Equity funding from the Ministry to DHBs (\$274.3 million)
- additional funding to meet increased drugs costs due to Covid-19 (\$35.0 million)
- DHB capital charge funding reflect the impact of revaluation of DHB assets (\$27.1 million)
- Investment to increase access to medicines initiative (\$20.0 million).



2.5 National disability support services

The increase expenditure of \$254.3 million against the original budget is due to the costs for providing essential disability and aged care support services as part of Covid-19 response (\$25.4 million), increases due to the devolution of equitable pay for care and support workers (\$139.9 million), and new funding in Budget 2020 to support disabled New Zealanders to live good lives (\$103.7 million). Additional funding to meet these costs was obtained through the Budget 2020 and Covid-19 Budget processes.

2.6 Public health service purchasing

The increase of \$370.8 million in actual expenditure against the budget is mainly due to expenses incurred relating to Covid-19 activities including supply chain and managed isolation costs. An additional funding increase of \$723 million was provided through the 2019/20 Supplementary and Additional Supplementary Estimates for Covid-19 activities, with \$324 million underspend reported at year end largely due to lower than anticipated costs for supply chain purchases and timing of when costs would be incurred. More information of Covid-19 costs incurred is available in the Covid-19 Response Expenditure note.

2.7 National personal health services

The increase of \$51.7 million in actual expenditure against the budget is mainly due to Covid-19 related costs including funding support to aged residential care providers, hospices, National Telehealth Service, and the funding arrangements relating to the Whakaari/White Island response.

2.8 Supporting Equitable Pay

The funding to support equitable pay was devolved to DHBs and National Disability Support Services appropriations.

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

The underspend of \$1,378.6 million against the budget is mainly due to the allocation of new funding from Budget 18/19 into the current year. This has subsequently been rephased to out years in line with expected expenditure profile with change to the way the appropriation is treated being amended to a multi-year appropriation in Budget 2020.

2.10 Health Sector Projects

The increase of \$98.6 million against the budget is mainly due to land acquisition for the Southern DHB's Dunedin Hospital redevelopment, and a transfer of funding from the 2018/19 year reflecting the timing of DHB and Crown agency capital projects work.

3 Covid-19 Response Expenditure for the year ended 30 June 2020

On 11 March 2020 the World Health Organization declared the outbreak of coronavirus (COVID-19) a pandemic. In response to the pandemic, total funding of \$1.78 billion has been appropriated to Vote Health for 2019/20 and outyears.

Total expenditure for the year ended 30 June 2020 across the Ministry is \$561.15 million against a budget of \$952.2 million. The total spend is made up of \$553.08 million in non-departmental expenditure and \$8.07 million in departmental expenditure. Cabinet has approved an expense transfer of the unspent funding of \$391.05 million to 2021/22 reflecting the uncertainty of when costs would be incurred.



Key spending on initiatives for the year ended includes:

- \$108 million – Personal Protection Equipment (PPE): For the purchase 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 \$71.5 million impairment of inventory after an assessment was performed at year end on the quality and value of PPE in accordance with PBE IPSAS 12. Refer to note 2.1 above for inventory balance at year end.
- \$92 million – General practice support including Community Based Assessment Centres (CBAC): For immediate impacts support resulting from the move to Alert Level 4.
- \$79 million – Enhanced border measures – managed isolation and quarantine: To provide managed isolation or quarantine facilities.
- \$38 million – COVID-19 testing – laboratory capacity: For purchase of testing equipment and consumables associated with processing tests to detect the presence of COVID-19.
- \$25 million – Increase in combine Pharmaceutical Budget and PHARMAC operating costs: To meet the increased in the price of medicines procured by PHARMAC resulting from the disruption to supply.
- \$25 million – Boosting Public Health capacity: To provide costs incurred at the border, invest in surge capacity, and to support contact tracing.
- \$24 million – Aged Residential Care Providers: To provide immediate support to providers maintaining their facilities free of COVID-19 and take in more residents to free up hospital beds if required.
- \$22 million – Māori Response Package: A tailored health response to ensure the health and wellbeing of Māori is protected during the COVID-19 pandemic.
- \$20 million – Introduce a GP and Community Health clinical telehealth consultation service: For DHBs and Primary Health Organisations to support telehealth, remote working and digital inclusion initiatives.

As the lead agency for the response to Covid-19, the main impacts on the Ministry Departmental Financial performance:

- received funding of \$12.25 million from the Crown to lead the response
- incurred \$8.070 million of costs that can be directly attributed to the response. The actual costs of leading the response will be higher than this as there are costs that cannot be directly attributed to the response activities.

Covid-19 has not caused a material impact on the carrying value of Hospital rebuild costs disclosed in the Schedule of non-departmental assets and liabilities.

The carrying value of Inventory (refer note 2.1) may be impacted over time as the understanding of Covid-19 increases as it may cause changes in relation to the market price and the quality standard requirements for Inventory, in particular for Protective Personal Equipment resulting in changes in the carrying value of these items. At balance date, the value of PPE on hand was reduced by \$71.5 million as a result of \$37.0 million of PPE where there were quality standard concerns at balance date, \$34.5 million of PPE that were purchased at market prices at the time that were higher than market prices at balance date.



Statement of budgeted and actual expenses and capital expenditure incurred against appropriations for the year ended 30 June 2020

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

There were no appropriation transfers or adjustments made in the Supplementary Estimates under section 26A of the PFA (2018/19: Nil).

Statement of expenses and capital expenditure incurred without, or in excess of, appropriation or other authority for the year ended 30 June 2020

Unappropriated expenditure		Expenditure after remeasurements	Approved appropriation	Unappropriated expenditure
2019		2020	2020	2020
\$000		\$000	\$000	\$000
	Non-Departmental Output Expenses			
6,690	Disability Support Services	–	–	–
	Non-Departmental Other Expenses			
22,588	Write-off of Crown Investments	–	–	–

During the 2018/2019 year, there were two instances where expenditure has exceeded the approved appropriation in Disability Support Services (managed under Section 26B of the Public Finance Act 1989) and a write-off of Crown Investments (validated by Parliament under Section 26C of the Public Finance Act).

There are no expenses or capital expenditure incurred without, or in excess of, appropriation or other authority for the year ended 30 June 2020.



the \mathbb{R}^n -valued function \mathbf{f} is a solution of the system (1) if and only if \mathbf{f} is a solution of the system (2).

Let us assume that \mathbf{f} is a solution of the system (1). Then, by (1), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (3)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (3), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (4)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (4), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (5)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (5), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (6)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (6), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (7)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (7), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (8)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (8), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (9)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (9), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (10)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (10), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (11)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (11), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (12)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (12), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (13)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (13), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (14)$$

for all $t \in I$. Let us denote by $\mathbf{f}(t)$ the matrix whose columns are the components of the vector $\mathbf{f}(t)$. Then, by (14), we have

$$\mathbf{f}'(t) = \mathbf{f}(t) \mathbf{A}(t) \quad (15)$$

Appendices

Ngā āpitihanga





Appendix 1: Outcome and impact measures

Outcome measures

Table 1: Outcome measures⁴

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 expectancy⁵								
	2019	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

- 4 The outcome measures for ‘independent life expectancy’ have been removed to reduce confusion with the ‘health-adjusted life expectancy’ results. The differences between these measures involve minor technical amendments in the calculation, which are useful for detailed health research purposes. The outcome measure for decrease in the ‘rate of growth in health spending over time’ has been removed due to changes in the Government priorities and strategic focus for the health sector.
- 5 Prior year results have been updated as the estimates are recalibrated and re-estimated based on new information, data and methods each year. URL: <http://ghdx.healthdata.org/gbd-results-tool>



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 birth⁶

	2017–19 ⁷	2012–14	2005–07	2000–02	1995–97
Female	83.5	83.2	82.2	81.1	79.7
Male	80.0	79.5	78.0	76.3	74.4

Ethnicity and sex ⁸	2017–19 ⁹	2012–14	2005–07	2000–02	1995–97
Māori females	N/A	77.2	75.1	73.2	71.3
Māori males	N/A	73.0	70.4	69.0	66.6
Non-Māori females	N/A	83.9	83.0	81.9	80.6
Non-Māori males	N/A	80.3	79.0	77.2	75.4

- 6 URL: www.stats.govt.nz/information-releases/new-zealand-period-life-tables-201214 and www.stats.govt.nz/information-releases/new-zealand-abridged-period-life-table-201719. Last year's report included life expectancy data for the period 2013–15 to 2016–18. This data was based on abridged period life tables which provide an interim indication of trends. The life expectancy table in this year's report has been updated to include data from complete period life tables (where available) based on the advice of Stats NZ. Complete period life tables are the most authoritative source on life expectancy (ref: Stats NZ, <http://datainfoplus.stats.govt.nz/item/nz.govt.stats/ebbc62a6-cac8-4c8e-bd89-lfblbe2bc159>)
- 7 Life expectancy figures for 2017–19 are an interim indication of trends from abridged period life tables which use 2013-base population estimates for the period. All other figures are based on complete period life tables. Care should be taken when comparing these two sets of data.
- 8 These are the latest results available and are the same as reported in our 2018/19 Annual Report.
- 9 Definitive results for the 2017–19 period will be available when complete period life tables, using 2018-base population estimates, are published in the next year. This will include Māori and non-Māori life tables.



Decrease age-standardised disability-adjusted life years (DALYs) per 1,000 people

Measure

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.

Target

Decrease

Result

Age-standardised DALY rates per 1,000 population decreased steadily from 1990 until 2017. The rate of decrease has slowed in recent years. As the population is growing and ageing, the absolute number of DALYs has slowly increased from 1,014,438 in 1990 to 1,162,704 in 2017.

Disability-adjusted life years (DALYs) per 1,000 people¹⁰

	2019	2018	2017	2016	2013	2010	2005
Male	217	217	215	215	220	227	244
Female	198	197	197	196	199	204	212
Total	207	207	205	205	209	215	227

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 expenditure.

Target

Maintain OECD position.

Result

New Zealand has maintained its position within the OECD as having relatively high life expectancy for relatively modest expenditure. New Zealand performs well internationally with the 17th-highest life expectancy out of 37 OECD countries while expenditure was only 19th highest in 2018.

OECD life expectancy and health expenditure – position out of OECD countries¹¹

	2018	2017	2015	2010	2005
Life expectancy	17th of 37	15th of 35	14th of 35	13th of 35	12th of 35
Health expenditure	19th of 35	19th of 35	19th of 35	20th of 35	23rd of 35

10 Prior year results have been updated as the estimates are recalibrated and re-estimated based on new information, data and methods each year. URL: <http://ghdx.healthdata.org/gbd-results-tool>

11 Japan had not reported 2018 life expectancy at the time these rankings were prepared, but as Japan was ranked 1st in 2017, it is very likely to be ranked higher than New Zealand in 2018. The life expectancy ranking has reduced slightly since 2007 as New Zealand has been overtaken by Ireland, Luxembourg, South Korea, Greece and the Netherlands, which made larger gains in life expectancy than New Zealand. Note other countries have made larger gains as well, but they started from a comparatively low life expectancy.

URL: https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT# (accessed 20 July 2020).

This information comes directly from the OECD. Prior year results are updated by the OECD 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 37 countries as countries join the organisation and/or when information is sent in. The differences in the number of countries in the denominator can be due to member countries not sending in data (for example, Chile has yet to report life expectancy numbers for 2017) and the fact that Columbia joined the OECD in April 2020.



Impact measures

Table 2: Impact measures

Measure						
The results of the burden of disease surveys are improved.						
Target						
Improved results						
Result						
Results have continued to improve from 1990 for most risk factors.						
Health loss attributable to selected risk factors based on age-standardised DALY rates per 1,000 people ¹²						
Risk factors surveyed	2019	2018	2017	2010	2000	1990
High blood pressure (systolic)	12.1	12.2	11.9	13.8	21.1	21.1
High low-density lipoprotein (LDL) cholesterol	6.8	6.8	6.7	7.8	12.7	20.3
Tobacco use	17.0	16.9	16.9	20.1	28.1	41.9
Alcohol use	10.7	10.7	10.6	10.1	11.1	14.5
Insufficient intake of vegetables	0.7	0.7	0.7	0.8	1.2	1.9
Insufficient intake of fruit	1.1	1.1	1.1	1.2	1.7	2.4
Low physical activity	1.7	1.7	1.6	1.6	1.9	2.6
Illegal drug use	3.8	3.9	3.8	3.7	3.8	3.2

12 Behavioural factors, including poor diet, insufficient physical activity and use of alcohol and tobacco, as well as the consequences of these behaviours, such as high body mass index, blood glucose and cholesterol, are the leading causes of health loss (measured by disability-adjusted life years) in New Zealand. The major health conditions contributing to health loss are coronary heart disease, respiratory conditions including chronic obstructive pulmonary disease (COPD), depressive disorders and transport-related injuries. This is consistent with a global trend, known as the epidemiological transition, whereby the leading causes of death and disability are shifting away from infectious causes and towards chronic conditions. Risk factors are cumulative; in general, the more risk factors that are present in a person's life, the poorer that person's health outcomes are likely to be over time. Multiple risk factors in one person are associated with earlier and more rapid development of a condition, more complications and recurrence, a greater health loss and disease burden and a greater need for management of a condition.

Prior year results have been updated as the estimates are recalibrated and re-estimated based on new information, data and methods each year. URL: <http://ghdx.healthdata.org/gbd-results-tool>



Measure

At least 85 percent of new babies are enrolled with Plunket in the Well Child / Tamariki Ora (WCTO) programme

Target

Greater than 85 percent

Result

For 2020/21 the Ministry expects DHBs to work with subcontracted WCTO providers and Plunket to collectively achieve 85 percent coverage of new babies across all quintiles within each DHB area. Overall, the enrolment rate of new babies in WCTO services has been declining since 2015/16; we aim to address this trend and improve the rate through our new DHB expectation along with changes resulting from the WCTO review.

Six-month data to December 2019 shows 78 percent of new babies are referred to WCTO. This data includes both Plunket and DHB WCTO providers. Although this is a significant drop from data for 2018/19 and 2017/18, the data from the earlier years came from estimates only.

New babies enrolled with the Well Child / Tamariki Ora programme ¹³	2019/20	2018/19	2017/18	2016/17
Percentage	88.7%	90.7%	89.8%	91.10%

Measure

Daily smoking prevalence falls to 10 percent by 2018 and Māori and Pacific rates halve from their 2011 levels as part of Smokefree 2025¹⁴

Target

Prevalence less than 10 percent. Targeted reduction: Māori greater than 50 percent, Pacific greater than 50 percent

Result

Overall, the prevalence of daily smoking has reduced since 2011 and the Ministry continues to focus on reducing smoking through prevention and providing support to quit.

Daily smoking prevalence (15 years and over) ¹⁵	2018/19	2017/18	2016/17	2015/16
Total population	12.5%	13.1%	13.8%	14.2%
Māori	30.9%	31.2%	32.5%	35.5%
Pacific	21.4%	20.0%	21.8%	21.8%

13 2016/17 results only include services provided by Plunket. DHBs also provide these services. The results for 2018/19 and 2017/18 have been updated to include all providers. 2019/20 results are for the period up to 15 May 2020.

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

15 Daily smokers (adults aged 15+ years) smoke every day and have smoked more than 100 cigarettes in their whole life. Total response measure of ethnicity. People who reported more than one ethnic group are counted once in each group reported.



Measure

B4 School Check (B4SC) is provided to 90 percent of the eligible population.

Target

90 percent

Result

The B4SC is a free health and development check for all four-year-old children. Identifying health or development problems early allows children to be connected to and access support services before they start school. The B4SC includes hearing, eyesight, height, weight and oral health assessments. It was not possible to deliver or complete B4 School Checks during COVID-19 Alert Levels 4 and 3, which has resulted in performance delivery below target.

Percentage of B4 School Checks provided to eligible population

	2019/20	2018/19	2017/18	2016/17
Percentage of eligible population	73.1%	91%	93%	94%

Measure

Suicide rates decline for all ages.

Target

Reduce

Result

The Ministry continues to focus on reducing suicide rates. In 2016, 560 people died by suicide in New Zealand, which equates to an age-standardised rate of 11 per 100,000.

Suicide rates (per 100,000 population)

Age	2016	2015	2014	2013
15–24 years	16.8	16.9	14.1	17.8
25–44 years	16.5	14.4	16.3	14.2
45–64 years	14.6	14.4	14.2	16.0
65+ years	9.3	9.5	9.5	8.9



Measure

The annual influenza programme of 1.2 million influenza vaccines is delivered.

Target

1.2 million vaccines

Result

Influenza is a significant public health issue in New Zealand. Each year it has a large impact on our community, with 10–20 percent of New Zealanders infected. The number of vaccines delivered as of 30 June 2020 has reached a record for any influenza season in New Zealand. This year's programme was impacted by increased demand due to COVID-19. In response, the Ministry supported the supply of an additional 700,000 vaccines to ensure that vaccination can continue until the end of the influenza season.

Number of vaccines delivered (million)	2019/20	2018/19	2017/18	2016/17
Number of vaccines delivered	1.34	1.32	1.29	1.20

Measure

Infant mortality rates continue to decrease from a baseline of 4.8 deaths per 1,000 live births in 2009.

Target

Decrease

Result

Infant mortality is an ongoing focus for the health sector. In particular, we have a sustained focus on reducing early neonatal deaths through improving maternity care and reducing sudden unexpected death in infancy (SUDI) and sudden infant death syndrome (SIDS).¹⁶

Infant mortality rates per 1,000 live births	2016	2015	2014	2013
Māori	6.3	4.9	7.2	5.3
Pacific peoples	6.7	7.1	7.1	7.6
Asian	2.8	4.3	5.0	4.1
Other	2.9	3.2	4.6	4.4
Total	4.2	4.3	5.7	5.0

16 The number of fetal and infant deaths in New Zealand is small, which may cause rates to fluctuate markedly from year to year. Accordingly, these rates should be interpreted with caution. These are the latest results available and are the same as those reported in our 2017/18 Annual Report.



Measure

Amenable mortality decreases.

The amenable mortality rate measures premature deaths (deaths of people aged under 75 years) from causes that the health system could potentially have prevented.

Target

Reduce

Result

Amenable mortality rates have reduced from 146 deaths per 100,000 in 2000 to 87.8 deaths per 100,000 in 2016. This shows that the health system has been successful in reducing amenable mortality. Although the overall rate of amenable mortality is declining, disparities between ethnicities remain.

Amenable mortality rates: deaths per 100,000 population¹⁷

	2016	2015	2014	2013
Deaths per 100,000 population	87.8	90.7	92.6	92.6

Measure

The service quality score (SQS) for public services (including health services) continues to improve.

The annual service quality scores collected in the Kiwis Count survey measure New Zealanders' satisfaction with a range of commonly used services. These include a public health sector score and three specific health services measures: stayed in a public hospital; used the 0800 health service phone line; and received outpatient services (including accident and emergency).

Target

Overall SQS for public service health targets continues to improve.

SQS for health services (0800 health services phone line and outpatient services) continues to improve.

Result

The Ministry and the health sector are engaged in a range of local and national initiatives to make gains in the areas identified in the Kiwis Count survey as being less satisfactory. The scores are by calendar year and do not capture the response to COVID-19 in the 2020 year.

Service quality score at the public health sector level¹⁸

	2019	2018	2017	2016
Service quality score at the public health sector level	73%	73%	73%	73%
Stayed in a public hospital	75%	72%	74%	73%
Used 0800 health phone line	76%	73%	73%	74%
Received outpatient services (including accident and emergency)	71%	72%	72%	72%

17 We have made a minor adjustment to the historical data since its publication in the 2018/19 Annual Report to reflect improved population data.

18 Public Service Commission – Kiwis Count Survey. URL: publicservice.govt.nz/our-work/kiwis-count



Measure

Reduction in the proportion of older people requiring residential care and in the rate of acute hospital use.

Target

Reduced prevalence

Result

The health sector is focusing on improving the independence of older people. The aim is to maintain, or slow the decline of, the health of older people so they do not deteriorate to the point where they are better off in residential care. The majority of older adults also prefer to stay in their own home.

Reduced prevalence shown through residential care¹⁹

	2018/19	2017/18	2016/17	2015/16
Number of older people aged 65+ requiring residential care	31,828	31,701	31,454	31,288
Proportion of older people aged 65+ requiring residential care	4.2%	4.3%	4.4%	4.6%

The rate of acute hospital use through bed days is a measure of how effectively health system resources are being used. It may be affected by the quality of primary health care, discharge planning and ongoing communication about a person's care between hospital and community care. The corresponding aim is to reduce the rate of acute hospital use.

Reduced prevalence shown through acute hospital use²⁰

	2018/19	2017/18	2016/17	2015/16
Acute hospital use number of bed days for older people aged 65+	1.10 m	1.06 m	1.04 m	1.04 m
Acute hospital use number of bed days per older person aged 65+	1.45	1.42	1.45	1.51

19 The aged residential care (ARC) numbers are derived from the Demand Planner that DHBs and providers are able to use to plan for future demand for ARC services. URL: <http://centraltas.co.nz/health-of-older-people>

20 Results are based on the latest results available at the time of reporting for the 12-month period ending March for 2015/16. Results for 2016/17, 2017/18 and 2018/19 are for the 12-month period ending June.



Measure

Ethnic health disparities are reduced.

Target

Reduce

Result

Reducing ethnic health disparities continues to be a key focus for the health sector. The following metrics indicate health inequities are persisting. Challenges for future improvement remain.

Current smokers unadjusted prevalence (percentage of population) of adults aged 15 years or older²¹

Ethnicity	2018/19	2017/18	2016/17	2015/16
Māori	34.0%	33.5%	35.3%	38.6%
Pacific peoples	24.4%	22.9%	24.5%	25.5%
Asian	8.4%	7.8%	8.2%	9.1%
European and other	12.4%	13.5%	14.2%	14.5%

Ambulatory sensitive hospitalisations (ASH) crude rate per 100,000 population for children aged 0–4 years²²

Ethnicity	2019	2018	2017	2016
Māori	7,950	8,538	7,283	7,272
Pacific peoples	12,145	12,879	11,635	12,543
Other	5,288	5,575	5,581	5,674
National total ²³	6,615	7,009	6,564	6,697

ASH age-standardised rate per 100,000 population by ethnicity for adults aged 45–64 years²⁴

Ethnicity	2019	2018	2017	2016
Māori	7,578	7,429	7,283	6,908
Pacific peoples	9,118	9,267	8,737	9,013
Other	3,022	3,128	3,174	3,106
National total	3,864	3,928	3,913	3,806

- 21 Current smokers are adults aged 15+ years that have smoked more than 100 cigarettes in their lifetime and currently smoke at least once a month. Total response measure of ethnicity. People who reported more than one ethnic group are counted once in each group reported.
- 22 The national total includes all ethnicities. Results from previous years (as reported in our 2018/19 Annual Report) have been updated. The data sets are updated regularly to take account of updates or corrections from inpatient records reported by DHBs. Source: National Minimum Dataset and Statistics New Zealand (base population). URL: www.nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive
- 23 National Minimum Dataset and Statistics NZ (base population). URL: www.nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive
- 24 National Minimum Dataset and Statistics NZ (base population). URL: www.nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive



Measure

The proportion of people with a K10 score greater than 12 is reduced.

K10 measures a person's experience of symptoms such as anxiety, confused emotions, depression or rage in the past four weeks. People with a score of 12 or more have a high probability of having an anxiety or depressive disorder.

Target

Reduce

Result

The 2018/19 New Zealand Health Survey found that 8.2 percent of adults experienced psychological distress in the four weeks before taking part in the survey.

Percentage of people with a K10 score ≥ 12 ²⁵

	2018/19	2017/18	2016/17	2015/16
Females	10.4	10.0	8.7	8.6
Males	5.9	7.1	6.4	5.0
Total	8.2	8.6	7.6	6.8
Māori	13.7	13.9	11.5	10.5
Pacific peoples	12.4	11.0	11.8	11.3

25 Annual Data Explorer 2018/19. URL: www.health.govt.nz/publication/annual-update-key-results-2018-19-new-zealand-health-survey (accessed 26 June 2020).

Psychological, or mental, distress (aged 15+ years) refers to a person's experience of symptoms such as anxiety, psychological fatigue or depression in the past four weeks.

Psychological distress means having high or very high levels of psychological distress, with a score of 12 or more on the 10-question Kessler Psychological Distress Scale (K10). Where people have these levels of psychological distress, the probability is high or very high that they also have an anxiety or depressive disorder. A K10 score of 12 or more is strongly associated with having a mental (depressive or anxiety) disorder in the previous month and in the previous year (Kessler et al 2003). (Kessler RC, Barker PR, Colpe LJ, et al. 2003. Screening for serious mental illness in the general population. Archives of General Psychiatry 60(2): 18)

Total response measure of ethnicity. People who reported more than one ethnic group are counted once in each group reported.



Appendix 2: System performance measures

The System Level Measures (SLM) programme has created a social movement for quality improvement. It has mobilised hundreds of people in the health system, in particular front-line health care professionals, to come together to improve quality of care delivered to their people. In some places, the SLM programme prompted clinicians from primary care and hospitals to work together for this purpose.

Outcome measures take years to change so it is too soon to measure the success of the programme with hard evidence such as reduction of ASH or bed day rates. Results achieved so far relate to strengthening the enablers and the ways of working.

Table 3 summarises the results of the programme.

Table 3: System Level Measures national dashboard

Baseline (previous 12 months)	Expected trend	Results
Ambulatory sensitive hospitalisations (ASH)²⁶ rates per 100,000 children aged 0–4 years		
6,929 ²⁷ per 100,000 national mean March 2019 results	↓	6,423 per 100,000 national mean March 2020 results
Comment		
The 12-month rolling average to March 2020 shows a downward trend for Māori, Pacific and total populations. The equity gap for Māori (7,737) persists when compared with the non-Māori, non-Pacific rate (5,136). The top four conditions contributing to ASH rates continue to be respiratory, dental, gastroenteritis and cellulitis.		
Total acute hospital bed days per capita (standardised)		
417 ²⁸ per 1,000 national mean March 2019	↓	401 per 1,000 national mean March 2020
Comment		
The 9-month rolling average showed a downward trend for hospital bed day use. The rate for Māori and Pacific populations remains significantly high when compared with the non-Māori, non-Pacific rate. The Pacific population continues to have the highest hospital bed day use (699) compared with the non-Māori, non-Pacific rate (356) and Māori rate (566).		

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

27 We have made a minor adjustment to this result since its publication in the 2018/19 Annual Report to provide the latest available results, which include any additional records and updates from hospitals across New Zealand in the live database.

28 We have made a minor adjustment to this result since its publication in the 2018/19 Annual Report to provide the latest available results, which include any additional records and updates from hospitals across New Zealand in the live database.



Baseline (previous 12 months)	Expected trend	Results
Patient experience of care²⁹ (November 2019 survey results)		
Communication		
National mean (patient score out of 10) Adult inpatient = 8.3 Adult primary care = 8.3	↑	National mean (patient score out of 10) Adult inpatient = 8.3 Adult primary care = 8.3
Partnership		
National mean (patient score out of 10) Adult inpatient = 8.5 Adult primary care = 7.5	↑	National mean (patient score out of 10) Adult inpatient = 8.4 Adult primary care = 7.6
Coordination		
National mean (patient score out of 10) Adult inpatient = 8.3 Adult primary care = 8.4	↑	National mean (patient score out of 10) Adult inpatient = 8.3 Adult primary care = 8.4
Physical and emotional needs		
National mean (patient score out of 10) Adult inpatient = 8.6 Adult primary care = 8.3	↑	National mean (patient score out of 10) Adult inpatient = 8.6 Adult primary care = 8.2
Comment		
Adult inpatient survey		
At the national level, survey scores for the four domains have remained broadly consistent. They did not vary greatly between DHBs. The national response rate was consistent with previous rounds at 24 percent. Although respondents are reasonably representative of all ages and genders, younger people tend to be under-represented, while those aged between 65 and 74 years are over-represented. New Zealand Europeans tend to be over-represented while other ethnicities are under-represented.		
Adult primary care survey		
The primary care survey is designed to find out what patients' experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists and hospital. Similar to the inpatient survey, the response rate and the four domain scores have remained consistent, with little variation between DHBs. Domain scores are slower to change.		
The primary care survey is now the largest health survey in New Zealand and the second largest of any survey after the Census. The survey gives patients a voice at general practice level, with patient comments providing a rich data source.		
The purpose of both surveys is to provide general practice teams and DHBs with patient feedback to improve the quality of health services.		
Work is being undertaken to increase the response rates for Māori and Pacific populations.		

29 The Patient Experience of Care SLM is made up of experience surveys of primary care patients and inpatients. The surveys are administered quarterly and results presented for four key domains. The February 2020 survey was cancelled due to a change in the survey provider; therefore the comparator is nine months (November 2019 compared with February 2019 survey results).



Baseline (previous 12 months)	Expected trend	Results
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Amenable mortality³⁰

90.8 per 100,000 national mean – 2015 data	↓	87.78 per 100,000 national mean – 2016
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Comment

The time lag before data is available occurs because it is necessary to wait for the outcome of coronial inquiries. Amenable mortality rates have been declining over the last 10 years and we expect this trend to continue. The rates for Māori, in particular, and for Pacific populations have reduced over the last 10 years. However, the equity gap between rates for Māori and Pacific peoples and the rate of the total population has remained. Māori and Pacific rates are more than twice the non-Māori, non-Pacific rate.

Babies living in smokefree homes at six weeks postnatal³¹

56.1% for July to December 2018 data	↑	59.1% for July to December 2019 data
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Comment

The target is for 90 percent of babies to be living in smokefree homes at six weeks postnatal. Average rates for babies living in smokefree homes at six weeks postnatal are improving slightly. The rates for Māori have improved from 2018 (29.7 percent) to 2019 (35.7 percent). However, there remains a large equity gap for Māori babies who have a rate of 35.7 percent compared to the non-Māori, non-Pacific rate of 70.1 percent.

Youth access to and use of youth-appropriate health services³²

Child and adolescent mental health services real-time survey results for those aged 12–24 years

2.7% July 2016 – June 2017 0.8% July 2017 – June 2018 ³³	↓	1.1% July 2018 – June 2019
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Comment

This measure captures real-time survey results from those aged 12–24 years who are seen in child and adolescent mental health services. The measure is calculated based on the number of surveys fully or partially completed relative to the total number of unique clients using the service. DHBs vary widely in the number of surveys completed. A number of DHBs do not use the survey at all. Although the number of clients seen increased from the first to the second 12-month period, the volume of surveys fully or partially completed declined significantly (from 1,394 to 598). In the absence of a tool that measures young people's experience of the health system, we are using this measure temporarily until a more suitable tool becomes available.

- 30 Amenable mortality means deaths from those conditions for which variation in mortality rates (over time and across populations) reflects variation in the coverage and quality of health care (preventative or therapeutic services) delivered to individuals.
- 31 Data for this SLM is reported at six-monthly frequency. A new data standard, including a change in the denominator, came into effect on 1 January 2019.
- 32 This SLM is made up of five domains, each with a corresponding national indicator. DHBs choose a minimum of one domain as the focus for their improvement activities.
- 33 This data period, 1 July 2017 to 30 June 2018, was extracted on 28 September 2020. This data excludes the following DHBs: Canterbury, South Canterbury, Taranaki, Wairarapa, Hutt Valley and Capital & Coast.



Baseline (previous 12 months)	Expected trend	Results
Chlamydia testing coverage for those aged 15–24 years		
2017 data 15–19 years Male = 4.9% Female = 24.1%	↑	2018 data 15–19 years Male = 4.9% Female = 22.8%
20–24 years Male = 9.4% Female = 37.2%		20–24 years Male = 9.6% Female = 35.3%
Comment		
This data captures the unique number of specimens tested for chlamydia nationally. Although the latest data is two years old, it provides an important indication of young people’s access to sexual health services. Evidence shows that at least 30 percent testing coverage is required to reduce the rate of chlamydia infections in the population. Testing coverage for males is significantly lower than for females, showing a consistent pattern of coverage across the two age groups, therefore, focus has been on increasing male testing coverage.		
Self-harm hospitalisations and short-stay emergency department presentations for those aged 10–24 years (standardised)³⁴		
51.0 per 10,000 2017/18	↓	52.1 per 10,000 2018/19
Comment		
The age group of 15–19 years has a higher rate of self-harm hospitalisation (80.3) than the age group of 20–24 years (57.7). Māori have a higher rate (69.5) than non-Māori, non-Pacific (49.2) and Pacific peoples (33.1). Females have a significantly higher rate (80.3) than males (25.6).		
Alcohol-related emergency department presentations for those aged 10–24 years		
3.5% 2017/18	↓	4.0% 2018/19
Comment		
It became mandatory for emergency departments to collect this data from 1 July 2018. Because significant data quality issues persist with this data set, no meaningful analysis can be provided. The current focus for this measure is to improve data quality, in particular to reduce the number of ‘unknown’ responses. Results include both primary and secondary alcohol-related presentations.		
Adolescent oral health use for school years 9–13		
71% 2017 calendar year	↑	71.4% 2018 calendar year
Comment		
This result is based on service use, not enrolment, which is not reported. The total national data cannot be disaggregated by ethnicity.		

34 This data does not exclude short-stay emergency department hospitalisations and the data is not standardised.



Better Public Services

During 2018, the Government announced it would not be continuing the Better Public Services programme. Accordingly, results are not available for reporting in 2019/20.

Health targets

From 2017/18, the Government has directed the Ministry of Health to develop a new set of performance measures to improve health outcomes for New Zealanders. While work is under way to develop these new measures, DHBs will continue to report to the Ministry against the current set of health targets, as well as against a previously established set of wider measures.

Table 4: National health target results for 2019/20

Target area	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Shorter stays in emergency departments	95%	84.8%	86.4%	87.3%	90.4%
Faster cancer treatment	90%	88.0%	89.1%	85.5%	84.9%
Increased immunisation	95%	91.2%	92.0%	90.8%	90.7%
Better help for smokers to quit	90%	82.9%	82.1%	80.8%	80.0%
Raising healthy kids	95%	97.6%	97.1%	96.8%	95.2%



Appendix 3: Legal and regulatory framework

Additional statutory reporting requirements

The Minister of Finance has not specified any additional reporting requirements.

Health Act 1956

The Health Act 1956 requires the Director-General of Health to report annually on the current state of public health. The Minister of Health tables a Health and Independence Report each year in Parliament. The Minister is required to table the report by the 12th sitting day of the House of Representatives after the date on which the Minister received the report.

The Act also requires the Director-General to report before 1 July each year on the quality of drinking-water in New Zealand. Copies of the most recent report are made available to the public through the Ministry's website.

New Zealand Public Health and Disability Act 2000

The New Zealand Public Health and Disability Act 2000 requires the Minister of Health to report annually on the implementation of the New Zealand Health Strategy, the New Zealand Disability Strategy and the National Strategy for Quality Improvement. The Minister must make the report public and present it to the House of Representatives as soon as practicable after the report has been made.

Public Finance Act 1989

Section 19B of the Public Finance Act 1989 requires the Minister of Health to report annually on non-departmental expenditure relating to health sector agencies other than Crown entities. The Minister of Health will table the Vote Health Report, in relation to selected non-departmental appropriations for the year ended 30 June 2020, in Parliament within four months of the end of the financial year (by the end of October) or, if Parliament is not in session, as soon as possible after the commencement of the next session of Parliament.



Legislation administered by the Ministry of Health

The Ministry of Health administers the following legislation:

Burial and Cremation Act 1964

Cancer Registry Act 1993

Compensation for Live Organ Donors Act 2016

COVID-19 Public Health Response Act 2020

Disabled Persons Community Welfare Act 1975 (Part 2A)

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

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

Support Workers (Pay Equity) Settlements Act 2017

Smoke-free Environments Act 1990

Substance Addiction (Compulsory Assessment and Treatment) Act 2017.



Other regulatory roles and obligations

In addition to the Ministry's role of administering legislation, key personnel within the Ministry (such as the Directors of Public Health and Mental Health) have specific statutory powers and functions, including under the following Acts:

Biosecurity Act 1993
Civil Defence Emergency Management Act 2002
Education Act 1989
Food Act 2014
Gambling Act 2003
Hazardous Substances and New Organisms Act 1996
Local Government Act 1974
Local Government Act 2002
Maritime Security Act 2004
Prostitution Reform Act 2003
Sale and Supply of Alcohol Act 2012
Social Security Act 2018
Victims' Rights Act 2002
Waste Minimisation Act 2008.

International compliance

The Ministry helps the Government to comply with certain international obligations by supporting and participating in international organisations such as the World Health Organization. The Ministry also ensures New Zealand complies with particular international requirements, such as the International Health Regulations (2005) and the Framework Convention on Tobacco Control and a range of United Nations conventions.

Web resources

For Ministry of Health publications, go to **health.govt.nz/publications**

For regulations administered by the Ministry go to **health.govt.nz/our-work/regulation-health-and-disability-system**

For full, searchable copies of the Acts and associated regulations administered by the Ministry, go to **legislation.govt.nz**



Appendix 4: Asset performance indicators

Table 5: Asset performance indicators

Actual 2018/19	Indicator	Indicator type	Actual 2019/20	Target 2019/20
Property				
83%	Percentage of buildings with a Property Council of NZ Grade ³⁵ of C or better	Condition	89%	>80%
100%	Percentage of buildings with an Initial Evaluation Process – New Building Standard Seismic Grade of C or better	Condition	100%	100%
100%	All building warrants of fitness ³⁶ current	Condition	100%	100%
15.3 m ²	Average occupancy m ² per head	Utilisation	14.62	<14 m ²
100%	Percentage of buildings with a functionality rating ³⁷ of 3 or better	Functionality	100%	100%
74 kwh/m ²	Average power used kWh/m ²	Functionality	73 kWh/m ²	<80 kWh/m ²
Information and communications technology (ICT)				
99.77%	Availability of five key ICT applications including internal Ministry and sector systems (note 1)	Availability	99.87%	99%
99.87%	Availability of key sector- and public-facing systems (note 1)	Availability	99.46%	99%
15,178	The number of active sector user logins to national systems (note 2)	Utilisation	5,069	15,000

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

Note 2: The methodology used to calculate the 2019/20 result was changed to reflect the number of active sector user logins that are registered in the national system.

35 URL: www.propertynz.co.nz/sites/default/files/uploaded-content/website-content/quality_grading_matrix.pdf

36 A building warrant of fitness is a building owner's annual statement confirming the specified systems in the compliance schedule for their building have been maintained and checked for the previous 12 months, in accordance with the compliance schedule. For more information, go to: www.building.govt.nz/building-officials/guides-for-building-officials/building-warrants-of-fitness/

37 Building functionality assesses the fitness for purpose or suitability of the building 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; and 4 ideal.



Appendix 5: Committees

Section 11 committees

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

Capital Investment Committee

The Capital Investment Committee provides independent advice to the Director-General of Health and the Ministers of Health and Finance on capital investment and infrastructure in the public health sector in line with government priorities. This includes working with DHBs to review their business case proposals, prioritisation of capital investment, delivery of a National Asset Management Plan and any other matters that the Minister may refer to it.

Membership

Evan Davies (chair)	Paul Carpinter	Jan Dawson
Professor Des Gorman	Murray Milner	Dr Margaret Wilsher

Health and disability system review

The Minister of Health appointed the Expert Review Panel for Health on 28 May 2018. The term of office started on 8 August 2018 and ended on 31 January 2020.

Membership

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

Māori Expert Advisory Group

Sharon Shea (chair)	Dr Terryann Clark	Dr Dale Bramley
Takutai Moana Natasha Kemp	Linda Ngata	Assoc. Professor Sue Crengle



Health Workforce Advisory Board

The Health Workforce Advisory Board is established under section 11 of the New Zealand Public Health and Disability Act 2000 (the Act) to provide advice to the Minister of Health (the Minister) on health workforce matters, including strategic direction, emerging issues and risks. It is a health workforce advisory committee under section 15 of the Act.

Membership

Prof Judith McGregor (chair)	Dr Joanne Baxter	Alisa Claire
Associate Professor Andrew Connolly	Lorraine Hetaraka	Karl Metzler
Sophie Oliff	Faumuina Associate Professor Fa'afetai Sopoaga	

Health and disability ethics committees

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

Membership: Northern A Health and Disability Ethics Committee

Kate O'Connor (acting chair)	Dr Karen Bartholomew	Dr Sotera Catapang	
Catherine Garvey	Dr Michael Meyer	Dr Kate Parker	Rochelle Style

Resigned between 1 July 2019 and 30 June 2020: Dr Christine Crooks, Manuka Henare, Graham Mellsop

Membership: Northern B Health and Disability Ethics Committee

Kate O'Connor (chair)	John Hancock	Dr Nora Lynch	Tangihaere Macfarlane
Stephanie Pollard	Leesa Russell	Susan Sherrard	

Resigned but staying on until a new member is appointed: Jane Wylie

Membership: Central Health and Disability Ethics Committee

Helen Walker (chair)	Helen Davidson	Dr Peter Gallagher
Sandy Gill	Dr Ptries Herst	Julie Jones
Dr Cordelia Thomas	Dr Jillian Wilkinson	

Resigned between 1 July 2019 and 30 June 2020: Dean Quinn

Membership: Southern Health and Disability Ethics Committee

Helen Walker (chair)	Dr Pauline Boyles	Dr Paul Chin
Dr Devonie Eglinton (nee Waaka)	Dominic Fitchett	Dr Sarah Gunningham
Associate Professor Mira Harrison-Woolrych		Professor Jean Hay-Smith

Resigned between 1 July 2019 and 30 June 2020: Raewyn Idoine and Nicola Swain



Other committees

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

Advisory Committee on Assisted Reproductive Technology

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

Membership:

Dr Kathleen Logan (chair)	Colin Gavaghan (deputy chair)	Calum Barrett
Tim Barnett	Rosemary de Luca	Seth Fraser
Dr Karen Reader	Catherine Ryan	Karaitiana Taiuru
Dr Analosa Veukiso-Ulugia	Dr Sarah Wakeman	

Ethics Committee on Assisted Reproductive Technology

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

Membership:

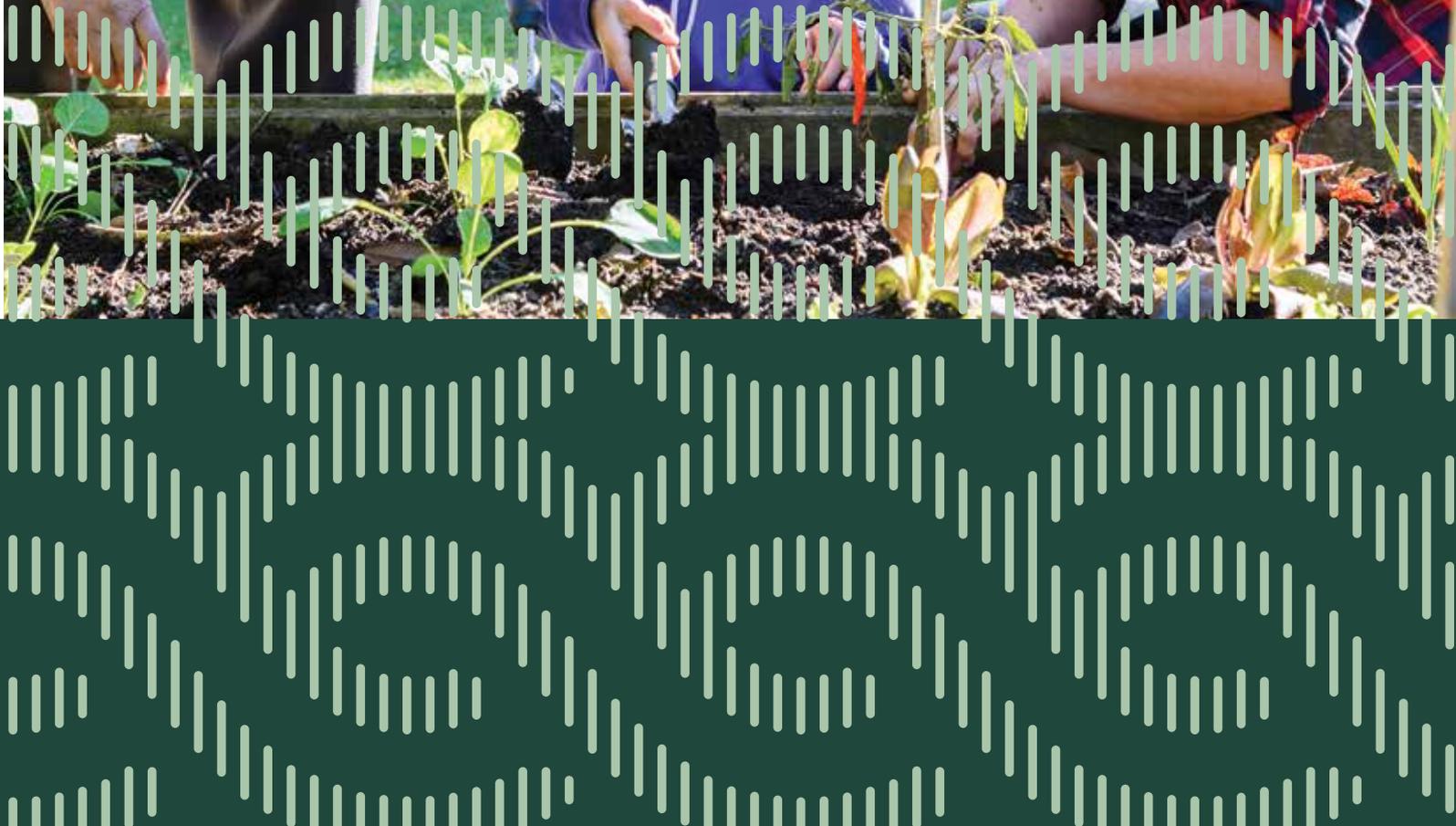
Iris Reuvecamp (chair)	Dr Mary Birdsall	Judith Charlton
Dr Paul Copland	Associate Professor Michael Legge	Michèle Stanton





TE AHO
O TE KAHU
CANCER
CONTROL
AGENCY

Annual Report 2019–2020



**Together weaving the
realisation of potential**

**Mā te whiritahi, ka
whakatutuki ai ngā
pūmanawa ā tāngata**

Introduction from the Chief Executive

It is my pleasure to present the inaugural Annual Report for Te Aho o Te Kahu, the Cancer Control Agency.

It is hugely gratifying to look back over the seven months since the Agency was formally established and to reflect on how much has been achieved in that relatively short, yet very disrupted period.

When we commenced in December 2019, the Cancer Control Agency was focused on achieving a balance of establishment activity and project delivery to bring about improvements in cancer care.

One of our first priorities was building very strong multi-level networks across the health sector; with those affected by cancer, Hei Āhuru Mōwai, the Māori Cancer Leadership Group and international experts and partners to help us to drive and support change.

As it happened, these networks and relationships, combined with the size, focus and agility of our organisation, placed us well to respond effectively to the challenges thrust upon New Zealand by the arrival of COVID-19. I am very proud of how the cancer sector rallied around the challenge of providing appropriate care to those affected by cancer during this time.

Our Agency has a lofty vision of fewer cancers; better survival; and equity for all. This is to be achieved through an agency that is equity-led, knowledge-driven, person- and whānau-centred and outcomes-focused, taking a whole-of-system focus to preventing and managing cancer.



We have structured Te Aho o Te Kahu to consider options in a 'deep' way; integrating clinical expertise across high level national policy to health service operationalisation via five workstreams:

- equity
- person and whānau centred care
- treatment, Quality and Standardisation
- data, Monitoring and Reporting
- prioritisation, Innovation and Research

Our Agency extends to three (shortly four) regional hubs across New Zealand Aotearoa, making the Agency a truly national organisation.

I would finally like to acknowledge all those affected by cancer and those whose efforts continue to be focused on improving cancer prevention, care and outcomes for all New Zealanders. Our staff feel the weight of responsibility and have a strong commitment to deliver on your vision.

Ngā mihi

Professor Diana Sarfati
Chief Executive and National Director of
Cancer



Who we are

On 1 September 2019, the Government announced their intention to establish a Cancer Control Agency (the Agency) and to create a single National Cancer Control Network. This was an innovative solution to a pressing need for improved quality and consistency of cancer care and prevention nationwide. On 2 December 2019 the Agency was opened by the Prime Minister and Hon. Dr David Clark and in Budget 20 the Government committed \$30.7 million to the establishment of the Agency over the next four years.

An agency focused on cancer

Te Aho o Te Kahu, the Cancer Control Agency is a newly established independent departmental agency. It is hosted by the Ministry of Health but reports directly to the Minister of Health. These new arrangements better recognise the impact cancer has on the lives of New Zealanders and provide 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 in the next two decades; the costs and complexity of care; and the pace of change present major challenges for our systems and service; and Māori and Pacific people have worse survival than other New Zealanders. Cancer survival is improving in New Zealand, but our rate of improvement is slower than other comparable countries, so we are at risk of falling behind.

The purpose of the Agency is to provide strong central leadership and oversight of cancer control. It is equity-led, knowledge-driven, person- and whānau-centred and outcomes-focused, taking a whole-of-system focus on preventing and managing cancer.

The Agency's vision is:

- fewer cancers
- better survival
- equity for all.

Our commitment to the goal of achieving equity is being embedded in all of the Agency's processes and work programmes.

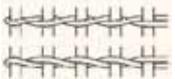
The Agency believes a strong regional presence is a key success factor in achieving the aims of the government with respect to cancer. To this end, the Agency has undertaken a change programme to move the previously contracted regional cancer networks into the Agency as regionally based internal teams.

Our name: Te Aho o Te Kahu

On 18 June 2020 at a ceremony hosted at Parliament, Hei Āhuru Mōwai – the Māori Cancer Leadership Group gifted the Cancer Control Agency with the name Te Aho o Te Kahu. In accepting the name, the Agency upholds its commitment to honour Te Tiriti o Waitangi, its principles and intentions and to uphold the mana and integrity of the name and its meaning.

Te Aho o Te Kahu refers to the central thread that binds and unites the many strands into one cloak to clothe and protect people and their whānau.

Metaphorically:

<p>Te Aho: <i>the central thread</i></p> 	<p>symbolises the Agency and its role as a leader and connector across the cancer control continuum.</p>
<p>Te Kahu: <i>the cloak/garment</i></p> 	<p>symbolises all the services/organisations/people and communities that work across the cancer continuum.</p>

Equity will not only be the priority of the agency in its role as 'Te Aho' but it will also be embedded into its architecture, processes, systems and tikanga.

Our governance and partners

Several groups have been established to strengthen external advice and input into the operation of Te Aho o Te Kahu. These are described briefly below.

Te Aho o Te Kahu, Cancer Control Agency Advisory Council

The Council provides expert and authoritative advice to the Chief Executive relating to a whole-of-system focus on preventing, treating and managing cancer. It is responsible for providing leadership, direction and oversight on the implementation of the Cancer Action Plan.

Hei Āhuru Mōwai

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.

Clinical Assembly

The Clinical Assembly provides clinical advice to support the long-term strategic direction for reducing cancer incidence and improving cancer services across the cancer continuum. The Clinical Assembly includes cancer-related clinicians from a broad range of medical, nursing and allied health specialities.

Consumer Group

Immediate work is under way to build an appropriate advisory group made up of cancer consumers, to ensure the right insights are integrated into our priorities and work. This group, once set up, will sit alongside Hei Āhuru Mōwai and the Clinical Assembly.

Partners

One of the key functions of the Agency is to link and liaise between the many parties and organisations involved with cancer prevention and care. In the current system, this includes direct relationships between the Chief Executive of the Agency and the Chief Executives of the Ministry of Health, Pharmac, Health Promotion Agency, Health Quality & Safety Commission and all 20 District Health Boards. The relationship between the Agency and its host the Ministry of Health is particularly important and is supported through co-location.

In addition to these core relationships, the Agency has developed strong active links with Māori and Pacific health leaders, consumer-led groups, clinical leadership groups, NGOs and primary care. In the seven months that the Agency has existed, these relationships have been established, embedded and strengthened.

Our people

As at 30 June 2020, Te Aho o Te Kahu employs 20.2 FTE, supported by an additional contracted 6.2 FTE.

No staff have departed the Agency as at 30 June 2020.



A greater proportion of both our leadership team and wider staff are female.



Te Aho o Te Kahu is committed to achieving a diverse workforce. As at 30 June 2020, 20 percent of our employed staff identify as Māori.





What we have achieved

In the past seven months, Te Aho o Te Kahu has focused on activity to establish itself as an effective and high performing agency and we have also progressed high priority work to improve cancer care. The Agency was also able to pivot and reassign resources rapidly to respond to the challenges associated with the COVID-19 pandemic.

The Cancer Action Plan

In January 2019, the Minister of Health announced at the Cancer at a Crossroads Conference that a new cancer control action plan would be developed. The development of the plan was undertaken by the Ministry of Health in consultation with a wide range of key stakeholders selected to ensure patient views would be prominent.

The plan published in February 2020 has a strong emphasis on delivering and targeting services to ensure equitable outcomes for all New Zealanders.

The Plan has four key outcomes.

1. New Zealanders have a system that delivers consistent and modern cancer care.

National leadership, a skilled and sustainable workforce and the right information to make the best possible decisions.

2. New Zealanders experience equitable cancer outcomes.

Following a cancer diagnosis, New Zealanders will receive the best treatment and care no matter who they are or where they live.

3. New Zealanders have fewer cancers.

Supporting prevention programmes and policies that will assist New Zealanders to make healthy choices.

4. New Zealanders have better cancer survival.

New Zealanders receive person- and whānau-centred cancer care that is appropriately timed and of high quality, from early detection through to living well with and beyond cancer and end-of-life care.



Response to COVID-19

During the recent COVID-19 response, Te Aho o Te Kahu showed its ability to lead the sector as a small and nimble agency. This

was perhaps the strongest illustration of the advantages of this structure in enabling strong national leadership. We were able to quickly mobilise and build consensus guidelines with clinical leaders to ensure that health services were able to appropriately maintain and optimise the availability of cancer treatment services at a time when the health system was seeking guidance and support on how to respond during the pandemic. As a result, cancer treatment was largely unchanged, supporting the wellbeing of many vulnerable New Zealanders.

Te Aho o Te Kahu worked closely with the cancer sector to support the ongoing delivery of cancer services in the context of COVID-19. This included rapid work with a wide range of experts to develop and distribute guidance on expectations around the provision of cancer treatment services (medical oncology, radiation oncology and haematology, cancer surgery and cancer imaging) at different hospital alert levels. We also worked in partnership with the Ministry of Health to provide guidance on gastrointestinal endoscopy services.

During the COVID-19 lockdown, Te Aho o Te Kahu met regularly with clinical working groups to address issues that arose and provided regular updates and a short video for cancer patients.

Te Aho o Te Kahu also released a well-received video for those affected by cancer during the lockdown. The video can be found here <https://www.health.govt.nz/our-work/diseases-and-conditions/cancer/te-aho-o-te-kahu-cancer-control-agency/cancer-and-covid-19-novel-coronavirus>.

Immediately following lockdown Te Aho o Te Kahu released monthly reports outlining the impact of COVID-19 on cancer services based on up-to-date diagnostic and treatment data to inform decision-making.

Equity-led

Our commitment to the goal of achieving equity is being embedded in all the Agency's processes and work programmes. This was demonstrated during the response to COVID-19 where the Agency worked closely with Hei Āhuru Mōwai to actively consider the effects of service changes on equity, mitigating this impact through equity-supporting guidance and following up with an analysis to quantify this impact. We were pleased to see that there was no direct impact of increasing inequalities for Māori and Pacific people as had been previously feared.

The Cancer Action Plan articulates a commitment to working with Māori in the development and implementation of a framework to support Māori to develop and exercise mātauranga approaches in the delivery and experience of cancer treatment and care. Te Aho o Te Kahu started to consider how this obligation may be met.

Te Aho o Te Kahu has commenced development of an equity action plan and equity prioritisation framework to inform our work and improve decision-making.

The Agency has actively focused on building the cultural capability of its staff.

Improving quality of care

The Agency is focused on improving quality and consistency of cancer care across the country. One key element of this is the quality performance indicator programme, with a commitment to complete at least three priority cancers, with recommendations for actions within our first year. Current work is focused on developing indicators for colorectal, lung, head and neck, prostate and pancreatic cancers, melanoma and neuroendocrine tumours.

A Lung Cancer Quality Performance Report has been compiled in partnership with the National Lung Cancer Working Group and a draft report is expected to be available for release in September. Early indications are that this report will show variation in outcomes for patients being treated for lung cancer. We will develop a quality improvement plan to support DHBs to respond to the findings of the report.

Data for a Prostate Cancer Quality Performance Report has been collated and is nearing completion.

Head and Neck Indicators have been developed following a detailed literature review of indicators internationally. These indicators have been sent out for sector consultation.

A Neuro Endocrine Tumours (NETs) Quality Performance Report is also close to completion.

Pancreatic Cancer Quality Performance Indicator work has commenced with the first meeting between the Agency and the sector working group held on 29 June 2020.

We are planning to begin the process of developing breast cancer quality performance indicators later this year.

Data and information to support services

The Cancer Action Plan has an action to improve integration of primary and community with secondary care services for those diagnosed with or in active treatment for cancer.

The Systemic Anti-Cancer Therapy New Zealand (SACT NZ) programme will produce clinically agreed, evidence-based anti-cancer drug regimens to support the national standardisation of treatment, equity of access

to therapy and improved planning / efficient use of resource. Up to the end of June 2020 Te Aho o Te Kahu had developed regimens for bowel, lung and prostate cancers. These regimens are expected to go live in December 2020.

Te Aho o Te Kahu actively administers the Radiation Oncology Collection (ROC). ROC is a national collection of detailed treatment data for people receiving radiation therapy in New Zealand Aotearoa across both the public and private sector. The insights generated through ROC data have driven a number of quality improvement and equity initiatives over the last two years to improve both access to treatment and the standardisation of treatment protocols.

In February 2020, Te Aho o Te Kahu initiated a report on the current state of cancer prevention, diagnosis, treatment and outcomes for cancer. This is due to be released in December 2020 to mark the Agency's first anniversary. This report provides a baseline against which we can monitor progress.

The Agency is working with several other groups including the Ministry of Health, the Health Promotion Agency and academic colleagues to produce a report to support strengthening our approach to cancer prevention. This report will focus on issues such as tobacco control, healthy food, physical activity, being sun smart and managing chronic infections that can cause cancer.

Access to services

Te Aho o Te Kahu has commenced two projects to ensure that those who most need a colonoscopy can get it quickly. The first was the development of new evidence-based surveillance guidance and the second is a project in partnership with the Ministry of Health involving incorporating an additional test for those waiting for a colonoscopy.

Both have the goal of ensuring those who need a colonoscopy receive their colonoscopy in a timely manner and that those who do not need a colonoscopy avoid the unnecessary harm of a procedure.

Other projects started this year aimed at improving access to and consistency of care include molecular and genetic testing for those diagnosed with cancer and radiological surveillance after treatment.

Work also commenced with cancer clinicians to improve access to clinical trials.

Establishing a high-performing agency

Te Aho o Te Kahu has been focused on creating a fit for purpose organisation that has the right foundations to be successful. The Agency is on track to achieve planned capability within one year of establishment.

Transition of the Ministry of Health Cancer Services Team

To create a foundation capacity and capability for Te Aho o Te Kahu, during December 2019 and January 2020 the Agency and the Ministry of Health undertook a change programme to transfer all the five existing staff from the cancer services team in the Ministry to Te Aho o Te Kahu.

Recruitment

A large amount of time and effort was spent undertaking recruitment to ensure a high calibre of appointments during a period of rapid growth across the Agency.

By the end of the financial year, Te Aho o Te Kahu had 20.2 FTE based in Wellington. A prioritised schedule of recruitment has supported the placement of 16 roles since December 2019.

Most recruitment to the senior leadership team is now complete, with only the appointment of a permanent Clinical Director outstanding.

Regional hubs

When the government announced their intention to establish a Cancer Control Agency, they also announced their intention to create a single National Cancer Control Network to improve consistency of cancer services across regions.

To achieve this end, Te Aho o Te Kahu ran a change programme to transfer contracted staff from three of the four regional cancer networks into the Agency. These staff are based in Hamilton, Palmerston North and Christchurch to remain well-connected to local service delivery. This was completed with all staff commencing as permanent employees on 1 July 2020.

Preliminary work to transfer the Northern Cancer Network was also completed. It is expected that these Auckland-based staff will transfer to Te Aho o Te Kahu by the end of December 2020.

Clear governance and accountability processes

As described in the 'Our governance and partners' section above, Te Aho o Te Kahu has rapidly established a governance and advisory structure to support achievement of Agency objectives.

Key to this is a very close relationship to three advisory groups, providing input from Māori, clinical experts and consumers.

The agency also regularly meets with specialist working groups to progress work relating to particular cancer services or tumour types.

The establishment of the Te Aho o Te Kahu Advisory Council has provided essential oversight of the Agency, whilst providing expert and authoritative advice.

Te Aho o Te Kahu has prioritised building good relationships with those to whom the Agency is accountable. The Chief Executive and General Manager have had monthly meetings with the Minister of Health and have initiated meetings with relevant Associate Ministers. A relationship has also been built with the Public Service Commission. Connections have been made with crucial central government processes including the Leadership Development Centre, Heads of HR, Procurement and Ethics and Integrity.

Development of performance and progress reporting and performance indicators has been delayed due to prioritisation of the COVID-19 response. However, Te Aho o Te Kahu is committed to developing robust and transparent performance measures and reporting by the end of the 2020 calendar year.

A brand and identity

As a departmental agency with a focused agenda it is important that we establish an identity and brand that represents our Agency vision, purpose and values. This identity is distinct from the Ministry of Health, yet supports the Ministry's strategic objectives.

During January to March 2020, Te Aho o Te Kahu worked with external support to clarify our Agency's vision and goal, while also working with Hei Āhuru Mōwai to discover an appropriate Te Reo name for the Agency. These parallel strands came together to deliver a very strong identity, name and ethos for the Agency built around the metaphorical concept of the Agency as the aho, or binding weave, of a cloak, bringing all parties with

interests in cancer together to provide warmth, comfort and hope for those affected by cancer.

Te Aho o Te Kahu is committed to living up to the ideals represented by the taonga that is the name gifted to us through Hei Āhuru Mōwai.

Communications and engagement

Te Aho o Te Kahu is working with Homecare Medical on development of a website for the Agency with up-to-date, relevant information we can provide to people with lived experience of cancer, clinicians and health service providers on cancer prevention, on treatment and support and on service performance and outcomes. The first phase of the website went live in September 2020.

Through this website and other established communication channels, the Agency aspires to be the official and trusted source of information on cancer and cancer services.

One of the foundational elements being embedded into the way Te Aho o Te Kahu does business is successful ongoing partnerships and networking. The Agency is aspiring to be implemented in a way that is Treaty of Waitangi compliant, with demonstrable partnership with Māori at every level of the organisation. Hei Āhuru Mōwai works closely with the Agency and facilitates the Agency's formation and supports its relationships with Māori.

The Agency has established proactive and ongoing engagement processes with key stakeholders, including the Minister and Associate Ministers of Health; Director General of Health and Ministry of Health staff; health services including District Health Boards at both leadership and operational levels; other Agencies responsible for delivery of actions in the Cancer Action

Plan; cancer clinicians; academics; those affected by cancer and their families; Pacific leaders and communities; and other groups disproportionately impacted by cancer.

Te Aho o Te Kahu have implemented a monthly sector e-newsletter which informs cancer service providers of Agency progress, current issues and updates

Operating model, policies and processes

Te Aho o Te Kahu follows most of the policies and process of its host agency, the Ministry

of Health. This includes corporate policies relating to human resources, procurement and finance. The Ministry and Te Aho o Te Kahu are currently developing their Departmental Agency Agreement.

In addition, the Agency has developed independent business continuity planning, risk and mitigation strategies, and work planning processes. The Agency is currently developing its formal operating model.



Statement of responsibility

I am responsible, as Chief Executive of the Cancer Control Agency (Te Aho o Te Kahu) 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 my opinion, the Annual Report fairly reflects the operations, progress, and organisational health and capability of Te Aho o Te Kahu.

Professor Diana Sarfati

Chief Executive

Te Aho o Te Kahu, Cancer Control Agency

30 November 2020

