

Ministry of Health

Annual Report

for the year ended 30 June 2021

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A message from the Director-General

Kia ora koutou katoa.

I am pleased to present the Ministry of Health's 2020/21 Annual Report. The financial year 2020/21 was another extraordinary one. It also included significant milestones such as the announcement of the health and disability system reforms, and the start of our COVID-19 Vaccine and Immunisation Programme as well as our ongoing response to the pandemic.



public health units to meet unprecedented demand on their services and worked with the wider health and disability system to lead them through the response..

From the beginning of the global pandemic, we have been flexible and responsive, shaping services and functions to meet the needs that each Alert Level has created for New Zealanders. We have always looked

ahead with a view to where we wanted to be and how to get there.

Responding to COVID-19

The COVID-19 pandemic has placed immense pressure on people and systems alike. It has been an honour to work alongside dedicated and talented people at the Ministry, throughout the health and disability sector and across government, and with the general public in support of our nation's COVID-19 Elimination Strategy. Leading the health sector response to COVID-19 has become a medium-term responsibility for the Ministry of Health.

Our COVID-19 Health System Response directorate is leading the ongoing health response, which ranges across incident response, testing, contact tracing, supply chain, staying on top of emerging science and evidence, to health at the border including in managed isolation and quarantine. Our COVID-19 Vaccination and Immunisation Programme is rolling out the largest vaccination programme in our history. We have supported the nation's

COVID-19 Vaccine and Immunisation Programme

Medsafe's approval of the Pfizer-BioNTech COVID-19 vaccine in February 2021 marked the start of the COVID-19 Vaccine and Immunisation Programme (CVIP), our largest-ever immunisation programme.

The phased vaccine roll-out is well under way, with over half a million New Zealanders fully vaccinated by 30 June 2021. We expect all eligible New Zealanders will be able to be vaccinated by the end of the 2021 calendar year and we are also supporting the vaccine roll-out in the Pacific.

The design and delivery of this programme is an enormous undertaking and a significant achievement.

This achievement reflects the huge amount of work by the Ministry's CVIP team



alongside district health boards (DHBs) and service providers, who continue to deliver the vaccine roll-out ahead of plan, on top of carrying out their usual responsibilities. Everyone supporting this important mahi deserves our thanks.

Health and disability system reforms

Following the Health and Disability System Review, released in June 2020, the Minister of Health, Hon Andrew Little announced a high-level operating model for the reformed system in April 2021.

This new model includes changes for the Ministry of Health, the proposed role of new structures such as a Māori Health Authority, Health New Zealand, a Public Health Agency within the Ministry of Health, and details of how the functions of DHBs will be delivered in the future.

With these significant changes, we expect most of the health and disability system will look and work differently in the future. The Ministry's role as chief strategic advisor and kaitiaki (steward) of the health and disability system will be strengthened, with a focus on strategy, policy, regulation and reporting, we will lead the wider sector and

monitor progress against our shared goals and objectives for New Zealand.

We are working with the Transition Unit in the Department of the Prime Minister and Cabinet to implement the reforms, while continuing to provide the health system with the support and guidance it needs for the wellbeing of all New Zealanders. The Ministry of Health is in good shape and well placed to continue its role as kaitiaki of the health and disability system.

I would like to thank my colleagues in the Ministry, along with those from across the wider health and disability system and the public sector, for their extraordinary efforts in 2020/21. Thank you too, for the manaakitanga shown by all, as we worked together during the 2020/21 year and look toward to 2021/22.

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



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**Who we are and
What we do**

**Ko wai mātou,
he aha ā mātou
mahi**







About the Ministry of Health

Health and disability policy choices are complex and challenging. As kaitiaki (steward) of the health and disability system and lead advisor to the Government on health and disability issues, the Ministry of Health provides clear and expert clinical, technical and practical advice, supported by strong, evidence-informed analysis.

Vote Health is the primary source of funding for New Zealand's health and disability system, which includes the Ministry of Health.

New Zealand's 20 district health boards (DHBs) carry out most of the day-to-day business of the health and disability system and administer nearly three-quarters of the Vote. 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.

Of 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 and delivery of the sector. Just over 1 percent of the Vote is for Ministry operating costs.

The health and disability 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. The Minister for COVID-19 Response also has responsibilities for some aspects of the Health response to COVID-19.

Our kaitiaki responsibilities

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

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 provide 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 cover the whole lifespan of health, disability and wellbeing – from maternity and childhood, through to palliative care and old age.

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 1,600 staff based in seven locations across New Zealand Aotearoa. 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.

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.

Procuring 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 national screening services, 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 2020/21, we received 399,063 telephone enquiries about payments.

Regulatory and enforcement services

As part of our regulatory and enforcement services, we ensure health products, services and premises are safe and meet international and legal obligations. We issue licences and certifications. In addition to coordinating public health protections, we 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 related services

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.

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.

National response to COVID-19 across the health sector

We lead and coordinate the national response to the COVID-19 pandemic across the health sector.

Implementing the COVID-19 Vaccine Strategy

We advise on and manage the implementation of the COVID-19 vaccine strategy.

Capital expenditure

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



Ngā Uaratanga | Our Values

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

how we work together within the Ministry, across the health and disability sector, with our public sector colleagues and with communities to achieve pae ora | healthy futures.

Our Ministry values | Ngā Uaratanga



Tā Tātou Rautaki | Our Strategy

Our organisational strategy Tā Tātou Rautaki sets out how we are working towards **pae ora | healthy futures**.

Tā Tātou Rautaki demonstrates **our purpose** as kaitiaki of the health and disability system and **our mission** to have

a fair, effective and sustainable system that people trust.

It also articulates the **strategic objectives** we want to achieve as a Ministry over the coming years and the **organisational capabilities** we will need to be successful.



Our 2020/21 at a glance

He tirohanga ki ā mātau whakahaere i te tu 2020/21



1,170,000

doses of Pfizer-BioNTech
COVID-19
vaccine administered

1,500,000

telehealth calls, texts,
emails, and webchats
answered
(up from 1 million in 2019/20)



1.77 million
influenza vaccines
distributed

140,000
New Zealanders
provided with
disability support
services



294
Million
NZ COVID
Tracer app
scans



Influenza equity gap for
Māori aged 65+
reduced from
12.1% to **8.4%**

8,622
COVID-19
vaccinators
trained



280,000+
screens through
BreastScreen Aotearoa
(1,409 cancers detected)



1.3 million
COVID-19 tests
in the community

102
COVID-19
media standups delivered

206,000
mental health and addiction
service contacts answered
supporting 105,000 people



540,000
COVID-19 Tests
for border workers
and MIQ guests

400,000+
screens in National
Cervical Screening
Programme
(181 Cancers detected)

408,000
Ministry contact centre
calls
(up from 336,000 in 2019/20)

4,261 WPQs received
4,186 answered
96 OPQs received and answered
2,071 OIAs received
1,849 completed

Need to Talk? 1737 service
answered more than
130,000 contacts
supporting 63,000 people
experiencing distress



77%
of DHB-employed **health care**
workers vaccinated for
influenza nationwide

**Our
performance
outcomes**

**Ā mātou
putanga ā-mahi**





Leading the COVID-19 health response

The Ministry of Health is the lead advisor to the Government on the COVID-19 health response and leads the response across the health and disability system.

Due to the success of the Government's COVID-19 Elimination Strategy, New Zealand was able to contain the disease, and the country was at Alert Level One for most of 2020/21. Although imported cases and limited community transmission occurred, the measures in place for border control, intensive testing, rapid contact tracing, and clear guidance on hygiene, illness, self-isolation and quarantine allowed most schools and workplaces to continue to operate safely.

For the majority of the year, New Zealand had few restrictions on personal movement, and people were encouraged to record their movements with the NZ COVID Tracer app. In 2020/21, NZ COVID Tracer app users recorded more than 294 million scans, an average of 807,000 per day. On 4/5 September 2020, 2.5 million scans were recorded.

Responding to COVID-19 has become part of the Ministry's core business. We have established a dedicated directorate to manage the ongoing COVID-19 health response, focused on disease management (rather than emergency management). These teams are responsible for contact tracing, testing and the health-related aspects of managed isolation and quarantine. They also support DHBs and public health units with COVID-19 related activities.

We established another directorate specifically for the COVID-19 Vaccine and Immunisation Programme.

COVID-19 health response in the community

The Ministry has made equity and Te Tiriti o Waitangi central pillars of the COVID-19 health response. We have provided up-to-date information in a range of accessible formats so that all communities have access to critical information – an approach that the World Health Organization has commended. We also engage widely with iwi and Pacific leaders to ensure our actions support equitable access to information, diagnosis, health, disability and social services.

There were 232 cases of community transmission of COVID-19 in 2020/21. The Ministry advises the Government on Alert Level settings and the risks community transmission poses to New Zealand.

In 2020/21 1,350,098 community and 547,195 border COVID-19 tests were completed in New Zealand.¹ The country has 14 laboratories with a combined capacity to complete more than 32,000 COVID-19 tests per day.

Case investigation and contact tracing are fundamental components of the COVID-19 response. The Ministry's National Investigation and Tracing Centre provides national oversight of case investigation and contact tracing, management of identified contacts, support to public health units during community outbreaks,

¹ Border tests include border workers (air crew, airport staff, maritime crew, port staff and managed isolation facility workers) and guests in managed isolation facilities. Not all tests classified as border workers are strictly mandatory. This was due to different border orders being in place over 2020/21, and different applications of testing requirements between locations.



and technical training and support on contact tracing.

All public health units use the Ministry's National Contact Tracing System to record interactions between cases and

contacts. The system includes the Border Management and Workforce Testing Register.



COVID-19 technology

The Ministry leads the development and ongoing management of health sector information systems. Our innovative and rapidly developed technology has played an essential role in New Zealand's COVID-19 response. We had an extraordinary year providing data and digital solutions to support the COVID-19 response and vaccination programme that culminated in three national awards.

- All public health units use the Ministry's National Contact Tracing System to record interactions between cases and contacts. The system includes the Border Management and Workforce Testing Register and provides a secure and managed pipeline for data from the sector.
- The Managed Isolation and Quarantine Patient Management System allows health professionals to undertake health assessments, document interventions and send the information to the person's registered general practitioner on their departure from managed isolation and quarantine (MIQ).
- Use of the NZ e-Prescription Service has increased by 280 percent over 2020/21, with 90 percent of general practices now using it. The service enables doctors and other prescribers to send electronic prescriptions securely and directly to pharmacies.
- The Inter-Regional Travel Exemption webform streamlines the application process for travellers needing to move between regions during Alert Levels Three and Four. Over three days in February 2021 when Auckland was at Alert Level Three, more than 4,800 applications were processed via this webform.
- A data and analytic platform was developed to support the Ministry's surveillance efforts and to share a national view of COVID-19 data and insights across the health sector. This platform reduced demand on DHBs to do their own reporting and analytics and can be extended to provide an early warning and surveillance response system for other communicable diseases.
- Through an agreement between the Ministry and the largest mobile data providers, mobile phone users have free access to 14 websites with essential information related to COVID-19 and health more generally, including covid19.govt.nz, health.govt.nz, depression.org.nz, lowdown.co.nz, plunket.org.nz and quitstrong.nz.



- We implemented an intensive programme to acquire and share data faster to support the COVID-19 health system response and the COVID-19 Vaccine and Immunisation Programme, including developing nearly 20 new datasets.
- The Ministry was jointly awarded the Qlik Excellence in Healthcare Award for our use of data and analytics in the COVID-19 response. We developed, released and maintained more than 20 new Qlik Sense applications to support COVID-19 data and analytics.
- The National Contact Tracing Solution won a Salesforce Innovation Award, and we also received awards from IT Professionals of New Zealand for Excellence in Digital Health and Excellence in Govtech.
- The Ministry continues to investigate innovative ways to enhance all parts of the Elimination Strategy. This includes exploring the potential use of wearable technologies such as contact tracing cards and apps to measure temperature changes for people in MIQ.

COVID-19 Vaccine and Immunisation Programme

The Ministry is responsible for planning the infrastructure, logistics, training and technology to support delivery of the COVID-19 Vaccine Strategy. An immunisation programme of this scale, cost or complexity has never been attempted before.

We are working across the health and disability system to make it easy for New Zealanders to be well informed and get vaccinated, with a particular focus on:

- putting safety first with all COVID-19 vaccines
- securing enough safe and effective vaccines to protect New Zealand Aotearoa and the Pacific region
- protecting Māori, Pacific peoples and other groups at greater risk of COVID-19
- making it easy for people to get vaccinated
- ensuring we are prepared for future outbreaks
- supporting New Zealand's contribution to global wellbeing.

The Ministry is a member of COVID-19 Vaccines Global Access (COVAX), a global mechanism for pooled procurement of COVID-19 vaccines. COVAX ensures fair and equitable access for all 190 participating nations, using an allocation framework that the World Health Organization developed.

The Ministry negotiated Advance Purchase Agreements with four pharmaceutical suppliers. In February 2021, Medsafe approved the use of the Pfizer-BioNTech COVID-19 vaccine. By 19 February 2021, New Zealand Aotearoa was administering the first vaccines to priority groups.

The Ministry purchased nine large -80°C freezers that together can store more than 1.5 million doses of vaccine. These are held in our central storage facility for the Pfizer-BioNTech vaccine, providing the ultra-low temperatures that the vaccine requires. Vaccines are distributed from these central storage facilities in a highly controlled way to our cold chain network across the country.

As an important part of planning and implementing the vaccine roll-out, the Ministry held hui with iwi leaders and fono



with Pacific leaders. Here we answered questions, provided information and harnessed support for the vaccination programme while learning the best ways to support whānau Māori and Pacific peoples to get immunised. To ensure that everyone eligible in New Zealand Aotearoa receives a vaccine, the Ministry staggered the vaccine roll-out into four groups.

Group 1: Border and MIQ workers and the people they live with (began 19 February)

Group 2: High-risk frontline workers and people living in high-risk places (began 19 February)

Group 3: People who are at risk of getting very sick from COVID-19 (began 1 May)

Group 4: All other people (scheduled to begin 1 September)

Supporting COVID-19 vaccinations in the Pacific region

The Ministry of Health is supporting vaccine roll-out in the Pacific. New Zealand supported the Cook Islands, Niue and Tokelau to complete full eligible population coverage by August 2021.

Support included provision of the Pfizer vaccine from New Zealand's portfolio, consumables, vaccination training, pharmacovigilance and communications materials. The New Zealand Medical Assistance Team (NZMAT), a Ministry-led, civilian-based deployable emergency medical team comprised of clinical and non-clinical personnel from the New Zealand health and disability system, was deployed to assist the Cook Islands reach approximately 90 percent vaccination coverage.

New Zealand will continue to support these countries with any ongoing vaccine needs alongside other support to our nearest neighbours in Polynesia including Samoa, Tonga and Tuvalu. Dose donation of COVID-19 vaccine is an important part of New Zealand's overall vaccine strategy, and the Ministry will continue to be actively involved alongside other agencies in particular the Ministry of Foreign Affairs and Trade, including supporting other countries such as Fiji.



As at 30 June 2021

1,174,810 doses
of Pfizer-BioNTech
COVID-19 vaccine
administered

8,622 COVID-19
vaccinators trained

18.2%
of the eligible population
had **at least one dose**

11.5%
of the eligible population
fully vaccinated





Health at the border

The greatest COVID-19 risk to New Zealanders is at our border. New Zealand went 'hard and early' to control the spread of COVID-19 and effectively closed our air and maritime borders to all but returning New Zealanders and vital trade supplies.

The Ministry is one of six agencies on the Border Executive Board. We have specific responsibility for the ongoing health presence at the border, enabling sustained and sustainable management of health risks at international points of entry and exit.²

More than 500 health border staff work in airports, ports and MIQ facilities to:

- diagnose and manage any COVID-19 disease at the border
- prevent transmission of COVID-19 by maintaining infection prevention and control standards
- provide a collaborative model of health to support the health and wellbeing of returnees and staff in MIQ facilities.

MIQ facilities and airports operate constantly at Alert Level Four settings (except for 'green' flights from quarantine-free travel locations). That brings a range of challenges for health staff, including:

- constant use of personal protective equipment and following the strictest hygiene measures
- having very tight operating processes and rules
- being frequently tested for COVID-19
- working with clients who are themselves tired, upset and sometimes unwell.

We provide advice to the Government on how and when our borders should open. During 2020/21 the Government was able to open quarantine-free travel with Australia, Niue and the Cook Islands. The Ministry closely monitors the quarantine-free travel arrangements and provides advice on travel restrictions as the COVID-19 situation in these and other countries changes.

2 The Border Executive Board was established in January 2021 as the first interdepartmental executive board under the Public Service Act 2020. An interdepartmental executive board is a new way to deal with complex issues that cannot be solved by one public service agency alone. It brings together agency chief executives to work collectively with joint accountability on a particular subject. The Border Executive Board members are: New Zealand Customs Service (Chair), Ministry of Business, Innovation and Employment, Ministry of Foreign Affairs and Trade, Ministry of Health, Ministry for Primary Industries and Ministry of Transport.



The stronger Delta variant of COVID-19 will pose future challenges for New Zealand, and the Ministry and other border agencies are prepared for potential future cases.

- 8,568 arrivals through quarantine-free travel with the Cook Islands
- 186,654 arrivals through quarantine-free travel with Australia
- 27 managed isolation facilities
- 4 dual isolation and quarantine facilities
- 1 dedicated quarantine facility
- 6 DHBs involved – Counties Manukau, Auckland, Lakes, Waikato, Capital & Coast, and Canterbury
- 982 COVID-19 cases detected at the border



Our achievements – equity

People differ in their level of health and independence in ways 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.

Our commitment to achieving equitable outcomes in health underpins everything the Ministry does. As steward of the health and disability system, we develop strategies and policies that set the direction for other agencies and providers, and we commission services specifically designed to meet the needs of the diverse people of New Zealand Aotearoa.

This year, we have taken the following actions to improve equitable outcomes for Māori and all other people.

We progressed Whakamaua | the Māori Health Action Plan 2020–2025

Whakamaua | the Māori Health Action Plan 2020–2025 gives life to He Korowai Oranga | the Māori Health Strategy. Whakamaua establishes the initial system settings necessary to meet obligations under Te Tiriti o Waitangi and achieve the aims of the health and disability system reforms to advance Māori health and well-being.

Whakamaua sets out 46 actions to achieve the outcomes sought. In 2020/21, 41 of the actions are being implemented. A monitoring approach will provide insights

to support momentum for wider system change and future direction.

Māori–Crown Partnerships

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

In 2020, the Ministry completed a stocktake of iwi Māori Health relationships with DHBs, including regional partnership models Kōtahi Hauora (Northern Iwi–DHB Partnership Board) and Te Manawa Taki Governance (Midlands Iwi–DHB Partnership Board). This work is contributing to the reform implementation programme through describing current Iwi Māori partnerships and informing future Māori–Crown relationships across the health and disability system. This work also contributed to the development of Wānanga Hauora to support and develop leadership in this area.

Wai 2575

The Ministry’s position statement on Te Tiriti o Waitangi was refreshed and expanded into a framework to better enable the health and disability system to meet its Tiriti obligations. It outlines the updated expression of the Crown’s Te Tiriti obligations in the context of the health and disability system, adopting the principles of Te Tiriti as articulated by the Waitangi Tribunal in the Hauora Report (Wai 2575).

Leading and responding to the recommendations of the Hauora Report and continuing to support subsequent stages of the Wai 2575 kaupapa inquiry



is explicitly prioritised as a Māori-Crown Partnerships action.

In the past year the Ministry has engaged with the Wai 2575 stage one claimants and provided support for them to undertake work to progress responses to the Hauora Report interim recommendations:

- developing a draft term of reference to explore the possibility of a stand-alone Māori health authority, and
- agreeing a methodology to assess the extent of underfunding of Māori PHOs and providers since 2000.

Whakamaua is itself the fulfilment of a key recommendation for the Crown to develop a national Māori health action plan and the implementation of the health reforms specifically addresses both these and other Hauora Report recommendations including the establishment of a Māori Health Authority and strengthening Te Tiriti in the new health legislation currently being drafted.

Pae Ora Commissioning Framework

Investment in equitable and sustainable approaches to commissioning kaupapa Māori and whānau-centred services is a key priority. A Pae Ora Commissioning framework (the framework) has been developed that sets out action across all stages of the commissioning process to ensure that the purpose, design, and delivery of services in the health sector focuses on what matters to whānau and Māori communities. This includes monitoring, evaluation and continuous improvement approaches.

The framework is grounded in Te Tiriti o Waitangi principles and draws on the insights from Puao-te-Ata-tū, Te Whare Tapa Whā, Whānau Ora and the Wai 2575 Health Services and Outcomes Kaupapa

Inquiry. The framework was also built from Te Puni Kōkiri's Te Piringa research developed in partnership with the Ministry of Health, with the aim of bringing the Whānau Ora vision into primary and community care.

Advice on effective commissioning is being integrated into organisation and system change processes.

Hui Whakaoranga 2021

Māori leadership and Māori health sector development includes investment in increasing opportunities for Māori leaders to guide decision-making, share, collaborate and plan together.

More than 360 people from across the Māori health and disability sector attended Hui Whakaoranga in Wellington, Dunedin, Waitangi, and Rotorua. Another 180 attended a national virtual hui held in July 2021. Hui Whakaoranga takes a generational approach to Māori health development, underpinned by the key theme 'Whāia te Pae Ora mō ngā mokopuna – Securing wellbeing for the next generation'.

Key themes from the Hui included a stronger focus on Māori leadership, embedding mātauranga Māori, mana-motuhake for Māori to lead their own kaupapa Māori services, supporting the growth of the Māori workforce and rangatahi leadership.

Key insights from the 2021 hui series will be published in a summary report. Hui Whakaoranga will continue annually throughout the implementation of Whakamaua.

Wānanga Hauora 2021

More than 300 leaders and governors from Iwi Māori Partnership Boards and DHBs



attended Wānanga Hauora across New Zealand Aotearoa from April to August 2021. These were the first step in a three-year programme that will enable health sector leaders and governors to meet their Tiriti o Waitangi responsibilities. Participants appreciated the opportunity to:

- get a first hand insight into **Whakamaua: Māori Health Action Plan 2020–2025** and how it will continue to drive action on Māori Health Equity over the next five years
- network with fellow DHB and Iwi Partnership Board members within and between regions and discuss shared challenges and opportunities
- engage with the Ministry to discuss their developmental needs to ensure future governance and leadership can give practical effect to Te Tiriti o Waitangi and Whakamaua
- start building a sense of joint health sector leadership, ownership, and accountability for addressing Māori health inequities.

Equity by Design

The Equity by Design Project is a partnership between the Ministry and the Health Quality System Commission to implement a human-centred design approach to thinking, practice and behaviour across the health and disability system.

Phase one is underway, and includes review of the Health Equity Assessment Tool, user personas, stocktake of existing equity and Te Tiriti tools, and a horizon scan to assess future opportunities.

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

The Ministry is leading a programme of work to address racism in the health and disability system. Phase one of Ao Mai

te Rā is a discovery phase – gathering evidence and insights to define racism, identify effective anti-racism solutions underway in the sector and develop an anti-racism maturity model. By the end of phase one the Ministry will have a better understanding of what is currently underway in the sector that aligns with best practice and great clarity for where areas of new investment into anti-racism solutions might be. Phase two will focus on ideation and proto-typing evidence based anti-racism solutions.

Monitoring Whakamaua

Whakamaua contains a monitoring framework containing three interrelated components:

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

Initial reports on the quantitative measures were presented to the Hui Whakaoranga and the full set will be published on the Ministry website. The first of the quantitative reports, the Māori Provider Funding Report to 2019/20, is already online at: [Funding to Māori Health Providers 2015/16 to 2019/20 | Ministry of Health NZ](https://www.health.govt.nz/publication/funding-maori-health-providers-2015-16-2019-20).³ The commissioning of external evaluation is progressing in partnership with the Health Research Council.

We progressed the disability system transformation

The Enabling Good Lives approach supports disabled people by offering greater choice and control over the support they receive, which in turn gives them greater control over the life they, as individuals, choose to lead. Three pilot regions (MidCentral, Canterbury and Waikato) are delivering improved

3 <https://www.health.govt.nz/publication/funding-maori-health-providers-2015-16-2019-20>.



outcomes for disabled people and their whānau. We provided certainty to disabled people and their whānau in these regions by securing ongoing funding for these activities.

Evaluations have shown that most participants in the Enabling Good Lives pilots report positive experiences and improved outcomes, including:

- increased independence, self-confidence and personal development
- expanded social networks
- opportunities to do things not possible under the previous system
- families and whānau feeling supported
- improved family dynamics
- parents feeling more confident and able to trust their family members' support worker because they and their adult child have chosen that support worker.

Through a 'try, learn and adjust' approach, we continue to make improvements to the Enabling Good Lives pilot, including by strengthening local governance and leadership roles and increasing capacity to meet demand.

We provided more than 140,000 people with disability support services

Each year, the Ministry of Health is responsible for planning and funding disability support services, worth \$1.7 billion, to people aged under 65 years who have a physical, intellectual or sensory disability likely to continue for at least six months, limiting their ability to function independently. Disability Support Services provides over 43,000 eligible disabled people with ongoing support and provides over 100,000 people with access to equipment, modifications and assistive devices such as hearing aids and cochlear implants.

This year we were able to permanently offer flexible Individualised Funding and Carer Support subsidies after the success of introducing them as a temporary help to families during the COVID-19 response in early 2020.

Individualised Funding is a mechanism that allows disabled people to manage the Home and Community Support Services they are allocated (eg, by choosing their own carer). Home and Community Support Services traditionally support personal care and home management. In 2020/21, around 8,000 people accessed Individualised Funding at a cost of \$164 million.

The Carer Support subsidy gives family members who are full-time carers of disabled people a break from their caring responsibilities and we have made it more flexible to allow people to use their subsidy in different ways. In 2020/21, almost 16,500 people accessed Carer Support at a cost of \$38.2 million.

We improved disability support services for Māori

Tāngata whaikaha form 18 percent of the total Ministry's funded disability support services population. Our commitment to achieving the vision of 'a good life with support' is centred on enabling tāngata whaikaha to move from dependence to independence with greater improved service choices, access options and control over their whānau and kaupapa Māori support.

Te Ao Mārama (Māori Disability Service Advisory Group) and Whānau Ora Interface Group have contributed to Enabling Good Lives system transformation planning, design, monitoring and provided support for demonstration site and community-based connector service delivery.



Contributions to the 2021 Health and Disability Services Standards review reflected tāngata whaikaha expectations and progressive provider modelling of services. The advice supported continued delivery of innovations which would lead to more person and whānau-centred health and disability services, provisions for allowing greater service choices, and practical solutions to improved control over the care and supports tāngata whaikaha and their whānau receive.

Te Ao Mārama advisory leadership members supported the drafting of the Ministry's COVID-19 response. Tāngata whaikaha leadership was represented across the Ministry's decision making on the COVID-19 response.

We improved disability support services for Pacific peoples

The Ministry has worked with Pacific disabled people, families, providers and government agencies to implement **Faiva Ora 2016–2021: National Pasifika Disability Plan**. Through this work, we have:

- increased access to disability support services
- developed and translated Pacific resources and tools
- implemented a Pacific cultural competency training programme
- supported the Tupu Aotearoa programme for Pacific disability through the Ministry for Pacific Peoples
- established the Faiva Ora Pasifika Community Innovation Fund, which supports community-based initiatives to enhance participation, reduce stigma and increase access to support.

We have held fono with disabled people from the Pacific community, their families

and providers to find out what is working and what we need to change in order to continue to improve disability support services for Pacific disabled people and their families. The advice we have received will inform the direction of the future Faiva Ora plan.

We began implementing Ola Manuia | Pacific Health and Wellbeing Action Plan 2020–2025

Ola Manuia | Pacific Health and Wellbeing Action Plan 2020–2025 is a high-level guide for reflecting the needs and aspirations of Aotearoa's Pacific peoples across the health and disability system. It focuses on eight areas:

- health system development
- Pacific health workforce
- Pacific leadership
- long-term conditions and communicable diseases
- mental health and wellbeing
- COVID-19 response
- data
- cross-sector collaboration.

We undertook work to strengthen commissioning approaches with Pacific health providers, and supported the COVID-19 response for Pacific peoples (working closely with Pacific providers to support them to deliver wraparound support for Pacific families in partnership with other agencies).

Ola Manuia will inform future planning activities for the new Pacific health strategy that is signalled as part of the health and disability system reforms.



We improved the Pacific Provider Development Fund commissioning framework

The Pacific Provider Development Fund strengthens the sustainability of Pacific health providers. It supports the delivery of high-quality health services with a distinct Pacific focus to achieve the best health outcomes for Pacific peoples.

Following a review, we strengthened the commissioning framework to support a more transparent administration process and to introduce other improvements such as setting regional allocations of funding, standardising application forms and processes and introducing a capability and capacity self-assessment tool.

In 2020/21, 27 Pacific health providers received funding towards activities such as governance training, strategic planning, workforce development, and recruitment and retention strategies.

We provided Pacific Health Scholarships

The Pacific Health Scholarships improve Pacific health equity outcomes by increasing the number of trained Pacific peoples in the regulated health workforce in New Zealand Aotearoa. A larger Pacific health workforce will result in more culturally appropriate care for the Pacific population.

The scholarships cover tuition fees for students undertaking health and disability-related studies such as medicine, dentistry, nursing, midwifery and allied health. In 2020/21, 193 Pacific Health Scholarships were offered, and 177 accepted. The students who declined a scholarship had received funding from other sources. Since 2002, around 2,000 scholarships have been awarded to Pacific students nationally.





More than just a jab: the Māori Influenza Vaccination Programme

Compared with the New Zealand population as a whole, Māori are more likely to experience almost every type of illness and almost every known determinant of poor health.

In 2020, the Ministry of Health developed the Māori Influenza Vaccination Programme (MIVP), with the goal of improving health equity for Māori. MIVP funding allowed providers and DHBs to set up community- and whānau-centred flu vaccination approaches that are clinically safe and culturally responsive to achieve the greatest possible outreach to Māori.

The programme worked to reduce the barriers that block some Māori from accessing primary health care services. In particular, it:

- supplemented general practitioner and pharmacy services with community-based, nurse-led vaccinations, where most staff were Māori who knew how to engage well with whānau
- reduced the costs of getting vaccinated for Māori by going out into the community where whānau gather and live or offering transport to services
- provided vaccination services after hours for those who could not take time off work
- offered wrap-around services to be responsive to the particular circumstances of individual whānau; for example, alongside influenza vaccinations, services might include health care assessments, catch-up vaccines for pēpi and tamariki, hygiene and food parcels, access to mental health services and COVID-19 testing
- used multiple communication channels.

As a result of MIVP, the National Immunisation Record database recorded significantly higher vaccination rates for Māori than in previous years. Influenza vaccination rates for Māori aged 65 and over increased from 45.8 percent in 2019 to 59 percent in 2020. This increase is especially significant given that improvement was much more limited between 2015 and 2019.

- In 2020, the overall influenza immunisation equity gap for Māori aged 65 and over reduced from -12.1 percent to -8.4 percent.
- While some of the increase in vaccination rates will be due to increased awareness associated with COVID-19, the evidence suggests the MIVP also contributed.

- To help us to provide effective initiatives in the future, the evaluation of the programme identified three core strategies that made a difference for whānau Māori:

- mobilising services to go into the community
- taking a whānau-centred approach
- focusing on Māori workforce capability and capacity.

These strategies will inform our future work in transforming the health and disability system to ensure whānau Māori enjoy high standards of health and wellbeing.



Our achievements – safe, sustainable and people-centred services

To meet current and future needs, the Ministry will prioritise making services clinically and financially sustainable, of high quality and safe. 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.

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.

As the lead advisor to the Government on health and disability services, we develop legislation, regulation, strategies and policies that assure the quality and safety of health and disability services. We design and commission delivery of services that meet the needs of the diverse people of New Zealand. As part of our stewardship role, we also regulate many aspects of the health and disability system.

This year, we have taken the following actions to ensure health and disability services are safe, sustainable and people-centred.

We delivered the National Immunisation Programme

The Ministry is responsible for delivering the National Immunisation Programme, which provides more than 20 of the vaccines on the National Immunisation Schedule. The vaccines cover New Zealanders aged six weeks to over

65 years and include specific vaccines for pregnant women.

Many staff in the vaccination workforce have been deployed to the COVID-19 vaccine and immunisation programme. To maintain capacity, the Ministry focused the national measles campaign on specific DHBs where it is most needed. We expect the vaccinator workforce will be able to apply the lessons learned from COVID-19 mass vaccinations to other immunisation programmes in the future.

The goal of childhood immunisations (for those aged six weeks to 12 years) is to achieve immunisation coverage of 95 percent or more, which will not only protect the individual from vaccine-preventable disease, but also achieve herd immunity to protect those who are not immunised. However, rates have been declining since 2017. There is a significant equity gap between tamariki Māori and tamariki of other ethnicities, and rates vary widely across DHBs. The Ministry is working with DHBs and primary health organisations to maintain their focus on childhood immunisations, including outreach immunisation services and school-based immunisation programmes.

The 2020 Influenza Immunisation Programme saw a record 1.77 million people immunised. This included vaccinations for 77 percent of DHB-employed health care workers, the highest rate since 2010. The campaign also saw influenza vaccination rates for Māori increase significantly, and a reduction in the overall equity gap for Māori.

We also worked towards developing a replacement for the National



Immunisation Register. A new system, the National Immunisation Solution will allow health workers to record vaccinations anywhere, anytime. The public will be able to digitally access their own immunisation records. The first iteration of the system supported the COVID-19 vaccine roll-out and additional functionality will be added through further iterations.

We developed a long-term pathway for mental health and addiction

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction found that significant shifts were needed to improve mental wellbeing outcomes for everyone in Aotearoa. It set out a clear and aspirational vision for the future – mental health and wellbeing for all. We're transforming how we support people who need help with mental health and addiction issues – broadening the scope to include prevention and early intervention, addressing equity issues and supporting our most vulnerable.

A long-term pathway for mental health and addiction has been developed following extensive stakeholder consultation, which confirms the priorities for mental health and addiction. The Ministry also began work on a national services framework that will describe models of care and provide guidance to the sector on service specifications and monitoring.

We managed national cancer screening programmes

The **National Bowel Screening Programme** provides free screening for people aged 60 to 74 years, with the aim of detecting bowel cancer at an early, more treatable stage. The national roll-out of this newest

cancer screening programme (and the first one to include men) started in July 2017.

Seven DHBs joined the programme in 2020/21, expanding the reach to 86 percent of the eligible population. By 30 June, 17 out of New Zealand's 20 DHBs were in the programme, and the final three DHBs are expected to join by December 2021.

The national breast screening programme, **BreastScreen Aotearoa**, provides screening for women aged 45 to 69. In 2020/21, more than 280,000 breast screens were carried out, detecting 1,409 cancers. During the year we also secured funding and prepared for necessary improvements to the information technology systems that support the screening programme to provide better patient experiences, make screening services more accessible for Māori and Pacific women, send targeted invitation campaigns, and support the move to an opt-out system.

The **National Cervical Screening Programme** provides cervical screening for women aged 25 to 69. In 2020/21, more than 414,000 screens were carried out, detecting 181 cancers.

During the year we also secured funding and prepared for the introduction of human papillomavirus (HPV) cervical screening in 2023. HPV is the cause of 99 percent of cervical cancers. The new test is a simple and quick swab that women can choose to do themselves in private when they visit their healthcare provider. This will reduce barriers to participation and increase the number of wahine Māori getting screened. HPV testing is also more sensitive than the current method, which means the screening interval can be extended from three to five years.



We updated Ngā Paerewa | the Health and Disability Services Standard

Ngā Paerewa | the Health and Disability Services Standard sets out the minimum requirements for acceptable care and support within services including hospices, birthing units, abortion clinics, residential aged care and residential disability services.

The Standard also outlines what people who use these services can expect from them. In 2020/21 we partnered with Standards New Zealand, Te Apārangi: Māori Partnership Alliance, service providers, and people and whānau with lived experience of our health and disability services to update the Standard.

Ngā Paerewa reflects the types of health and disability services being provided today, while being flexible enough to reflect changing models of care. Ngā Paerewa puts people and whānau at the centre and supports providers to meet their obligations under Te Tiriti o Waitangi.

The updated Standard comes into effect in February 2022. Over the coming months, the Ministry will work with providers on implementation.

We implemented the Medicinal Cannabis Scheme

The Medicinal Cannabis Scheme came into effect in April 2020. The scheme improves access to high-quality medicinal cannabis products for patients. Medicinal cannabis products are only available to patients on prescription from a doctor, and quality standards are regulated by the Medicinal Cannabis Agency, which is part of the Ministry.

In 2020/21 the Agency received 66 applications for medicinal cannabis licences and issued 41 licences, covering

cultivation, possession for manufacture, nursery and supply activities. As at 30 June 2021, two cannabidiol (CBD) products and two products containing tetrahydrocannabinol (THC) have been verified as meeting the minimum quality standard.

We improved air ambulance services

New Zealanders are getting to hospital faster, as a result of a programme to modernise the country's air ambulance service. As part of the 10-year modernisation programme, in 2020/21 single-engine helicopters have been replaced with larger, safer and faster twin-engine machines. The National Air Ambulance Desk that manages and coordinates the 24-hour, seven-day service has also been expanded, which has contributed to the improved response times.

We reviewed the health response to lead contamination in drinking-water

The Director-General of Health commissioned an independent rapid review into the health sector response to elevated lead levels in the drinking-water supply in Waikouiti and Karitane, Otago.

The overall finding of the review report was that the public health risk assessment and response were timely and appropriate, particularly around informing the community and undertaking lead screening. Key strengths of the health response were public communications and advice. Both the local council and community board expressed very high levels of satisfaction with the timely and responsive advice which was presented in ways which were easily understood by the community.



The review considered whether any amendments were required to health legislation, compliance and operational processes to improve public safety and reduce risk to health and wellbeing, from which it made several recommendations. Registered drinking-water suppliers and laboratories will be reminded of their obligations in relation to contaminants. In addition, the Ministry of Health is working with the Ministry of Business, Innovation and Employment to review the current plumbing standards to reduce allowable lead levels in tapware and fittings.

We worked towards a Smokefree Aotearoa

It has been a decade since New Zealand adopted the goal to reduce smoking prevalence and tobacco availability to be Smokefree by 2025. Over this time, smoking rates have continued to decline; however, work is still required to reduce smoking rates among Māori and Pacific peoples and in disadvantaged communities. In 2020/21 we engaged with more than 5,000 stakeholders to identify actions that we might include in the Smokefree Aotearoa 2025 Action Plan. Advice is being prepared for the Government on the draft Action Plan.

Around 4,500 people die each year from smoking or exposure to second-hand smoke. That equates to roughly 12 people every day. From 2006/07 to 2019/20, smoking prevalence has reduced from 17.0 to 10.1 percent among the European/Other population, from 39.2 to 28.7 percent among Māori and from 24.8 to 18.3 percent among Pacific peoples.

The Smokefree Environments and Regulated Products (Vaping) Amendment

Act 2020 came into force in November 2020. This means that vaping products, in addition to tobacco products and herbal smoking products, are now regulated under the Smokefree Environments and Regulated Products Act 1990 (the Act).

The amended Act gave the Ministry new regulation-making powers, and in 2020/21 we consulted stakeholders on several regulatory proposals to support the new provisions of the Act. These included proposed requirements for:

- point-of-sale purchase age information
- packaging requirements, product availability notices, and authorised harm-reduction notices in retail settings
- manufacturers' price lists for tobacco products
- product notification and safety requirements
- annual reporting and returns, and fees.

The Regulations came into force in August 2021.

We prepared to implement the End of Life Choice Act

From November 2021, people who experience unbearable suffering from a terminal illness will be able to legally ask for medical assistance to end their lives. The Ministry is responsible for implementing the End of Life Choice Act, which sets out the legal framework and high-level process for accessing assisted dying, including strict eligibility criteria and safeguards.

The Ministry will be responsible for overseeing and funding the assisted dying service. This is an entirely new service within the health and disability system. In 2020/21, the Ministry progressed implementation through:



- policy work to determine the approach to providing and funding assisted dying services
- ensuring the wider health workforce is aware of the Act and their obligations under it, including the right to conscientious objection
- developing and training the workforce, including medical and nurse practitioners
- establishing the two statutory bodies set out in the Act – the Support and Consultation for End of Life in New Zealand group and the End of Life Review Committee
- putting in place appropriate administrative systems, regulations, professional guidance, information and supports
- developing public information about the assisted dying service.

We prepared for abortion law reform

The Abortion Legislation Act 2020 was passed to decriminalise abortion, treat abortion as a health issue and align the regulation of abortion services more closely to those of other health services.

In 2020/21, the Ministry began a detailed work programme to deliver the system transformation for abortion services. The work focuses on workforce sustainability, improving equity of access and enabling abortion services to take place in a wider range of settings and locations.

The Ministry is funding three innovative service items: community-led service design; innovation to improve service access; and health practitioner training. The aim of these innovations is to provide new, better approaches to abortion services for those who wish to use them, especially for those communities that experience the greatest inequity.



Increasing mental health and addiction services

The Budget 2019 Mental Health and Wellbeing Package provided significant investment in mental health and addiction services. The following are some of the increased services it funded.

Access and Choice

The Access and Choice programme gives people access to primary mental health and addiction support that suits their needs, when and where they need it. A total of 218 sites across 16 DHBs are now offering primary mental health and addiction services integrated into general practice. These services cover an enrolled population of around 1.4 million people and have delivered more than 135,000 sessions.

School-based health services

We have expanded school-based health services to all decile 5 schools, so that they now reach approximately 96,000 students in almost 300 decile 1–5 secondary schools, teen parent units and alternative education sites.

Commissioning for outcomes

Using an innovative and more responsive procurement process, we have a range of new mental health and addiction services: 7 kaupapa Māori, 9 Pacific and 17 youth-specific services. These services together employ more than 150 full-time equivalent staff and have delivered more than 15,000 sessions to vulnerable New Zealanders.

Telehealth services

We have funded Te Hīringa Hauora to procure, deliver and promote digital microtools that support mental health and wellbeing, including positive thinking, positive lifestyle and problem-solving tools. We also provided capacity for an additional 34,000 telehealth contacts in 2020/21.

Haven Recovery Café

The Haven Recovery Café is run by Odyssey House in Auckland for people with alcohol and other drug recovery needs. Since funding started in May 2020, the Café has had around 600 drop-ins each weekend, with some individuals visiting multiple times in one weekend.



Aoake te Rā

Aoake te Rā provides online and face-to-face services to support those bereaved by suicide. Since national services began in March 2020, the service has received more than 200 referrals and has provided over 400 sessions. Now more than 60 providers are providing face-to-face services across 13 DHB areas.

Well Child / Tamariki Ora enhanced support pilot programmes

Once fully implemented, these pilot programmes will provide whānau-led mental and social wellbeing support for around 140 young parents and whānau during pregnancy and in the first two years of a child's life. A nurse or kaiāwhina is supported by a multidisciplinary team to ensure the young parent and their whānau get the assistance they need from health and other community organisations, across mental health, health care, social services and education.

Our achievements – an integrated, collaborative and innovative system

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

As kaitiaki of the health and disability system, the Ministry works to ensure the system is well-functioning, and steward system-wide investments. To achieve an integrated, collaborative and innovative system, this year we have taken the following actions.

We worked with DHBs to improve performance

- **DHB performance programme and intensive support:** We have established an integrated approach to monitoring, diagnosing and supporting the improvement of DHB performance issues. The Ministry has been working with seven DHBs by agreeing targeted improvement plans and providing additional monitoring, assistance of sector experts and support for service improvements.
- **Support to the DHB Boards:** We have provided governance training, mentoring and development of Board Chairs and Board members to support improvement in both financial and service performance.
- **DHB-led improvement sustainability project funding:** \$18.8 million has been allocated to over 90 improvement projects focused on addressing equity, financial sustainability or service improvement. Many projects

are innovative and will be applicable following health and disability system reforms, and several have potential to scale up nationally.

- **National analytics:** National analytics is part of the DHB performance programme, which supports the development of consistent and transparent frameworks. A web-based benchmarking tool has been created as part of this work. This tool allows both the Ministry and DHBs to understand key areas of performance improvement.
- **System flow – acute care work programme:** The Ministry's acute care work programme has been established and will take a greater strategic role in guiding the system in its response to acute demand, for example, through the establishment of an acute care advisory group to identify workstreams to support improved acute and wider system flow.
- **System flow – COVID-19 recovery:** Planned Care waiting lists significantly increased in April and May 2020 as a result of the COVID-19 response which led many treatments and assessments to be deferred. In Budget 2020, Cabinet approved \$282.5 million over three years for initiatives to reduce planned care waiting lists. Phase One has been completed with DHBs addressing the immediate COVID-19 backlog. Phase Two, looking at reducing waitlists, is underway.

We improved the health and disability infrastructure

The Ministry is responsible for investment in health infrastructure. Our Health Infrastructure Unit has oversight of more than 100 health and disability system



infrastructure projects in various stages of implementation. In addition, the Ministry itself leads four major infrastructure projects.

- **Te Nīkau hospital and health centre in Greymouth** opened in September 2020. It replaces the Grey Base Hospital. Constructed from materials hardy to the West Coast weather, it includes 56 inpatient beds, acute and planned care services, maternity services, an emergency department, radiology and laboratory services, a pharmacy, a paediatric ward and an outpatient ward. Due to its innovative use of space and attractive, light-filled rooms, Te Nīkau is also a finalist in the 2021 New Zealand Property Council Awards.
- **Waipapa hospital in Christchurch** opened in November 2020. The name Waipapa means 'surface water' and refers to the many natural springs in the area. The new building houses an emergency department, 12 new operating theatres, an intensive care unit, a paediatric ward, state-of-the-art radiology facilities, a haematology ward and 413 inpatient beds. Waipapa won a Master Builders Gold Award and a New Zealand Institute of Architects Award, and is a finalist in the 2021 New Zealand Property Council Awards.
- **Taiao Ora, the integrated stroke unit at Auckland City Hospital**, opened in November 2020. It is the first integrated stroke and rehabilitation unit in the country. It will serve approximately 2,000 people who suffer from stroke each year in the Auckland region, providing co-located acute care and rehabilitation services.
- **The new Dunedin Hospital build**, which began recently, is the largest health infrastructure project ever undertaken in New Zealand. The new hospital will be accredited 5-Star Green Star

and will provide 421 beds, more than 16 theatres and 30 intensive care or high-dependency beds as well as new inpatient and outpatient facilities. We expect the regional economy will receive an estimated \$429 million boost to gross domestic product and employ thousands of construction workers over the lifetime of the project, which is due for completion in 2028.

This year we also established the Mental Health Infrastructure Programme (MHIP) to provide greater support to DHBs in improving mental health infrastructure. We have progressed investments in four mental health and addiction facilities (MidCentral, Lakes, Waitematā and Tairāwhiti DHBs) and another is working its way through approvals. We have identified five more projects for significant upgrade or new mental health and addiction facilities, with a combined total value of more than \$200 million.

We strengthened the mental health and addiction workforce

The Ministry has a pivotal role in building the capacity and capability of the health and disability workforce. The significant investment in the mental health and addiction workforce in Budget 2019 has seen:

- 102 additional 'new entry to specialist practice' places each year for nurses, social workers and occupational therapists to enter the mental health and addiction workforce
- 8 additional clinical psychology internships each year
- 72 new training places for postgraduate study in specialist practice areas such as cognitive behaviour therapy and infant, child and adolescent mental health and addiction



- 200 additional places for registered nurses to gain mental health and addiction credentials in 2021
- 46 new bursaries for Māori and 30 new Pacific scholarships for mental health and addiction students
- over 800 additional places made available on cultural competency programmes to ensure mental health and addiction services better meet the needs of diverse New Zealanders.

We progressed major technology projects

Hira is an ecosystem of secure and trusted data and digital services that offer a new way of enabling innovation. Hira is designed to:

- improve the ability of health and disability organisations to respond to consumer needs
- facilitate more efficient and effective patient journeys
- implement new, digitally enabled models of care
- improve workforce experience and satisfaction
- transform the way people interact with health services
- reduce preventable hospital admissions and demand on hospital services.

The Health Sector Agreements and Payments project will progressively replace the legacy system used by the Ministry to manage agreements and distribute payments on behalf of the Crown and DHBs. The new system will provide the flexibility to respond to the changing needs of the New Zealanders, the sector and the health system reforms.

The legacy system processes approximately 90 million transactions a year, valued at about \$10 billion.

Other major technology improvements include developing and providing a national standard cardiovascular risk assessment calculator to the sector and upgrading the National Health Index to enhance data matching and to support collection of gender diverse code. We continued roll-out of a purpose built National Bowel Screening Solution to DHBs to support the National Bowel Screening Programme.

We also began developing a common regulatory platform that will be used for vaping products regulation. We also began working on a replacement for the systems that support radiation safety compliance processes and information under the Radiation Safety Act 2016.

We improved provision of health and disability data

In 2020/21 we began to publish monthly data about helicopter air ambulance services. We were already regularly publishing road ambulance data but adding helicopter data provides a more detailed picture of our national emergency ambulance services, which will assist with decision-making and planning.

We also worked with the Suicide Prevention Office and the Ministry of Justice's Coronial Services Unit to develop an interactive tool that combines information from the Ministry of Health Suicide Facts report and the Ministry of Justice publications on deaths from suspected intentional self-harm. The joint reporting approach will promote consistency and reduce confusion caused by suicide data being published in different places and formations. The first publication of data will be in September 2021.

In 2020/21 we developed four other new online interactive web tools for publications, including maternity data,



fetal and infant deaths, mortality data, and the virtual diabetes register.

We also enhanced access to the Death Documents tool for mortuary technicians to readily access documentation of the deceased persons brought to their hospital's mortuary. Approximately 85 percent of HP4720 Medication Certificate Cause of Death documents are now completed online.

We led and coordinated responses to health emergencies in New Zealand and abroad

The Ministry provides leadership and coordination for the health and disability system in planning, preparing for, and responding to a health emergency, and we lead all-of-government responses to national health emergencies.

We maintain capability and capacity of the Ministry and the wider health and disability system to provide interdisciplinary and dynamic approaches to emergencies or other severe disruptions with health implications.

We maintain the capability to activate an emergency response within two hours of notification of an emergency event requiring national coordination, including activation of the National Health Coordination Centre. Our system allows for the National Health Coordination Centre to be set up at an alternate location if required.

During 2020/21 the health sector responded to a range of incidents impacting the health and disability system. The Ministry led and coordinated domestic health sector responses, including the Waikato DHB cyber breach, the Kermadec earthquake sequence, and the Canterbury and West Coast flooding

events. In addition, a range of weather-related events impacted DHBs at local and regional levels, requiring coordination through the Ministry's emergency management response function.

Internationally, the New Zealand Medical Assistance Team was deployed on two concurrent occasions to support the Cook Islands COVID-19 vaccination roll-out and support the joint Australia/New Zealand humanitarian response to the COVID-19 outbreak in Fiji.

We surveyed the health of New Zealanders

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

The Health Survey has a multi-stage sampling design that involves randomly selecting a sample of small geographic areas, households within the selected areas, and individuals within the selected households. In 2019/20, it collected information from 9,699 adults and 3,290 children (via their parent or caregiver).

The Ministry released disability statistics from the Health Survey for the first time in 2019/20 and continues to capture this data through the Health Survey each year. Among the key findings were that 56.0 percent of disabled adults reported having 'good', 'very good' or 'excellent' health, well below the 89.9 percent of non-disabled adults who rated their health in this way.

We will use these insights into health outcomes for disabled people to monitor progress of key action plans, including



Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan, Faiva Ora 2016 to 2021: National Pasifika Disability Plan, Disability Action Plan 2019 to 2023, and progress implementing recommendations of the Waitangi Tribunal Health Services and Outcomes Inquiry (Wai2575).

We use the Health Survey results to inform initiatives and work programmes that we undertake to improve the health of New Zealanders in areas such as smoking, hazardous drinking, obesity, mental health and addiction, access to health care, oral health, Māori health, Pacific health and rainbow community health. The 2020/21 Health Survey results will be published in November 2021.

The 2019/20 results were published in November 2020. The following were among their key findings.

- The percentage of New Zealanders who currently smoke tobacco has decreased. About 13.4 percent of respondents, or an estimated 535,000 adults, were current smokers (defined as smoking at least monthly), compared with 16.6 percent in 2014/15 and 18.2 percent in 2011/12.
- One in five adults (20.9 percent) were hazardous drinkers in 2019/20, which indicates no significant change since the time series began in 2015/16.
- Among adults aged 15+ years, 30.9 percent (an estimated 1.24 million New Zealanders) are obese. This overall prevalence has been relatively stable since 2012/13; however, between 2011/12 and 2019/20 the prevalence for adults aged 45–54 years and 55–64 years increased.



Building our organisational capability

To build our organisational capability so that we can perform our stewardship functions well, this year the Ministry has taken the following actions.

We demonstrated our commitment to Papa Pounamu

The Ministry is committed to the five Papa Pounamu areas. All of the activities below contribute to Te whakawhanaungatanga | Building relationships.

Te Āheinga ā-Ahurea | Cultural Competence

Over the year, 130 staff participated in te reo and tikanga Māori programmes. A further 60 staff are currently attending level 1 and 30 level 2 of te reo Māori. In February 2021 we held a noho marae, where 90 participants, 10 facilitators and 8 guest speakers and provocateurs were all situated in te ao Māori. As a result of the noho marae, we tested, iterated and rolled out nine innovative solutions across the Ministry to build our capability, and a community of 100 champions now drive this kaupapa in their work areas.

Te Urupare i te Mariu | Addressing Bias

It is mandatory for all staff to complete unconscious bias e-learning as part of the Ministry's Gender Pay and Accessibility Tick Action Plans. The training forms part of the induction that staff and people leaders undertake when joining the Ministry. As at 30 June 2021, 98 percent of people leaders and 92 percent of all staff had completed the unconscious bias training.

Hautūtanga Ngākau Tuwhera | Inclusive Leadership

In 2020/21, we developed Whiria te Tangata: Culture and Inclusion Strategy and Turuki! Paneke: Workforce Strategy. To achieve pae ora – healthy futures, the Ministry needs the right people doing the right work at the right time. The workforce strategy sets out a high-level, three-year programme of work to address vulnerabilities and capability gaps.

We participate in the **Ministry for Ethnic Communities Graduate Programme**.

This programme directly addresses low representation of ethnically diverse employees in the public service and the barriers they face to accessing meaningful employment pathways.

In addition, the Ministry is participating in **Tū Mau Mana Moana**, the new scholarship programme that provides targeted leadership development for Pacific leaders in the public sector. We also have participants in the Leadership Development Centre's inaugural **Te Manutaki Hou | New Senior System Leader Action Learning Group**.

In the year ahead, we will be launching and/or participating in the Leadership Development Centre's **New People Leader, New Leader of Leaders** and **Experienced People Leaders** programmes. We will also be establishing a centralised fund for leadership coaching and 360-degree assessment opportunities and implementing a leadership succession programme. We intend to include **'The Wall Walk'** in our leadership development programmes to build competency in Te Tiriti o Waitangi and Māori-Crown relations.



We will monitor and report on the diversity of those participating in the Leadership Development and Succession programmes. Reporting will allow us to understand whether we are achieving good representation or whether we need to take an alternative approach to engage specific target groups.

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

The Ministry actively supports several employee-led networks and is working collaboratively with them to develop guidelines, including guidelines for funding. This work aims to enhance manager engagement and raise the visibility of the employee-led networks across the Ministry. The following are the employee-led networks that we support.

- Womens Network
- Te Whakaruruhau (Māori caucus)
- Pacific Forum
- Rainbow Network
- Disability Network
- Asian Network
- ASPIRE
- HAA – Health Advisor and Analyst network
- Project and Programme Management Community of Interest
- Project and Programme Management Community of Practice
- Eco Hauora Network
- Cycling
- Kia kaha te reo Māori
- Sports teams.

We improved our use of data, insights and evidence to drive our decisions

Although the Ministry benefits from having analytic capability embedded in functional

teams and directorates, it can increase the risk of inconsistent decisions and duplicated effort. Our Analytics Operating Model co-ordinates across the people delivering those functions to manage those risks, share capabilities and drive developments that support evidence-based decision making for the Ministry, and this year has delivered:

- documented standards for using Statistics New Zealand population data, Ethnicity data, with several initiatives due for completion by the end of 2021 such as data standards for gender and geography
- improved technology and analytic tools such as the implementation of an RStudio Server for analytics, DBT for data transformation, and Qlik Sense for Dashboards
- training for analysts in R language and in data visualisation and presentation
- an ‘analyst network’ across Health with more than 150 members, sharing and discussing new developments and best practice.

We invested in robust and functional technology

During the year, the Ministry has upgraded its technology to provide staff with the tools they need to work productively in our activity-based working environments. This has included:

- introducing Microsoft Outlook to replace the Lotus Notes email system
- introducing Microsoft Teams to support activity-based and remote working, and to provide enhanced collaboration tools
- conducting pre-pilot testing of ‘Bring Your Own Mobile’, which will enable staff to access email, Microsoft Office and Microsoft Teams from their mobile device
- refreshing and upgrading several security systems and servers to increase security and raise service capacity.



We are making the Ministry a great place to work

This year we launched a Health Safety and Wellbeing Strategy to ensure we continually improve the way we manage

risk of harm to our people. It has five pillars, with corresponding strategic objectives and actions. An Annual Plan sets out the specific areas of focus for action each year.

	Our strategic objectives What we want	Our strategic actions What we will do
1. Leadership and improvement	<ul style="list-style-type: none"> Well-led health and safety performance which continually improves 	<ul style="list-style-type: none"> Provide clear direction and leadership when taking action to improve health and safety performance
2. Risk management	<ul style="list-style-type: none"> The risk of harm to be reduced as much as reasonably practicable 	<ul style="list-style-type: none"> Maintain visibility of our health and safety risks and proactively manage them
3. Capability and competence	<ul style="list-style-type: none"> People who are competent and empowered to contribute to health and safety 	<ul style="list-style-type: none"> Build the capability of our leaders and workers to contribute to health and safety
4. Culture and engagement	<ul style="list-style-type: none"> A health and safety culture which is based on genuine engagement with people 	<ul style="list-style-type: none"> Ensure every opportunity to engage with people on matters of health and safety is taken
5. Management systems	<ul style="list-style-type: none"> Health and safety management systems which are effective and efficient 	<ul style="list-style-type: none"> Align our health and safety management system with best practice

We also developed a new performance and remuneration framework that is guided by the Government Workforce Policy and associated pay restraint guidance issued by Te Kawa Mataaho | Public Service Commission. Implemented from July 2021, the framework is guided by our values of manaakitanga, kaitiakitanga, kōkiri ngātahi and whakapono. It is underpinned by the principles of being:

- equitable, acknowledging our people's mahi and expertise
- transparent, shared and communicated clearly to be understood by all our people
- consistently applied with confidence throughout the Ministry
- affordable and sustainable to support our role as kaitiaki of the health and disability system.



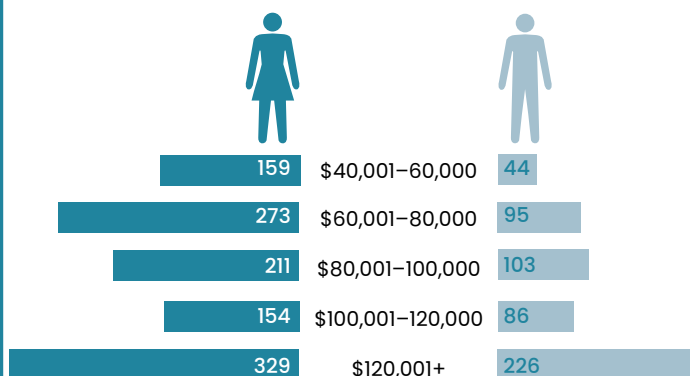
Our people

A snapshot as at 30 June 2021

**1680
employees**

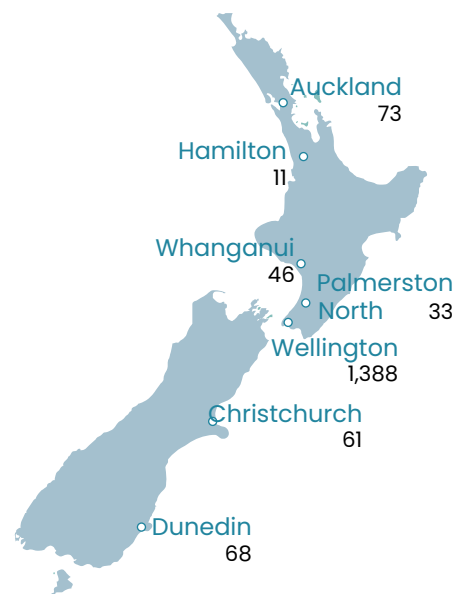
work for the Ministry of Health
(1631 FTE)

Gender and remuneration

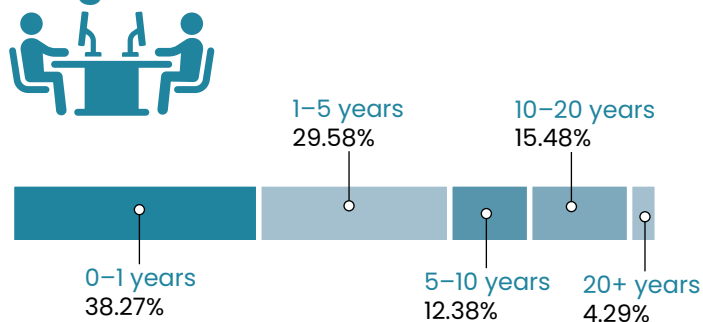


Our locations

as at 30 June 2021



Length of service



Average salary

\$107,393

(+2.1% from 2019/20)

47.3%

Staff paid over

\$100,000

(45.4% 2019/20)



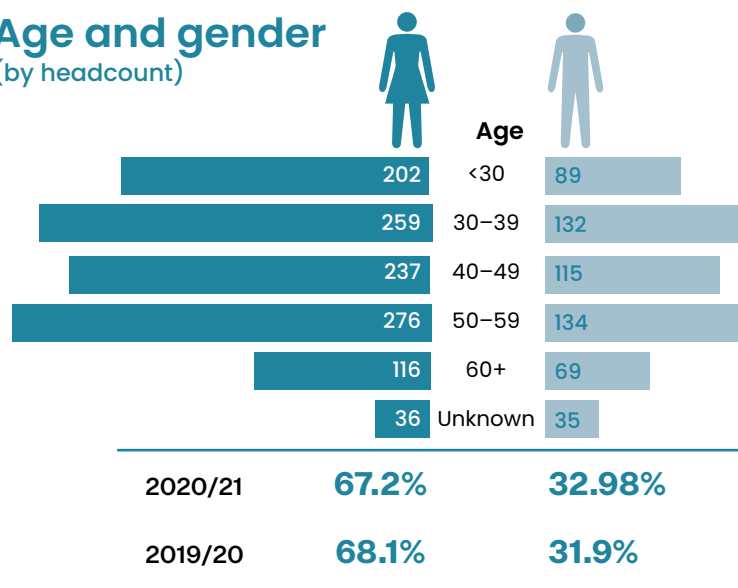
Gender pay gap

11.4%
as at
30 June 2020

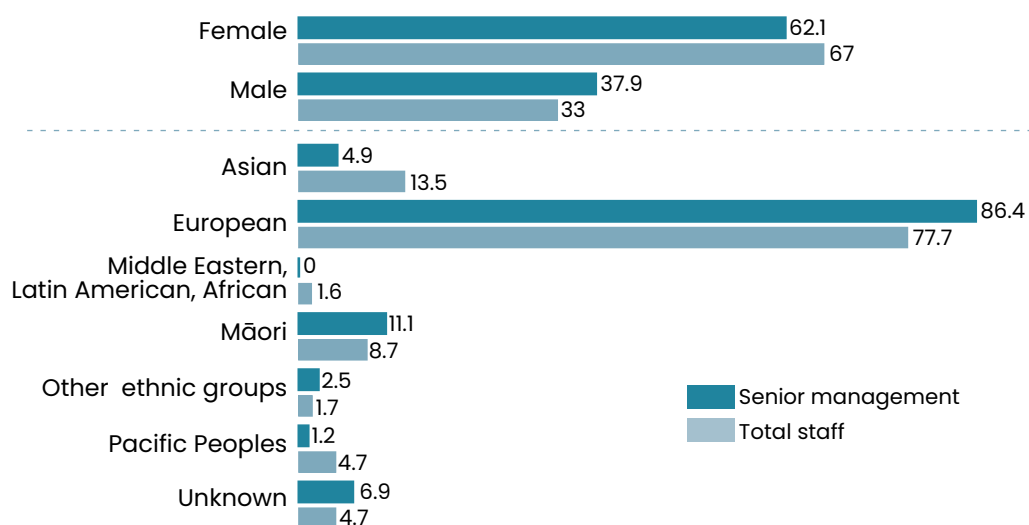
11.3%
as at
30 June 2019

18%
as at
30 June 2017

Age and gender (by headcount)



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



**Our
performance
Te kiko**







This section outlines our performance against the outputs that are specified in Vote Health – Main Estimates of Appropriation 2020/21⁴ and, where updated, 2020/21 Vote Health – Supplementary Estimates of Appropriation.⁵

Performance information for selected non-departmental appropriations for the year ended 30 June 2021 is available in a separate Vote Health Report.

4 <https://treasury.govt.nz/publications/estimates/vote-health-health-sector-estimates-2020-21>

5 <https://treasury.govt.nz/publications/supplementary-estimates/vote-health-supplementary-estimates-2020-21>



Policy advice and related services

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

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

Performance assessment

Performance measure	Actual 2019/20	Budget standard 2020/21	Actual 2020/21
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	3.63	Greater than 3.2 out of 5	3.70
Percentage of ministerial letters accepted without substantive amendment	96%	95%	100%
Ministerial satisfaction with the policy advice service (note 1)	No result	Equal to or greater than 4 out of 5	3.9
Percentage of responses provided to the Minister within agreed timeframes: (note 2)			
Written parliamentary questions	New measure	95%	100%
Ministerial Official Information Act requests	New measure	95%	96.5%
Ministerial letters	New measure	95%	96.2%

Note 1: The Ministerial Policy Satisfaction Survey is used to assess Ministers' satisfaction with the services provided by the policy function within agencies.

For 2020/21 the Minister of Health, Hon Andrew Little, was surveyed. The Associate Ministers of Health for the 2020/21 financial year were not asked to complete the survey as the Minister of Health was the primary customer for policy advice from the Ministry in 2020/21. In accordance with the DPMC guidance, the Ministerial satisfaction survey covers 19 questions related to policy, and the scores are aggregated to provide a final result. The Minister rated 13 of the 19 questions a 4 out of 5. Six questions were rated a 3 or 3.5 out of 5. Comprehensive policy advice provided in this period is acknowledged for its quality and being well presented. The Ministry values all feedback and is working to ensure that all policy advice continues to be of a high quality, that it is provided in a timely manner and that it captures implementation details in the advice provided.

For 2019/20 the Minister of Health for that financial year, Hon Dr David Clark, resigned in early July 2020. The Ministry decided not to request him to complete the 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.

Note 2: In previous years, different groupings were used for measures of ministerial response timeframes. The measures have now been split by response type. The budget standard remains consistent with previous years.



Financial performance

Policy advice and related services	Actual 2019/20 \$000	Main estimates 2020/21 \$000	Voted appropriation 2020/21 \$000	Actual 2020/21 \$000
Crown revenue	37,604	27,441	34,306	34,306
Other revenue	-	-	-	-
Total revenue	37,604	27,441	34,306	34,306
Total expenses	31,416	27,441	34,306	34,144
Net surplus (deficit)	6,188	-	-	162

This appropriation was established in 2020/21 to replace the old multi-category appropriation and 'Policy advice and ministerial servicing', which was made up of three categories: Policy Advice, Ministerial Servicing and Supporting the Review of the New Zealand Health System.

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 2019/20	Budget standard 2020/21	Actual 2020/21
Client insight and analytics			
Percentage of published Tier 1 statistics meet Statistics New Zealand standards within agreed timetable	100%	100%	100%
The National Collections meet the Statistics New Zealand standards for Tier 1 statistics	New measure	Achieved	Achieved
National infrastructure and Ministry information systems			
The percentage of time for which key sector- and public-facing systems are available (note 1) (note 2)	99.85%	99%	98%
Number of times that IT systems operated by the Ministry of Health have been compromised by an unauthorised third party	New measure	0	0
The percentage of scheduled updates to the New Zealand Formulary, a key sector independent resource, providing healthcare professionals with the clinically validated medicines for patients, delivered in line with contractual requirements (note 3)	100%	100%	100%

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. The budget standard was not met primarily due to a vendor platform hardware failure which resulted in a significant outage of the NHI in July 2020.



Note 2: In 2020/21 the Ministry operated systems to support the COVID-19 health response and the COVID-19 Vaccine and Immunisation Programme. The overall availability of the key systems was 99.97%. The table below provides the name of each system, the availability target and percentage of time that the system was available.

Note 3: This performance measure was previously provided as performance information for the non-departmental appropriation 'National health information systems'. In the 2020/21 year that appropriation was combined with the 'Health sector information systems' appropriation and the performance measure was transferred.

COVID-19 health response or COVID-19 vaccination and immunisation programme information system	Target	Actual 2020/21
National Contact Tracing Solution (NCTS)	99%	99.67%
National Border Solution (NBS)	99%	100%
National Immunisation Booking Solution (NIBS)	99%	100%
Border Clinical Management Solution (BCMS)	99%	99.67%
COVID-19 Immunisation Register (CIR)	99%	99.56%
COVID Immunisation Consumer Support (CICS)	99%	100%
Centre Adverse Reaction Monitoring (CARM)	99%	100%
COVID-19 Vaccination and Immunisation Programme (CVIP)	99%	100%
Total	99%	99.97%

Financial performance

Health sector information systems	Actual 2019/20 \$000	Main estimates 2020/21 \$000	Voted appropriation ⁶ 2020/21 \$000	Actual 2020/21 \$000
Crown revenue	61,886	55,868	106,519	106,519
Other revenue	-	-	-	16
Total revenue	61,886	55,868	106,519	106,535
Total expenses	56,931	55,868	106,519	93,445
Net surplus (deficit)	4,955	-	-	13,090

The variance against the Voted appropriation for 2020/21 budget mainly reflects timing of the work associated with continuing to meet the costs of running, maintaining and enhancing the technology to support the COVID-19 response; the National Immunisation Register; and work associated with the start of the Hira Trache I programme (formerly known as the National Health Information Platform).

An in-principle transfer of funding from 2020/21 to 2021/22 has been agreed by the Minister of Finance and the Minister of Health to transfer any unspent funding, reflecting uncertainty of timing of some expenditure associated with these projects.

⁶ As reported in the 2020/21 Supplementary Estimates for Vote Health



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 2019/20	Budget standard 2020/21	Actual 2020/21
The Ministry procurement process is in line with government standards	Achieved	Achieved	Achieved
The percentage of Ministry feedback to Crown funding agreement variation (CFAV) monitoring reports that are supplied to DHBs within agreed timeframes (note 1)	98.4%	95%	67%
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 2)	92.8%	95%	85.5%

Note 1: The timeliness of providing reports to DHBs was impacted by resource constraints, which occurred due to the redeployment to and prioritisation of the COVID-19 response actions, new initiatives and existing priorities. When the Ministry receives a monitoring report, it is logged into an electronic system. This generates an automated letter stating that 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 in-person visit.

Note 2: Figure is lower than the budget standard due to resource constraints. Training and reminders are also provided to staff about the expectations of complaint management and resolution timeframes.

Financial performance

Managing the purchase of services	Actual 2019/20 \$000	Main estimates 2020/21 \$000	Voted appropriation 2020/21 \$000	Actual 2020/21 \$000
Crown revenue	57,427	51,276	71,556	71,556
Other revenue	141	-	798	734
Total revenue	57,568	51,276	72,354	72,290
Total expenses	54,665	51,276	72,354	71,199
Net surplus (deficit)	2,903	-	-	1,091

The variance against last year and the main estimates was mainly due to the additional costs incurred in the non-core responsibilities of the National Health Crisis Centre to support COVID-19; the revised balance of central versus regional/sector responsibility for building the Mental Health and Addictions System that was



funded by a fiscally neutral transfer from the non-departmental output expense National Mental Health Services appropriation; and transfer of responsibility for oversight and monitoring of abortion services from Vote Courts to Vote Health.

An in-principle transfer of funding from 2020/21 to 2021/22 has been agreed by the Minister of Finance and the Minister of Health to transfer any unspent funding, reflecting uncertainty of timing of some expenditure associated with some projects funded within this appropriation.

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 2019/20	Budget standard 2020/21	Actual 2020/21
The percentage of claims paid on time	100%	98%	99.9%
The percentage of claims processed accurately	98.9%	95%	95.3%
The percentage of draft agreements prepared for funders within target timeframes (note 1)	94.5%	95%	84.9%
The percentage of agreements prepared accurately (note 2)	100%	95%	100%
The percentage of calls to contact centre answered within service specifications for timeliness (20 seconds) (note 3)	81.7%	80%	72.7%
The percentage of calls abandoned by callers prior to being answered by the contact centre is less than	3.2%	5%	4.5%
The percentage of enquiries resolved within 10 working days (note 3)	95.7%	95%	93%
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	99%	95%	100%

Note 1: The result reflects the impact of COVID-19 on contracts across the year and the high volumes of work in the July–October 2020 period.

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

Note 3: High demand from COVID-19 enquiries and workflow changes in the contact centre due to changes in Alert Levels nationally and regionally in August and September 2020 have negatively impacted our ability to meet the measure for contact centre timeliness.



Financial performance

Payment services	Actual 2019/20 \$000	Main estimates 2020/21 \$000	*Voted appropriation 2020/21 \$000	Actual 2020/21 \$000
Crown revenue	16,340	18,340	18,710	18,710
Other revenue	-	-	-	27
Total revenue	16,340	18,340	18,710	18,737
Total expenses	15,871	18,340	18,710	19,600
Net surplus (deficit)	469	-	-	(863)

The overspend in this appropriation is driven by the operational planning and associated costs incurred ahead of the finalisation of the Health Sector Agreements and Payments programme, and other activities where associated costs were higher than budget.

* The Ministers of Finance and Health as Joint Ministers agreed to support a fiscally neutral adjustment between this output expense and the Sector planning and performance output expense appropriation under section 26A of the Public Finance Act 1989, increasing the 2020/21 Supplementary Estimate budget of \$18.710 million by \$917,000 to a total budget of \$19.627 million. The transfer was approved by way of an Order in Council prior to 30 June 2021.

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 2019/20	Budget standard 2020/21	Actual 2020/21
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	81%	90%	91%
The percentage of certificates issued to providers under the Health and Disability Services (Safety) Act 2001 within target timeframes	92%	90%	93%
The percentage of licences and authorities issued to providers under the Medicines Act 1981 and Misuse of Drugs Act 1975 within target timeframes	93%	90%	95%
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	92%	90%	94%



The percentage of new medicines applications (for ministerial consent to market) that receive an initial assessment within 200 days	91%	80%	82%
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 1)	3.75 out of 5	4 out of 5 or greater	3.58

Note 1: Committee members acknowledged the good work of Ministry staff and recent improvements in the support provided to the various committees. However, they identified opportunities for improvements in relation to some aspects of the current administrative functions and also the Ministry's advisory service. The Ministry is taking action to improve these areas.

Financial performance

Regulatory and enforcement services	Actual 2019/20 \$000	Main estimates 2020/21 \$000	Voted appropriation 2020/21 \$000	Actual 2020/21 \$000
Crown revenue	12,285	12,839	12,795	12,795
Other revenue	11,505	14,519	16,329	13,022
Total revenue	23,790	27,358	29,124	25,817
Total expenses	24,936	27,358	29,124	27,994
Net surplus (deficit)	(1,146)	-	-	(2,177)

The appropriation increased from last financial year with the establishment of the vaping products regulator and the transfer of responsibility from Justice to Health, for the Contraception, Sterilisation and Abortion Act 1977. The deficit position arose because the vaping products regulator was in the establishment phase and under-recoveries within the radiation safety and the medicinal cannabis product regulators.

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 2019/20	Budget standard 2020/21	Actual 2020/21
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)	99.2%	100%	83%
The percentage of quarterly and monthly monitoring reports about DHBs provided to the Minister within agreed timeframes (note 2)	0%	100%	0%
The percentage of quarterly and monthly monitoring reports about Crown entities (excluding DHBs) provided to the Minister within agreed timeframes (note 3)	100%	100%	72.7%
Maintain the capability and capacity to respond to national emergencies and emerging health threats (note 4)	Not 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 5)	93%	95%	100%

Note 1: The timeliness of providing reports to DHBs was impacted by resource constraints, which occurred due to the redeployment to and prioritisation of the COVID-19 response actions, new initiatives and existing priorities.

Note 2: The timeliness of providing reports to the Minister was impacted by delays in receiving financial information from some DHBs, due to the impact of responding to COVID-19, and by delays in the Ministry's internal sign-off process as resources are prioritised to the COVID-19 response, new initiatives and existing priorities.

To ensure that financial information was received in a timely manner, a process has been in place throughout the financial year whereby Ministers received a summary of year to date financial results within five working days of the DHBs making the financial results available to the Ministry. The final monthly monitoring reports submitted to Ministers contained the same financial information along with additional analysis on those areas of financial performance that required further explanation from DHBs.

Note 3: Reporting to Minister on the Crown entity monitoring reports was delayed by resource constraints and the need to seek ministerial input on more urgent matters.

Note 4: 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.

The emergency management function is in the rebuild stage. It is not yet structured to maintain a capability and capacity beyond minimum viable product. To address this, the implementation of the three-year strategy (concluding June 2023) to position the emergency management function appropriately (to deliver both the legislative obligations of the Ministry and implement necessary change associated with the health and disability system reform) is underway and on track. Growth of the function continues toward implementing a new framework from 1 July 2021.

Note 5: This percentage does not include unexpected resignation or departure before the term expires.



Financial performance

Sector planning and performance	Actual 2019/20 \$000	Main estimates 2020/21 \$000	*Voted appropriation 2020/21 \$000	Actual 2020/21 \$000
Crown revenue	69,902	69,500	81,649	81,649
Other revenue	-	149	149	2
Total revenue	69,902	69,649	81,798	81,651
Total expenses	56,822	69,649	81,798	73,674
Net surplus (deficit)	13,080	-	-	7,977

The variance against last year and the main estimates was mainly due to the phasing of the work programme for the Budget 2019 initiative Improving the Financial Sustainability and Performance of DHBs, and a fiscally neutral transfer from the non-departmental output expense 'National personal health services' appropriation to reflect a change in delivery model for services by the Cancer Control Agency. The increase in expenses in 2020/21 mainly as a result of the improvement programme work commenced for initiatives to improve the financial sustainability and performance of DHBs.

An in-principle transfer of funding from 2020/21 to 2021/22 has been agreed by the Minister of Finance and the Minister of Health to transfer unspent funding, reflecting uncertainty of timing of some expenditure associated with some projects funded within this appropriation.

* The Ministers of Finance and Health as Joint Ministers agreed to support a fiscally neutral adjustment between this output expense and the 'Payment services' output expense under section 26A of the Public Finance Act 1989, reducing the 2020/21 Supplementary Estimate budget of \$81.798 million by \$917,000 to a total budget of \$80.881 million. The transfer was approved by way of an Order in Council prior to 30 June.



National health response to COVID-19

This appropriation is limited to purchasing services to manage and coordinate the overall national health response to COVID-19.

The intention for the Ministry is to support health system response to COVID-19.

Performance assessment

This appropriation was established in early 2020/21. During the 2020/21 financial year any further funding for activities associated with COVID-19 came under the 'National health response to COVID-19' departmental expense category in the multi-category appropriation 'National response to COVID-19 across the health sector'.

The performance associated with this output expense are included and addressed as part of performance information contained under the multi-category appropriation for the performance assessment (see page 58).

Financial performance

National health response to COVID-19	Actual 2019/20 \$000	Main estimates 2020/21 \$000	Voted appropriation 2020/21 \$000	Actual 2020/21 \$000
Crown revenue	-	-	8,554	8,554
Other revenue	-	-	-	-
Total revenue	-	-	8,554	8,554
Total expenses	-	-	8,554	8,432
Net surplus (deficit)	-	-	-	122

This appropriation was established during 2020/21 for the initiative of funding the Health System Response to COVID-19. This appropriation has been merged into the newly established multi category appropriation 'National response to COVID-19 across the health sector' since January 2021.

National response to COVID-19 across the health sector

The purpose of this multi-category expense appropriation is to implement a national response to COVID-19 across the health sector.

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

Performance assessment

Performance measure	Actual 2019/20	Budget standard 2020/21	Actual 2020/21
Appropriation as a whole			
Ministerial satisfaction with the national response to COVID-19 across the health sector (note 1)	New measure	Equal to or greater than 4 out of 5	4

Note 1: For 2020/21 the Minister for COVID-19 Response, Hon Chris Hipkins, was surveyed.

Departmental output expenses

National health response to COVID-19

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

Performance measure	Actual 2019/20	Target	Actual 2020/21
Provisional COVID-19 disease indicators			
Ministerial satisfaction with the Ministry of Health's management and coordination of the national response to COVID-19 across the health sector (note 1)	New measure	Equal to or greater than 4 out of 5	4

Note 1: For 2020/21 the Minister for COVID-19 Response, Hon Chris Hipkins, was surveyed.

Non-departmental output expenses

COVID-19 public health response

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

Performance measure	Actual 2019/20	Target	Actual 2020/21
Provisional COVID-19 disease indicators			
System-level indicator			
S001 Time from exposure to contact isolation/quarantine	New measure	≥ 80% within 96 hours	38%
S002 Time from case first symptom to contact isolation/quarantine	New measure	≥ 80% within 96 hours	32%
S003 Time from test sample taken to close contact isolation/quarantine	New measure	≥ 80% within 72 hours	69%
Community-level indicator			
C001 Time from first symptom to test sample taken for positive cases (note 1)	New measure	≥ 80% within 48 hours	47%



Laboratory sector indicator L001 Time test sample taken to notification of positive result (note 2)	New measure	80% within 24 hours	74%
Public health sector indicators P001 Time notification to case interview	New measure	≥ 80% within 24 hours	96%
P002 Time case notification to isolation/quarantine of contact (note 3)	New measure	≥ 80% within 48 hours	64%
P003 Time from close contact identification to isolated/quarantined	New measure	≥ 80% within 24 hours	90%
P004 Proportion of contacts traced (note 3)	New measure	≥ 80% within 48 hours	71%
P005 Regular monitoring and follow-up of cases and contacts completed (note 4)	New measure	≥ 90% monitoring of contacts is successful	84%

Note 1: The system- and community-level indicators were significantly skewed by community cases who appear in this indicator but were tested and diagnosed with COVID-19 many days after the onset of symptoms.

Note 2: Performance for this indicator is lower (74%) than the target of 80%. The target was met at 34 hours.

Note 3: Performance for 'Time from case notification to isolation/quarantine of contact', and 'Proportion of contacts traced', is lower than the target of 80% for this period. This is largely due to the late addition of new close contacts after the 48-hour period since case notification. Such late additions can happen for several reasons, such as that a case recalls further details following the original case interview or that more time is needed to prepare a list of close contacts (eg, a list of people who visited a workplace). However, the contact tracing performance reported by indicator 'Time from close contact identification to isolated/quarantined' shows the time it takes to isolate contacts once these contacts are identified is well above target. For this period, 90% of close contacts were contacted within 24 hours of contact notification.

Note 4: Performance for this indicator (84%) is lower than the target of 90% for this period. This is largely because Auckland Regional Public Health Service decided to reduce the frequency of daily follow-up phone calls in the early stages of the August 2020 Auckland community outbreak. Daily follow-up check-ins were reduced to every second day due to the large volumes of cases and associated contacts in the first two weeks of the outbreak. Performance is above target for all months following August 2020, where usual process resumed.

Background on provisional COVID-19 disease indicators

The provisional COVID-19 disease indicators were the first versions developed by the Ministry in the 2020/21 financial year and signed off by the Director of Public Health. The finalised COVID-19 disease indicators are available on the **Ministry's website**

These provisional COVID-19 disease indicators presented in the table above provide an end-to-end view of the public health response to COVID-19. The indicators have been grouped by focus area.

- System-level indicators provide a view of the end-to-end collective actions of the wider health system response.
- The community-level indicator focuses on community behaviours and the impacts of communication, education and social attitudes.
- The laboratory sector indicators provide insights into the effectiveness of testing facilities and programmes.



- Public health sector indicators provide a national overview on contact tracing and case and close contact management by public health units and the National Investigation and Tracing Centre.

The results are for community-based cases and contacts during the period 1 July 2020 to 30 June 2021. Border and managed isolation facility results have not been included as they are not applicable to all measure types. All measures include contacts identified through case investigation or those that self-identify through Healthline.

The system- and community-level indicators are significantly skewed by community cases who appear in this indicator but were tested and diagnosed with COVID-19 many days after the onset of symptoms.

The paragraphs below provide further contextual information about each measure.

System-level indicators

S001 Time from exposure to contact isolation/quarantine: A person is at risk of transmitting the disease from shortly after exposure (being exposed) to a COVID positive case until they are isolated or quarantined. This indicator measures the 'risk period' for contacts of COVID positive cases from when they were exposed to when they go into isolation or quarantine (when contact receives formal advice from contact tracers to isolate or quarantine). The system (S#) and community (C#) indicators are significantly skewed by community cases who appear in this indicator but were tested and diagnosed with COVID-19 many days after the onset of symptoms.

S002 Time from case first symptom to contact isolation/quarantine: The speed at which contacts are traced is critical to limiting the risk that a person could transmit the disease to others. This indicator measures the 'risk period' for close contacts of COVID positive cases from when the case develops symptoms to when the case goes into isolation or quarantine (when they receive formal advice from contact tracers to isolate or quarantine). If a case has not reported symptoms, they are not included in this measure. Symptom onset time is not recorded in the system, so this is set to midday for each case.

S003 Time from test sample taken to close contact isolation/quarantine: This measures the health system's ability to respond to cases of disease, incorporating its components of identification, investigation and contact tracing. The time the sample was taken is not currently recorded nationally, and so the time the laboratory received the sample is used as a proxy for this measure. This indicator measures the 'risk period' for close contacts of COVID positive cases from the time of case swabbing to when the close contact goes into isolation or quarantine (when they receive formal advice from contact tracers to isolate or quarantine).

Community-level indicator

C001 Time from first symptom to test sample taken for positive cases: The speed at which a person recognises their symptoms and accesses testing is critical to limiting the spread of the disease. This takes into consideration the two issues of public education and health



literacy as well as availability and access to testing facilities. If a case has not reported symptoms, they are not included in this measure. Symptom onset time is not recorded in the system, so this is set to midday for each case. The time the sample was taken is not currently recorded nationally, and so the time the laboratory received the sample is used as a proxy for this measure.

Laboratory sector indicator

L001 Time test sample taken to notification of positive result: This measures the health system's ability to take samples, transport the sample to the laboratory, analyse it and report a positive result to the medical officer of health. The time the sample was taken is not currently recorded nationally, and so the time the laboratory received the sample is used as a proxy for this measure.

Public health sector indicators

P001 Time notification to case interview: This indicator measures the resource capacity of the public health system to investigate cases in a timely manner. It measures the time from when a positive result is reported to the medical officer of health to when case investigators inform the case of the positive result.

P002 Time case notification to isolation/quarantine of contact: This indicator measures the resource capacity of the public health system to investigate cases, identify close contacts and contact those close contacts and ensure that they are isolated or quarantined. It measures the time from when a positive result is reported to the medical officer of health to when the contact receives formal advice from contact tracers to isolate or quarantine.

P003 Time from close contact identification to isolated/quarantined: The case interview and subsequent investigation lead to the identification of close contacts who should be contacted and isolated or quarantined as fast as possible to limit the risk of secondary transmission. This indicator measures the time from when the contact is identified by contact tracers (and loaded into the system) to when the contact receives formal advice from contact tracers to isolate or quarantine.

P004 Proportion of contacts traced: Once close contacts are identified, as many as possible should be reached and isolated or quarantined as soon as possible. This indicator measures the proportion of identified contacts who are traced within 48 hours of reporting the case to the medical officer of health. The calculation includes only contacts connected to exposure events that were entered into the system within the 48-hour period.

P005 Regular monitoring and follow-up of cases and contacts completed: Service providers are expected to contact people in isolation and quarantine at regular intervals and confirm their isolation (monitoring of unwell people) or quarantine (follow-up of well people), and check on their health status and welfare. This indicator measures the proportion of people in isolation or quarantine who have been contacted at the expected frequency identified. This measure counts the number of completed daily follow-up calls to cases and contacts, over the number of scheduled daily follow-ups.

Financial performance

National response to COVID-19 across the health sector	Actual 2019/20 \$000	Main estimates 2020/21 \$000	Voted appropriation 2020/21 \$000	Actual 2020/21 \$000
Departmental output expenses				
National health response to COVID-19				
Crown revenue	-	-	21,711	21,711
Other revenue	-	-	-	-
Total revenue	-	-	21,711	21,711
Total expenses	-	-	21,711	13,250
Net surplus (deficit)	-	-	-	8,461
Non-departmental output expenses				
Total expenses	-	-	692,406	217,850

This was a new multi-category appropriation established during 2020/21 for implementing a national response to COVID-19 across the health sector.



Implementing the COVID-19 vaccine strategy

The purpose of this multi-category expense appropriation is to implement the COVID-19 Vaccine Strategy to minimise the health impacts of COVID-19.

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

Performance assessment

Performance measure	Actual 2019/20	Budget standard 2020/21	Actual 2020/21
Appropriation as a whole			
Ministerial satisfaction with the implementation of the COVID-19 Vaccine Strategy (note 1)	New measure	Equal to or greater than 4 out of 5	5

Note 1: For 2020/21 the Minister of Health, Hon Andrew Little, was surveyed.

Departmental output expenses

Supporting the implementation of the COVID-19 vaccine strategy

This category is intended to achieve the following: to enable the Ministry of Health to support the Government's COVID-19 Vaccine and Immunisation Strategy including the purchasing of potential and proven COVID-19 vaccines and other therapeutics, and rolling out of a national immunisation programme to deliver COVID-19 vaccines.

Performance measure	Target	Actual 2020/21
Ministerial satisfaction with the Ministry of Health's advice on, and administration of, the implementation of the COVID-19 Vaccine Strategy (note 1)	Equal to or greater than 4 out of 5	4

Note 1: For 2020/21 the Minister of Health, Hon Andrew Little, was surveyed.

Non-departmental output expenses

Implementing the COVID-19 immunisation programme

This category is intended to achieve the following: to implement the Government's COVID-19 Immunisation Strategy by establishing and delivering a national immunisation programme for COVID-19 vaccines.

Performance measure	Actual 2019/20	Budget standard 2020/21	Actual 2020/21
Number of Pfizer COVID-19 vaccine doses distributed from central storage facilities to vaccination facilities in line with plan (note 1)	New measure	Achieved	Achieved
Number of doses of Pfizer COVID-19 vaccine administered to individuals in line with plan (note 2)	New measure	Achieved	Achieved



Purchasing potential and proven COVID-19 vaccines and other therapeutics

This category is intended to achieve the following: to implement the Government's COVID-19 Vaccine Strategy, including the purchase of a portfolio of potential and proven COVID-19 vaccines and other therapeutics.

Performance measure	Actual 2019/20	Budget standard 2020/21	Actual 2020/21
Number of Pfizer COVID-19 vaccine doses purchased and received in the central storage facilities in line with plan (note 3)	New measure	Achieved	Not Achieved

Note 1: 1,196,664 doses of the Pfizer COVID-19 vaccine were distributed from central storage facilities to DHBs. Delivery of the Pfizer vaccine to DHBs was in line with the distribution plan that was to enable DHBs to hold sufficient stock to meet their agreed administration plans. Pfizer vaccine was distributed to DHBs in vials. The distribution plan was based on the assumption that six doses, on average, would be extracted from each vial. This assumption is based on operational guidance provided in the COVID-19 Vaccine Operating Guidelines here: <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-information-health-professionals/covid-19-vaccine-operating-and-planning-guidelines..>

Note 2: The administering of the Pfizer COVID-19 vaccine to individuals is based on weekly plans that the Ministry and DHBs agreed to. The plan to the week ending 4 July 2021 was to administer 1,161,952 doses. Actual doses administered to the week ending 4 July 2021 was 1,236,688. Actual doses administered is recorded by the DHB administering the vaccination to the individual, rather than by the individual's DHB of residence.

Note 3: The plan to 30 June 2021 was to purchase and receive 1,250,000 doses, with a further 100,620 doses from COVAX. The number of actual doses received in central storage facilities was 1,272,960. The shortfall was due to a deferred delivery (shorter than desirable expiry date) from Pfizer in the last week of April 2021. The deferred delivery was made with shipment in the first week of July.

Additional performance information

Trained vaccinators	Actual 2020/21
Number of trained vaccinators	8,622

Vaccine doses administered by DHB			
DHB of service (note 4)	Dose 1	Dose 2	Total
Auckland metro ⁷	270,567	161,405	431,972
Bay of Plenty	37,805	24,817	62,622
Canterbury	58,301	38,805	97,106
Capital & Coast and Hutt Valley	45,715	34,586	80,301
Hawke's Bay	26,055	17,202	43,257
Lakes	20,559	13,789	34,348
MidCentral	27,668	13,678	41,346
Nelson Marlborough	32,161	22,527	54,688
Northland	32,294	17,603	49,897

⁷ Auckland metro consists of Auckland DHB, Waitematā DHB and Counties Manukau DHB.



Vaccine doses administered by DHB			
DHB of service (note 4)	Dose 1	Dose 2	Total
Other sites ⁸	22,745	16,349	39,094
South Canterbury	11,228	7,760	18,988
Southern	49,105	31,466	80,571
Tairāwhiti	7,183	4,439	11,622
Taranaki	8,752	4,720	13,472
Waikato	44,066	29,842	73,908
Wairarapa	7,957	4,104	12,061
West Coast	6,543	4,239	10,782
Whanganui	10,631	8,144	18,775
Total	719,335	455,475	1,174,810

By DHB: Eligible population fully vaccinated by DHB of residence (note 1) (note 5)	
DHB of residence	Proportion fully vaccinated (note 1)
Auckland metro ⁹	12.4%
Bay of Plenty	12.5%
Canterbury	9.1%
Capital & Coast and Hutt Valley	9.5%
Hawke's Bay	13.0%
Lakes	15.4%
MidCentral	11.6%
Nelson Marlborough	17.7%
Northland	12.0%
South Canterbury	15.7%
Southern	11.7%
Tairāwhiti	11.7%
Taranaki	5.3%
Waikato	9.4%
Wairarapa	11.1%
West Coast	15.8%
Whanganui	16.6%
Total	11.5%

⁸ Other sites includes nationally led vaccination programmes, for example, New Zealand Defence Force, New Zealand Police and St John.

⁹ Auckland metro consists of Auckland DHB, Waitematā DHB and Counties Manukau DHB.



Vaccine doses administered by age group (note 5)			
Age range (years)	Dose 1	Dose 2	Total
Unknown ¹⁰	1	2	3
12 to 15	21	3	24
16 to 19	10,023	6,349	16,372
20 to 24	29,614	22,064	51,678
25 to 29	38,867	29,677	68,544
30 to 34	41,040	30,981	72,021
35 to 39	36,848	27,315	64,163
40 to 44	35,192	25,848	61,040
45 to 49	40,208	29,536	69,744
50 to 54	48,367	34,369	82,736
55 to 59	59,319	40,493	99,812
60 to 64	63,121	40,073	103,194
65 to 69	85,854	46,686	132,540
70 to 74	84,226	44,187	128,413
75 to 79	62,240	32,367	94,607
80 to 84	43,223	22,374	65,597
85 to 89	24,197	13,090	37,287
90+	16,974	10,061	27,035
Total	719,335	455,475	1,174,810

Eligible population fully vaccinated by age group (note 5)	Proportion fully vaccinated (note 1)
Age range (years)	
12 to 15	–
16 to 19	2.61%
20 to 24	7.00%
25 to 29	8.27%
30 to 34	8.60%
35 to 39	8.30%
40 to 44	8.54%
45 to 49	9.09%
50 to 54	10.76%
55 to 59	12.64%
60 to 64	13.92%
65 to 69	18.90%
70 to 74	20.83%
75 to 79	22.17%
80 to 84	23.19%

¹⁰ Unknown age refers to a dose being captured but insufficient other information being captured to identify the recipients age.



Eligible population fully vaccinated by age group (note 5)	
Age range (years)	Proportion fully vaccinated (note 1)
85 to 89	23.77%
90+	31.63%
Total	11.53%

Vaccine doses administered by ethnicity (note 5)			
Ethnicity	Dose 1	Dose 2	Total
Asian	112,393	73,197	185,590
European or other	484,610	306,105	790,715
Māori	69,122	43,204	112,326
Pacific peoples	47,239	29,011	76,250
Unknown	5,971	3,958	9,929
Total	719,335	455,475	1,174,810

Eligible population fully vaccinated by ethnicity (note 5)	
Ethnicity	Proportion fully vaccinated (note 1)
Asian	12.93%
European or other	11.82%
Māori	8.45%
Pacific peoples	11.14%
Unknown	18.31%
Total	11.53%

Vaccine doses administered by sequencing group (note 5)			
Sequencing group (note 3)	Dose 1	Dose 2	Total
Group 1	57,224	52,297	109,521
Group 2	359,415	258,249	617,664
Group 3	217,477	96,585	314,062
Group 4	85,219	48,344	133,563
Total	719,335	455,475	1,174,810



Eligible population fully vaccinated by sequencing group (note 5)	
Sequencing group (note 3)	Proportion fully vaccinated (note 1)
Group 1	84.35%
Group 2	49.66%
Group 3	8.05%
Group 4	2.23%
Total	11.53%

Note 1: Fully vaccinated means two doses have been administered to an individual.

Note 2: The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by StatsNZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by StatsNZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections StatsNZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.

The Total population estimate based on HSU as at 30 June 2020 is 5,044,806. This is 43,014 below the Stats NZ total projected population of 5,087,820 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.



Total population	HSU	Stats NZ	Difference
Māori	776,111	850,880	(74,769)
Pacific	371,506	343,210	28,296
Asian	740,715	845,960	(105,245)
Other	3,156,474	3,047,770	108,704
Total	5,044,806	5,087,820	(43,014)

Note 3: Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions; and disabled people living in the Counties Manukau DHB area. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4: The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5: The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

Financial performance

Implementing the COVID-19 vaccine strategy	Actual 2019/20 \$000	Main estimates 2020/21 \$000	Voted appropriation 2020/21 \$000	Actual 2020/21 \$000
Departmental output expenses				
Supporting the implementation of the COVID-19 vaccine strategy				
Crown revenue	-	-	48,990	48,990
Other revenue	-	-	-	-
Total revenue	-	-	48,990	48,990
Total expenses	-	-	48,990	44,838
Net surplus (deficit)	-	-	-	4,152
Non-departmental output expenses				
Implementing the COVID-19 immunisation programme				
Total expenses	-	-	166,352	95,438
Purchasing potential and proven COVID vaccines and other therapeutics				
Total expenses	-	-	231,521	5,567

This was a new multi category appropriation established during 2020/21 for implementing the COVID-19 Vaccine Strategy so as to minimise the health impacts of COVID-19.



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 2019/20	Budget standard 2020/21	Actual 2020/21
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 2019/20 \$000	Main estimates 2020/21 \$000	Voted appropriation 2020/21 \$000	Actual 2020/21 \$000
Total appropriation	11,977	9,242	15,918	11,110

The underspend in capital expenditure was mainly due to the change in timing of the National Immunisation Solution project, which was deferred to 2021/22 as priority has been given in 2020/21 to building the COVID-19 Immunisation Register.



**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 2021 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
23 November 2021



Fergus Welsh
Chief Financial Officer
23 November 2021

Independent Auditor's Report

To the readers of the Ministry of Health's annual report for the year ended 30 June 2021

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 79 to 106 that comprise the statement of financial position, statement of commitments, statement of contingent liabilities and contingent assets as at 30 June 2021, 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 2021 on pages 47 to 70 and 127 to 133;
- the statements of expenses and capital expenditure of the Ministry for the year ended 30 June 2021 on pages 116 to 120 and 123 to 124; and
- the statements and schedules of non-departmental activities which are managed by the Ministry on behalf of the Crown on pages 107 to 115 and 120 to 123 that comprise:
 - the schedules of assets; liabilities; commitments; and contingent liabilities and contingent assets as at 30 June 2021;
 - the statement of expenses; and schedule revenue and capital receipts for the year ended 30 June 2021; and
 - the notes to the statements and schedules that include accounting policies and other explanatory information.

Opinion

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

In our opinion:

- the financial statements of the Ministry on pages 79 to 106:
 - present fairly, in all material respects:
 - its financial position as at 30 June 2021; 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 116 to 120 and 123 to 124 are presented fairly, in all material respects, in accordance with the requirements of section 45A of the Public Finance Act 1989.



- the statements and schedules of non-departmental activities which are managed by the Ministry on behalf of the Crown on pages 107 to 115 and 120 to 123 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 2021; and
 - expenses; and revenue for the year ended 30 June 2021.

Qualified opinion on the prior year performance information

In our opinion, except for the possible effects of the matter described in the *Basis for our opinion* section of our report, the performance information of the Ministry on pages 47 to 70 and 127 to 133:

- presents fairly, in all material respects, for the year ended 30 June 2021:
 - 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 23 November 2021. This is the date at which our opinion is expressed.

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

Emphasis of matters

Without further modifying our opinion, we draw your attention to the following matters:

HSU population information was used in reporting Covid-19 vaccine strategy performance results

Note 2 on page 68 and 69 outlines the information used by the Ministry to report on its Covid-19 vaccine coverage. The Ministry uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out in Note 2. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity, age and District Health Board. The Ministry has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Breach of statutory reporting deadline

Note 18 on page 106 outlines that the Ministry did not meet the requirement of section 45D of the Public Finance Act 1989. For the reasons provided, including the impact of Covid-19, the required information was not made available to us within two months after the end of the financial year. We could therefore not meet the requirement to issue the audit report within three months after the end of the financial year.



Basis for our opinion

Our work was limited in the prior year as the Ministry was unable to report on the satisfaction of the Minister with the policy advice service

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 “ministerial satisfaction with the policy advice service”.

As disclosed on page 48, the Minister of Health for the 2019/20 financial year, Hon Dr David Clark, resigned in early July 2020 and the Ministry decided not to request him to complete a ministerial satisfaction survey in the prior year. Consequently, the Ministry did not report a result for the above-mentioned performance measure in the 2019/20 annual report. 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 for 2019/20 and our audit opinion on the performance information for the year ended 30 June 2020 was modified accordingly.

This issue has been resolved for the 30 June 2021 year. As the limitation on our work cannot be resolved for the 30 June 2020 year, the Ministry’s performance information reported for this measure for the 30 June 2021 year may not be directly comparable to the 30 June 2020 performance information.

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

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

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

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

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

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



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

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

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

Responsibilities of the audit or for the information to be audited

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

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

For the budget information reported in the information we audited, our procedures were limited to checking that the information agreed to the Ministry's Statement of Strategic Intentions 2017 to 2021, Estimates and Supplementary Estimates of Appropriations 2020/21 and the 2020/21 forecast financial figures included in the Ministry's 2019/20 Annual Report.

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

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

- We identify and assess the risks of material misstatement of the information we audited, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Ministry's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Director-General of Health.
- We evaluate the appropriateness of the reported performance information within the Ministry's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Director-General of Health and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Ministry's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the information we audited or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Ministry to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the information we audited, including the disclosures, and whether the information we audited represents the underlying transactions and events in a manner that achieves fair presentation.

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Director-General of Health is responsible for the other information. The other information comprises the information included on pages iii to vii, 3 to 43, 73 and 134 to 179, but does not include the information we audited, and our auditor's report there on.

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

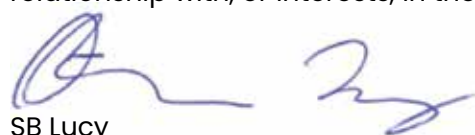
Our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the information we audited or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there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

Independence

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

During the year ended 30 June 2021, the Auditor-General undertook an audit and published the "Preparations for the nationwide roll-out of the Covid-19 vaccine" report; the Ministry paid the Auditor-General's costs for that report.

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



SB 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 2021

Actual	Note	Actual	Unaudited budget	Unaudited forecast
2020		2021	2021	2022
\$000		\$000	\$000	\$000
Revenue				
255,444	Revenue Crown	404,790	235,264	428,452
11,646	Other revenue	13,801	14,668	17,582
267,090	Total revenue	418,591	249,932	446,034
Expenses				
134,648	Personnel costs	179,947	141,541	205,890
6,710	Depreciation and amortisation expense	10,864	9,000	10,519
2,584	Capital charge	2,288	2,412	2,951
96,699	Other expenses	193,477	96,979	226,674
240,641	Total expenses	386,576	249,932	446,034
26,449	Total comprehensive revenue and expense	32,015	–	–
26,449	Surplus/(deficit)	32,015	–	–
Other comprehensive revenue and expense				
–	Item that will not be reclassified to net surplus/(deficit)	–	–	–
–	Total other comprehensive revenue and expense	–	–	–
26,449	Total comprehensive revenue and expenses	32,105	–	–

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 2021

Actual		Note	Actual	Unaudited budget	Unaudited forecast
2020			2021	2021	2022
\$'000			\$'000	\$'000	\$'000
Equity					
43,621	Taxpayers' funds		56,130	47,153	63,339
2,590	Property revaluation reserve		3,555	2,590	2,590
(3,753)	Memorandum accounts		(6,002)	(3,753)	(6,002)
42,458	Total equity	12	53,683	45,990	59,927
Represented by:					
Assets					
Current assets					
6,180	Cash and cash equivalents		2,639	7,000	7,000
6,872	Receivables		16,847	2,059	5,762
34,663	Crown debtor		84,334	12,619	7,930
–	Inventory		–	32	–
4,018	Prepayments		4,343	2,894	5,000
51,733	Total current assets		108,163	24,604	25,692
Non-current asset					
8,696	Property, plant and equipment	6	9,463	14,142	11,879
47,501	Intangible assets	7	42,228	37,692	58,849
56,197	Total non-current assets		51,691	51,834	70,728
107,930	Total assets		159,854	76,438	96,420
Liabilities					
Current liabilities					
24,596	Payables	8	52,737	18,980	22,842
27,345	Return of operating surplus	9	34,264	–	–
214	Provisions	10	–	1,600	345
11,591	Employee entitlements	11	17,328	8,168	11,580
63,746	Total current liabilities		104,329	28,748	34,767
Non-current liabilities					
1,726	Employee entitlements	11	1,842	1,700	1,726
1,726	Total non-current liabilities		1,842	1,700	1,726
65,472	Total liabilities		106,171	30,448	36,493
42,458	Net assets		53,683	45,990	59,927

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 2021

Actual 2020 \$000		Note	Actual 2021 \$000	Unaudited budget 2021 \$000	Unaudited forecast 2022 \$000
40,210	Balance as at 1 July		42,458	40,207	49,914
26,449	Total comprehensive revenue and expense		32,015	–	–
	Owner transactions				
(27,345)	Return of operating surplus to the Crown	9	(34,264)	–	–
–	– Property revaluation		965	–	–
3,144	Capital contribution – cash		12,509	5,783	10,013
42,458	Balance as at 30 June		53,683	45,990	59,927

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 2021

Actual	Note	Actual	Unaudited budget	Unaudited
2020		2021	2021	forecast
\$000		\$000	\$000	2022
				\$000
Cash flows from operating activities				
238,064	Receipts from revenue Crown	355,119	227,712	428,357
6,762	Receipts from other revenue	4,957	14,668	17,982
(102,704)	Payments to suppliers	(160,614)	(98,342)	(237,476)
(130,467)	Payments to employees	(174,307)	(135,378)	(196,523)
(2,561)	Payments for capital charge	(2,288)	(2,412)	(2,951)
2,457	Goods and services tax (net)	(1,462)	–	–
11,551	Net cash flow from operating activities	21,405	6,248	9,389
Cash flows from investing activities				
–	Receipts from sale of property, plant and equipment	–	–	4,000
(111)	Purchase of property, plant and equipment	(171)	(6,213)	(6,213)
(11,866)	Purchase of intangible assets	(9,939)	(3,029)	(17,189)
(11,977)	Net cash flow from investing activities	(10,110)	(9,242)	(19,402)
Cash flows from financing activities				
3,144	Capital injection	12,509	5,783	10,013
(5,442)	Return of operating surplus	(27,345)	–	–
(2,298)	Net cash flow from financing activities	(14,836)	5,783	10,013
(2,724)	Net increase in cash held	(3,541)	2,789	–
8,904	Cash at the beginning of the year	6,180	4,211	7,000
6,180	Cash at the end of the year	2,639	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 2021 (continued)

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

Actual		Actual
2020		2021
\$000		\$000
26,449	Net surplus/(deficit)	32,015
	Add/(less) non-cash items:	
6,710	Depreciation and amortisation expense	10,864
1,709	Impairment of work in progress intangibles	3,472
8,419	Total non-cash items	14,336
	Add/(less) items classified as investing or financing activities	
8	(Gains)/losses on disposal of property, plant and equipment	69
8	Total items classified as investing or financing activities	69
	Add/(less) movements in working capital items:	
(4,805)	(Increase)/decrease in receivables	(9,975)
(17,380)	(Increase)/decrease in Crown debtor	(49,671)
32	(Increase)/decrease in inventory	-
(400)	(Increase)/decrease in prepayments	(325)
(2,683)	Increase/(decrease) in payables*	29,317
(1,297)	Increase/(decrease) in provisions	(214)
3,208	Increase/(decrease) in employee entitlements	5,853
(23,325)	Total movements in working capital items	(25,015)
11,551	Net cash flow from operating activities	21,405

* Payables for capital expenditure have been excluded when calculating the increase/decrease in the payables movement as they are relating to investing activities.

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 2021

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		Actual
2020		2021
\$000		\$000
Capital commitments		
236	Intangible assets	1,078
236	Total capital commitments	1,078
Operating leases as lessee		
Future aggregate lease payments to be paid under non-cancellable operating leases are as follows:		
8,021	Not later than one year	10,300
31,526	Later than one year and not later than five years	35,507
44,108	Later than five years	41,159
83,655	Total non-cancellable operating lease commitments	86,966
83,891	Total commitments	88,044

* The comparative year has been restated to exclude operating costs such as insurance and maintenance.

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

The accompanying notes form part of these financial statements.



Statement of contingent liabilities and contingent assets as at 30 June 2021

The Ministry is defending a small number of legal disputes involving past employees for which a potential liability has not yet been quantified as at 30 June 2021.

The Ministry had no other contingent liabilities as at 30 June 2021 (2020: \$nil).

The Ministry had no contingent assets as at 30 June 2021 (2020: \$nil).

The accompanying notes form part of these financial statements.



Notes to the financial statements for the year ended 30 June 2021

Notes index

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

1 Statement of accounting policies

Reporting entity

The Ministry of Health (the Ministry) is a government department as defined by section 5 of the Public Service Act 2020 and is domiciled and operates in New Zealand. The relevant legislation governing the Ministry's operations includes the Public Finance Act 1989 (PFA), Public Service Act 2020, and the New Zealand Public Health and Disability Act 2000. The Ministry's ultimate parent is the New Zealand Crown.

The financial statements of the Ministry for the year ended 30 June 2021 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).

In addition, the Ministry has reported on Crown activities and trust monies that it administers in the non-departmental statements and schedules on pages 107 to 124.

The Ministry's primary objective is to provide services to the New Zealand public. The Ministry funds, administers and monitors the delivery of health services.



The Ministry has designated itself as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice (GAAP).

The financial statements are for the year ended 30 June 2021 and were approved for issue by the Director-General of Health on 23 November 2021.

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 GAAP and Treasury Instructions.

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

Presentation currency and rounding

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

Changes in accounting policies

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

Comparative figures

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

Standards issued, 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 the year ending 30 June 2022, with early application permitted. The amendment will result in additional disclosures. The Ministry has decided not to early adopt the amendment.

PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The Ministry has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The Ministry has decided not to early adopt the standard.



PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with early adoption permitted. The Ministry has not yet determined how application of PBE FRS 48 will affect its statement of service performance. The Ministry has decided not to adopt the standard early.

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 2020/21 budget figures are for the year ended 30 June 2021 and were published in the 2020 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 2020/21.

Basis of the forecast figures

The 2021/22 forecast figures are for the year ending 30 June 2022, 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 2021/22.

The forecast financial statements have been prepared as required by the PFA to communicate forecast financial information for accountability purposes. The 30 June 2022 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 19 April 2021.

While the Ministry regularly updates its forecasts, updated forecast financial statements for the year ending 30 June 2022 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 2021/22 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 19 April 2021, 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 and anticipated workforce changes for new pieces of work as well as COVID-19 response



- 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 2020/21 was used as the opening position for the 2021/22 forecasts.

The actual financial results achieved for 30 June 2022 are likely to vary from the forecast information presented and the variance may be material. Factors that may lead to a material difference between information in these forecast financial information statements and the actual reported results include changes to the budget through initiatives approved by Cabinet, technical adjustments to (including transfers between) financial years and timing of expenditure relating to significant programmes and projects.

2 Revenue

Accounting policy

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

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

Revenue Crown

Revenue from the Crown is measured based on the Ministry's funding entitlement for the reporting period. The funding entitlement is established by Parliament when it passes the Appropriation Acts for the financial year. The amount of revenue recognised takes into account any amendments to appropriations approved in the Appropriation (Supplementary Estimates) Act for the year and certain other unconditional funding adjustments formally approved prior to 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		Actual
2020		2021
\$000		\$000
8,861	Medicines registration	9,970
342	Service fees	381
2,278	Annual licence and registration fees	2,686
165	Other revenue	764
11,646	Total other revenue	13,801

3 Personnel costs

Accounting policy

Salary and wages

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

Superannuation schemes

Defined contribution schemes

Employer contributions to the State Sector Retirement Savings Scheme, KiwiSaver and the Government Superannuation Fund are accounted for as defined contribution superannuation schemes and are expensed in the surplus or deficit as incurred.

Breakdown personnel costs

Actual		Actual
2020		2021
\$000		\$000
124,983	Salaries and wages	166,070
3,798	Employer contributions to defined contribution plans	4,879
3,076	Increase/(decrease) in employee entitlements*	5,853
2,791	Other personnel costs	3,145
134,648	Total personnel costs	179,947

* The increase in employee entitlements reflects the higher leave balances as a result of the travel restrictions due to COVID-19 impacting on leave taken as well as Holidays Act remediation.

4 Capital charge

Accounting policy

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

The Ministry pays a capital charge to the Crown on its equity balance (adjusted for memorandum accounts) as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2021 was 5.0% (2020: 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 budget	Unaudited forecast
2020		2021	2021	2022
\$000		\$000	\$000	\$000
450	Fees to Audit New Zealand for audit of financial statements	560	450	470
–	Payment made for Auditor-General's costs for COVID-19 vaccination report	242	–	–
25,410	Contractors and consultants	54,235	16,206	77,564
28,178	Computer services*	81,927	29,142	76,317
3,350	Travel	2,786	2,951	4,006
7,010	Communications and couriers	7,705	7,249	10,694
1,238	Printing and stationery	1,809	1,281	1,597
11,931	Operating lease payments	13,173	13,831	14,769
3,398	Occupancy costs other than leases	3,557	3,472	3,779
9,631	Professional specialist fees	9,423	9,839	19,362
1,280	Sector and public consultations	2,351	2,083	7,156
1,709	Impairment of work in progress intangibles	3,472	–	–
8	Net loss on sale/disposal of property, plant and equipment	69	–	–
461	Advertising**	8,578	591	416
2,645	Other expenses	3,590	9,884	10,544
96,699	Total other expenses	193,477	96,979	226,674

* The variances reflect 2020/21 funding changes mainly related to COVID-19 response and disclosed in the 2020/21 Supplementary Estimates.

** Advertising comparison has been moved from Other Expenses to reflect the 2021 and forecast 2022 classification. The 2021 year includes \$8 million incurred for the COVID-19 vaccination public information campaign.



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-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 which is at 108 Victoria Street, Christchurch was valued by Telfer Young, an independent valuer. The effective date of the valuation is 30 June 2021, resulted in an increase in the revaluation reserve. The building on the land was damaged and had been written off as a result of the 2011 Christchurch earthquake.

	Land	Leasehold improvements	Furniture plant and equipment	Motor vehicles	Computer hardware	Total
	\$000	\$000	\$000	\$000	\$000	\$000
Cost or valuation						
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
Balance as at 1 July 2020	5,350	5,271	1,622	373	3,100	15,716
Additions	–	–	467	–	106	573
Revaluation increase	965	–	–	–	–	965
Disposals	–	–	(114)	(30)	(1,465)	(1,609)
Balance as at 30 June 2021	6,315	5,271	1,975	343	1,741	15,645
Accumulated depreciation and impairment losses						
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
Balance as at 1 July 2020	–	2,433	1,296	298	2,993	7,020
Depreciation expense	–	527	113	–	63	703
Eliminate on disposal	–	–	(88)	(24)	(1,429)	(1,541)
Balance as at 30 June 2021	–	2,960	1,321	274	1,627	6,182
Total property, plant and equipment including WIP						
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
At 30 June 2021	6,315	2,311	654	69	114	9,463

Work in Progress

As at 30 June 2021 there is furniture on hand of \$0.4 million and accrued for refurbishing the Whanganui warehouse, this project has since been completed and capitalised in 2021/22 (2020: \$0.03 million of computer hardware was bought for use in specific IT projects, these were completed and capitalised in 2020/21).



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	3–7 years	14.3–33.3%
Software – other	3–7 years	14.3–33.3%

Impairment

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



Critical accounting estimates and assumptions

Useful lives of software

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

Breakdown of intangible assets

	Acquired software \$000	Internally generated software \$000	Total \$000
Cost			
Balance as at 1 July 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
Balance as at 1 July 2020	20,131	109,265	129,396
Additions	–	8,360	8,360
Disposals	–	–	–
Impairment	–	(3,472)	(3,472)
Balance as at 30 June 2021	20,131	114,153	134,284
Accumulated amortisation and impairment losses			
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
Balance as at 1 July 2020	19,629	62,266	81,895
Amortisation expense	148	10,013	10,161
Balance as at 30 June 2021	19,777	72,279	92,056
Total intangible assets including WIP			
At 30 June 2019	703	35,302	36,005
At 30 June 2020	502	46,999	47,501
At 30 June 2021	354	41,874	42,228

Work in Progress

The Ministry has numerous IT projects in progress resulting in work in progress of \$5.9 million (2020: \$25.7 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 the amount payable.

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

Breakdown of payables

Actual		Actual
2020		2021
\$000		\$000
4,011	Creditors	3,538
2,169	Revenue in advance	3,302
13,806	Accrued expenses	42,754
4,610	GST payable	3,143
24,596	Total payables	52,737

9 Return of operating surplus

Actual		Actual
2020		2021
\$000		\$000
26,449	Net surplus/(deficit)	32,015
	Add:	
896	(Surplus)/deficit of memorandum accounts	2,249
27,345	Total operating surplus/(deficit)	34,264
27,345	Total return of operating surplus	34,264

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. By June 2021, the restructure was fully implemented.

Breakdown of provisions

Actual	Actual
2020	2021
\$000	\$000
Current portion	
214 Restructuring	–
214 Total current portion	–
214 Total provisions	–

Movement of provisions

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



11 Employee entitlements

Accounting policy

Short-term employee entitlements

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

These include salaries and wages accrued up to 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 0.38% (2020: 0.22%) 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 \$13,840 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 \$26,255 higher/lower.



Breakdown of employee benefits

Actual		Actual
2020		2021
\$000		\$000
Current position		
8,677	Annual leave	12,910
768	Retirement and long service leave	865
2,146	Accrued salaries	3,553
11,591	Total current portion	17,328
Non-current position		
1,726	Retirement and long service leave	1,842
1,726	Total non-current portion	1,842
13,317	Total employee entitlements	19,170

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.

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

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		Actual
2020		2021
\$000		\$000
Taxpayers' funds		
40,477	Balance as at 1 July	43,621
26,449	Surplus/(deficit)	32,015
896	Transfer of memorandum account net deficit for the year	2,249
(27,345)	Return of operating surplus to the Crown	(34,264)
3,144	Capital injection	12,509
43,621	Balance as at 30 June	56,130
Property revaluation reserves		
2,590	Balance as at 1 July	2,590
–	Revaluation gains on land	965
2,590	Balance as at 30 June	3,555
Memorandum accounts		
(2,857)	Balance as at 1 July	(3,753)
(896)	Net memorandum account deficits for the year	(2,249)
(3,753)	Balance as at 30 June	(6,002)
42,458	Total equity	53,683

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 undertaken fees reviews, and is completing consultation on proposed fees changes. It is expected new fee schedules will be introduced in the coming year.



Breakdown of memorandum accounts

	Problem Gambling*	Office of Radiation Safety	Medsafe	Medicinal Cannabis	Vaping	Total
	\$000	\$000	\$000	\$000	\$000	\$000
Balance as at 1 July 2019	(707)	(104)	(2,046)	–	–	(2,857)
Revenue	–	956	8,400	277	–	9,633
Expenditure	–	(1,527)	(8,839)	(163)	–	(10,529)
Balance as at 30 June 2020	(707)	(675)	(2,485)	114	–	(3,753)
Balance as at 1 July 2020	(707)	(675)	(2,485)	114	–	(3,753)
Revenue	–	928	9,577	570	–	11,075
Expenditure	–	(1,670)	(9,695)	(806)	(1,153)	(13,324)
Balance as at 30 June 2021	(707)	(1,417)	(2,603)	(122)	(1,153)	(6,002)

* The Problem Gambling memorandum account was disestablished in 19/20. The Ministry is in the process to seek capital injection from the Crown to close the deficit balance of the account. Revenue collected and expenditure incurred in relation to problem gambling services are disclosed in the 'Problem Gambling Revenue Report' on page 112.

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	Actual
2020	2021
\$000	\$000
Leadership team including the Director-General:	
5,793 Remuneration	7,099
18 Full-time equivalent staff	20

The above key management personnel disclosure excludes the Minister of Health and Minister for COVID-19 Response. The Minister's remuneration and other benefits are not received only for his role as a member of key personnel of the Ministry. The Minister's remuneration and other benefits are set by the Remuneration Authority under the Members of Parliament (Remuneration and Services) Act 2013 and are paid under Permanent Legislative Authority, not by the Ministry 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

Te Aho o Te Kahu | Cancer Control Agency

On 28 August 2019, Cabinet approved the establishment of Te Aho o Te Kahu | Cancer Control Agency as a departmental agency, hosted by the Ministry of Health.

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

The nature of this arrangement means while the agency is a separate departmental operating unit within the Ministry, it is functionally independent, with separate ministerial reporting lines and Chief Executive. The Ministry's financial statements include the operations of the Cancer Control Agency, and 2020/21 is the first full year of operation for the agency.

The Cancer Control Agency is funded from within Vote Health baselines.

In summary its financial performance for the year ended 30 June 2021 was as follows:

Actual	Actual
2020	2021
\$000	\$000
Departmental activities	
Revenue	
2,251	11,031
Revenue Crown	
Expenses	
1,230	5,225
Personnel costs	
535	1,810
Other expenses	
1,765	7,035
Total expenses	
486	3,996
Surplus/(deficit)	
Non-departmental activities	
8,947	1,795
Appropriation: National personal health services	
8,947	1,795
Total non-departmental expenditure	



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 \$169.526 million higher than the budget mainly due to the Ministry receiving additional funding through the 2020/21 Supplementary Estimates for Vote Health for additional activities, including additional funding for:

- administering the purchase of COVID-19 vaccines and other therapeutics, and supporting the delivery of an immunisation programme for COVID-19 vaccines (\$48.99 million)
- managing and coordinating the overall national health response to COVID-19 (\$21.71 million and \$8.554 million carried forward from 2019/20)
- delivering and maintaining the operational response through the National Close Contact Service and technology to support the management of COVID-19 (\$19.169 million)
- additional costs associated with non-core responsibilities of the National Health Crisis Centre to support COVID-19 (\$5.800 million)
- policy advice and related services to support the Ministry's capability for ongoing response to COVID-19 (\$4.265 million)
- Public Finance System modernisation (\$17.411 million for a fiscally neutral transfer from the non-departmental output expense National Health Information Systems appropriation, to realign appropriation types and services)
- improving the Financial Sustainability and Performance of DHBs initiative (\$10.5 million)
- the initiative Modernising the Patient Healthcare Experience through the Hira programme (formerly the 'National Health Information Platform' programme, \$5.347 million)
- the development of the National Immunisation Solution (\$5.201 million)
- building the Mental Health and Addictions system (\$5.156 million, fiscally neutral transfer from the non-departmental output expense National Mental Health Services).

Personnel costs

Personnel costs have increased by \$38.4 million mainly due to additional resources required for the COVID-19 response, and the financial impact of higher than anticipated leave balances due to COVID-19 impacting on leave taken.



Other expenses

Other expenses were higher than the budget by \$96.5 million. The main reasons for this are higher contractors and consultants expenditure, which is mainly related to supporting activities associated with the response to COVID-19 and other project work programmes (\$38 million); and additional computer expenses incurred relating to COVID-19 response such as the national close contacts tracing services, National Immunisation Solution, National Health Information Systems and Modernising the Patient Healthcare experience through the Hira programme (\$52.8 million).

Statement of financial position

Current assets

Current assets were \$83.5 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 by 30 June 2021 (\$71.7 million). 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 \$33.7 million higher than the budget due primarily to higher accrued expenses in relation to COVID-19 vaccination programme (\$14 million), COVID-19 related advertising (\$8.2 million) and IT projects in progress (\$5.6 million).

18 Statutory reporting timeframe

The Ministry was unable to meet the statutory obligation under the Public Finance Act 1989 (section 45D) to provide all relevant information to the Auditor-General to audit within two months after the end of the financial year. This meant that the Auditor-General was unable to provide an audit report within three months after the end of the financial year.

Finalising appropriate performance measures and the associated results relating to the National Resonse to COVID-19 Across the Health Sector and Implementing the COVID-19 Vaccine Strategy (CVIP) Multi-Category Appropriations along with providing the information to Audit New Zealand was significantly impacted by the August/September 2021 COVID-19 response.



Non-departmental statements and schedules for the year ended 30 June 2021

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

The accompanying notes form part of these financial statements.
For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statement of the Government for the year ended 30 June 2021.



Statement of non-departmental expenses for the year ended 30 June 2021

Actual 2020 \$000		Actual 2021 \$000	Unaudited budget 2021 \$000	Revised budget 2021 \$000
16,004,117	Contracted services funding to DHBs (devolved and non-devolved funding, including COVID-19 costs)	17,467,320	16,920,107	17,048,656
28,126	Services from Pharmaceutical Management Agency Limited	34,921	23,488	30,262
19,642	Services from Institute of Environmental Science and Research Limited	26,987	17,014	20,813
16,239	Services from Health Promotion Agency	24,276	16,048	16,048
13,342	Services from Health Quality and Safety Commission	14,453	12,976	12,976
13,370	Services from the Health and Disabilities Commissioner	14,370	13,370	14,370
–	Services from other Crown entities	2,891	2,445	8,209
16,094,836	Total services from Crown Entities	17,585,218	17,005,448	17,151,334
86,798	Workforce training and development services	78,654	93,352	92,776
63,118	Mental health services	68,008	103,592	100,248
1,469,359	Disability support services	1,396,173	1,392,233	1,401,237
185,627	Maternity services	211,575	202,192	229,072
271,198	COVID-19 activities	167,643	–	1,315,153
274,719	Other services from third parties	758,091	570,866	1,196,839
71,519	Impairment of inventory (PPE) (note 2.1)	56,391	–	–
2,422,338	Total services from third parties	2,736,535	2,362,235	4,335,325
18,517,174	Total services	20,321,753	19,367,683	21,486,659
–	Revaluation loss on property, plant and equipment	–	–	–
1,318	Net movement in residential care loans book value	(1,388)	–	–
1,318	Total revaluation and impairment adjustments	(1,388)	–	–
18,518,492	Total non-departmental expenses	20,320,365	19,367,683	21,486,659
2,770,022	GST input expense	3,042,575	2,887,574	3,205,911
21,288,514	Total non-departmental expenses GST inclusive	23,362,940	22,255,257	24,692,570

The accompanying notes form part of these financial statements.

For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statement of the Government for the year ended 30 June 2021.



Schedule of non-departmental revenue and capital receipts for the year ended 30 June 2021

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 2020 \$000		Actual 2021 \$000	Unaudited budget 2021 \$000	Revised budget 2021 \$000
Revenue				
Reimbursement from the Accident Compensation Corporation (ACC)				
21,223	Reimbursement of complex burns costs	7,163	6,899	21,687
29,272	Reimbursement of work-related public hospital costs	31,672	30,182	31,672
346,106	Reimbursement of non-earners' account	367,323	356,864	374,486
112,118	Reimbursement of earners' non-work-related public hospital costs	121,311	115,603	121,311
54,294	Reimbursement of motor vehicle-related public hospital costs	58,746	55,981	58,746
3,280	Reimbursement of medical misadventure costs	3,549	3,382	3,549
6,816	Reimbursement of self-employed public hospital costs	7,376	7,029	7,376
573,109	Total ACC reimbursements	597,140	575,940	618,827
Other non-departmental revenue				
302,267	Payment of capital charge by DHBs and NZ Blood Service	249,586	420,376	374,638
14	Fines and penalties	12	–	–
–	Miscellaneous	18,792	–	30,130
875,390	Total non-departmental revenue	865,530	996,316	1,023,595
Non-departmental capital receipts				
13,558	Repayment of residential care loans	16,931	20,000	20,000
–	Repayment of DHB debt	–	–	–
12,580	Equity repayments by DHBs	12,800	12,499	12,499
26,138	Total non-departmental capital receipts	29,731	32,499	32,499
901,528	Total non-departmental revenue and capital receipts	895,261	1,028,815	1,056,094

The accompanying notes form part of these financial statements.

For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statement of the Government for the year ended 30 June 2021.



Schedule of non-departmental assets and liabilities as at 30 June 2021

Actual	Note	Actual	Unaudited budget	Revised budget
2020		2021	2021	2021
\$000		\$000	\$000	\$000
Assets				
Current assets				
343,822	Cash and cash equivalents	258,941	88,630	343,822
92,470	Inventory	219,050	8,507	92,470
25,625	Receivables from DHBs	2,476	1,962	1,822
164,431	Receivables from ACC	370	36,198	34,800
16,048	Receivables from government departments	5,897	59	1,000
11,884	Other receivables	7,011	–	10,062
112,972	Prepayments	145,494	32,720	112,972
630,055	Hospital rebuild projects	–	–	–
1,397,307	Total current assets	639,239	168,076	596,948
Non-current assets				
Advances:				
44,114	Residential care loans	46,949	41,546	44,114
Investments:				
97,926	Hospital rebuild projects	195,389	172,889	267,056
142,040	Total non-current assets	242,338	214,435	311,170
1,539,347	Total non-departmental assets	881,577	382,511	908,118
Liabilities				
Current liabilities				
Payables:				
35,755	DHB payables	78,189	–	–
19,984	Other payables	68,092	7,199	7,464
Accrued liabilities and provisions:				
261,765	DHB accrued liabilities	371,119	277,544	310,722
2,269	Other Crown entities	–	–	–
310,180	Other accrued liabilities	220,583	170,882	290,852
629,953	Total non-departmental current liabilities	737,983	455,625	609,038

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

The accompanying notes form part of these financial statements.

For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statement of the Government for the year ended 30 June 2021.



Schedule of non-departmental commitments as at 30 June 2021

Breakdown of capital commitments

Actual 2020 \$000	Actual 2021 \$000
Capital commitments	
58,262 Not later than one year	71,948
41,553 Later than one year and not later than five years	44,571
50,000 Later than five years	70,000
149,815 Total capital commitments	186,519

There are five projects in progress. All are related to hospital redevelopment.

Schedule of non-departmental contingent liabilities and contingent assets as at 30 June 2021

Breakdown of contingent liabilities

Actual 2020 \$000	Actual 2021 \$000
46,010 Legal proceedings and disputes	3,110
46,010 Total contingent liabilities	3,110

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 (2020: \$nil).

The accompanying notes form part of these financial statements.
For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statement of the Government for the year ended 30 June 2021.



Problem Gambling Revenue Report for the year ended 30 June 2021

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 2021 \$000	Departmental actual 2021 \$000	Total actual 2021 \$000
2020 \$000				
Problem Gambling non-departmental expenditure				
11,106	Balance as at 1 July	7,574	(574)	7,000
13,794	Revenue	14,797	990	15,787
(17,900)	Expenses	(17,962)	(630)	(18,592)
7,000	Balance as at 30 June*	4,409	(214)	4,195

* The balance represents the accumulated balance of surpluses and deficits incurred in providing problem gambling services, they are not formal assets or liabilities of the Crown.

Revenue is actual levies collected by 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 Statement of the Government for the year ended 30 June 2021.



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 2021

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 2021.

Basis of preparation

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

Measurement and recognition rules applied in the preparation of the non-departmental statements and schedules are consistent with generally accepted accounting practice (Public Benefit Entity Accounting Standards) as appropriate for public benefit entities.

Presentation currency and rounding

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

Changes in accounting policies

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

Standards issued, not yet effective and not early adopted

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

PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The Ministry has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The Ministry has decided not to early adopt the standard.



Summary of significant accounting policies

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

Revenue and receipts

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

Cash and cash equivalents

Cash and cash equivalents are subject to the expected loss requirements of PBE IFRS 9. However, no loss allowance has been recognised because the estimated loss allowance for credit losses is considered to be nil or trivial.

Debtors and receivables

Receivables from ACC recoveries are measured at amortised cost and recorded at the value of the contract and agreed with ACC, less an allowance for credit losses as per the requirements of PBE IFRS 9. The estimated loss allowance is considered to be nil. Receivables from capital charges are recorded at estimated realisable value.

Residential care loans

An actuarial valuation of residential care loans was carried out in May 2021.

Inventory

Inventories held for consumption in the provision for services are recorded at the lower of cost or net realisable value in accordance with PBE IPSAS 12. Any write-down from cost to net realisable value is recognised in the Statement of Non-Departmental Expenses and Capital Expenditure against appropriations.

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 2020/21 Vote Health 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 2021. 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 2021

Actual expenditure 2020 \$000	Appropriation title	Note	Actual expenditure 2021 \$000	Unaudited budget 2021 \$000	Revised budget* 2021 \$000	Location of end-of-year performance information^
Departmental output expenses						
54,665	Managing the purchase of services		71,199	51,276	72,354	1
24,936	Regulatory and enforcement services		27,994	27,358	29,124	1
56,822	Sector planning and performance		73,674	69,649	80,881	1
56,931	Health sector information systems		93,445	55,868	106,519	1
15,871	Payment services		19,600	18,340	19,627	1
-	National health response to COVID-19		8,432	-	8,554	1
-	Policy advice and related services		34,144	27,441	34,306	1
209,225	Total departmental output expenses		328,488	249,932	351,365	
Multi-category expenses						
	Policy advice and ministerial servicing MCA					
7,108	Ministerial servicing		-	-	-	N/A
19,895	Policy advice		-	-	-	N/A
4,413	Review of health & disability support services		-	-	-	N/A
	Implementing the COVID-19 vaccine strategy MCA					
-	Supporting the implementation of the COVID-19 vaccine strategy		44,838	-	48,990	1
	National response to COVID-19 across the Health Sector MCA					
-	National health response to COVID-19		13,250	-	21,711	1
31,416	Total multi-category expenses		58,088	-	70,701	



Actual expenditure 2020 \$000	Appropriation title	Note	Actual expenditure 2021 \$000	Unaudited budget 2021 \$000	Revised budget* 2021 \$000	Location of end-of-year performance information^
240,641	Total departmental and multi-category output expenses		386,576	249,932	422,066	
	Departmental capital expenditure					
11,977	Ministry of Health – permanent legislative authority		10,110	9,242	15,918	1
11,977	Total departmental capital expenditure		10,110	9,242	15,918	
252,618	Total departmental output appropriations		396,686	259,174	437,984	
	Non-departmental output expenses					
	Health/disability support services for district health boards (DHB)					
646,528	Northland		706,919	701,814	706,929	2
1,655,318	Waitematā		1,734,496	1,727,434	1,734,507	2
1,424,527	Auckland		1,490,114	1,488,802	1,490,125	2
1,557,372	Counties Manukau		1,649,756	1,646,763	1,649,765	2
1,296,190	Waikato		1,404,967	1,402,590	1,404,976	2
351,120	Lakes		382,784	381,058	382,793	2
783,960	Bay of Plenty		856,609	850,803	856,617	2
175,629	Tairāwhiti		191,226	190,625	191,236	2
371,857	Taranaki		401,127	399,986	401,136	2
538,967	Hawke's Bay		588,092	584,103	588,103	2
241,407	Whanganui		263,542	261,102	263,552	2
556,666	MidCentral		605,941	602,102	605,948	2
425,931	Hutt Valley		457,895	455,669	457,905	2
834,385	Capital & Coast		876,119	874,620	876,127	2
153,557	Wairarapa		167,676	166,633	167,685	2
476,831	Nelson-Marlborough		518,858	517,054	518,869	2
139,154	West Coast		154,887	151,334	155,056	2
1,556,180	Canterbury		1,648,555	1,639,047	1,658,239	2
195,765	South Canterbury		207,278	205,000	207,288	2
953,173	Southern		1,035,179	1,027,770	1,035,189	2
14,334,517	Total health/disability support services for DHBs	2.4	15,342,020	15,274,309	15,352,045	



Actual expenditure 2020 \$000	Appropriation title	Note	Actual expenditure 2021 \$000	Unaudited budget 2021 \$000	Revised budget* 2021 \$000	Location of end-of-year performance information^
National services						
1,598,936	National disability support services		1,658,856	1,706,581	1,659,024	3
811,062	Public health service purchasing	2.5	938,666	468,955	1,092,975	3
105,549	National child health services		109,199	111,518	110,518	3
373,998	National planned care services	2.6	466,484	424,590	514,740	3
156,025	National emergency services		169,620	147,590	173,170	3
17,061	National Māori health services		10,986	9,328	12,995	3
192,121	National maternity services		217,091	204,992	231,872	3
132,321	National mental health services		191,236	207,782	201,665	3
23,488	National contracted services – other		30,262	23,488	30,262	5
26,346	Monitoring and protecting health and disability consumer interests		31,347	26,346	31,347	2
17,076	Problem gambling services		17,962	20,609	22,612	3
205,323	Health workforce training and development		196,333	218,877	211,077	3
340,896	Primary health care strategy		348,765	367,368	352,243	3
118,727	National personal health services		91,085	67,007	93,336	3
9,377	National health information systems		-	8,382	-	3
11,115	Health sector projects operating expenses		4,751	2,000	7,402	3
591	Auckland health projects integrated investment plan		29	-	749	4
-	Health services funding		17,282	23,681	24,800	3
9,584	Supporting safe working conditions for nurses		-	-	-	4
-	Minimising the health impacts of COVID-19	2.7	120,755	-	224,874	3
4,149,596	Total national services		4,620,709	4,039,094	4,995,661	
18,484,113	Total non-departmental output expenses		19,962,729	19,313,403	20,347,706	



Actual expenditure 2020 \$000	Appropriation title	Note	Actual expenditure 2021 \$000	Unaudited budget 2021 \$000	Revised budget* 2021 \$000	Location of end-of-year performance information^
Multi-category expenses						
	Implementing the COVID-19 vaccine strategy MCA					
-	Implementing the COVID-19 immunisation programme	2.8	95,438	-	166,352	1
-	Purchasing potential and proven COVID-19 vaccines and other therapeutics	2.8	5,567	-	231,521	1
	National response to COVID-19 across the Health Sector MCA					
-	COVID-19 public health response	2.9	217,580	-	692,406	1
-	Total multi-category expenses		318,585	-	1,090,279	
18,484,113	Total non-departmental and multi-category output expenses		20,281,314	19,313,403	21,437,985	
Non-departmental other expenses						
2,081	International health organisations		2,150	2,230	2,230	4
1,034	Legal expenses		2,046	7,028	2,922	4
29,946	Provider development		36,243	45,022	43,522	3
33,061	Total non-departmental other expenses		40,439	54,280	48,674	
Non-departmental revaluation and impairment adjustments						
1,318	Net movement in residential care loans book value		(1,388)	-	-	4
1,318	Total non-departmental revaluation and impairment adjustments		(1,388)	-	-	
18,518,492	Total non-departmental expenses		20,320,365	19,367,683	21,486,659	
Non-departmental capital contributions to other persons or organisations						
430,000	Equity support for DHB deficit		240,000	39,211	315,000	2
128,840	Equity for capital projects for DHBs and Health Sector Crown agencies		-	-	-	3
139,210	Health sector projects		-	-	-	3



Actual expenditure 2020 \$000	Appropriation title	Note	Actual expenditure 2021 \$000	Unaudited budget 2021 \$000	Revised budget* 2021 \$000	Location of end-of-year performance information^
	– Health capital envelope 2020–2025 (MYA)	2.10	966,203	583,000	1,048,146	3
18,003	Residential care loans – payments		18,395	20,000	20,000	4
716,053	Total non-departmental capital contributions to other persons or organisations		1,224,598	642,211	1,383,146	
19,234,545	Total non-departmental appropriations		21,544,963	20,009,894	22,869,805	
19,487,163	Total Vote: Health		21,941,649	20,269,068	23,307,789	

* These are the total approved appropriations from the 2020/21 Vote Health Supplementary Estimates, adjusted for any transfers under section 26A of the Public Finance Act 1989.

^ The numbers in this column represent where the end-of-year performance information has been reported for each appropriation administered by the Ministry, as detailed below:

1 The 'Our performance' section of the Ministry's annual report.

2 The DHBs and other Crown Entity annual reports.

3 The Vote Health Report in relation to selected non-departmental appropriations for the year ended 30 June 2021.

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 and liabilities

2.1 Inventory

The total value of inventory on hand at balance date was \$210.543 million higher than the budget. This was mainly made up of the COVID-19 personal protective equipment (PPE) (\$185.272 million), the COVID-19 vaccines (\$5.709 million), and COVID-19 lab inventory (\$5.076 million).

The Ministry performed an assessment on the quality of stock on hand at year end in accordance with PBE IPSAS 12, as a result, the value of the stock was written down by \$56.391 million and this was included in the statement of non-departmental expenses.

2.2 Payables

Payables were not provided for in the main estimate budget.

2.3 DHB accrued liabilities

The DHB accrued liabilities were \$93.575 million higher than budgeted. This was mainly due to the accruals required at year end for the DHB's COVID-19 related (\$75.0 million) and other contract services provided but not invoiced to the Ministry. The increased accrual balance resulted in the higher than budgeted cash balance at year end accordingly.



Schedule of non-departmental expenses and capital expenditure against appropriations

2.4 Health and disability support services for DHBs

The increase of \$67.711 million actual expenditure against the budget across the DHBs reflected the additional support funding provided to DHBs to fund the COVID-19 related activities, including funding for the continuity of supply of medicines and medical devices due to COVID-19, and funding from the National Disability Support Services appropriation for the devolution of In-Between Travel Part A funding and responsibilities to the DHBs. These increases were partly offset by a technical adjustment to reflect the change in the capital charge rate from 6% to 5%.

2.5 Public health service purchasing

The increase of \$469.711 million in actual expenditure against the budget was mainly due to expenses incurred relating to COVID-19 activities including supply chain and managed isolation costs.

An additional net funding increase of \$624.020 million was provided through the 2020/21 Supplementary Estimates for COVID-19 activities, with a \$154.309 million underspend reported at year end mainly due to lower than anticipated costs and inventory adjustments for the emergency management stock and the COVID-19 PPE stock. More information of COVID-19 costs incurred is available in the COVID-19 Response Expenditure note.

2.6 National planned care services

The increase of \$41.894 million in actual expenditure against the budget was mainly due to expenses incurred in lifting the level of planned care delivery to address the COVID-19 backlog and waiting list experienced during and following the Level 4 lockdown period.

2.7 Minimising the health impacts of COVID-19

This was a new appropriation established during 2020/21 for minimising the health impact of COVID-19, including the purchase of potential or proven vaccines, the purchase of therapeutics, and the establishment and delivery of an immunisation strategy.

2.8 Implementing the COVID-19 vaccine strategy MCA

Implementing the COVID-19 immunisation programme

This was a new multi category appropriation (MCA) established during 2020/21 for delivering approved vaccines through an immunisation programme as part of minimising the health impacts of COVID-19.

Purchasing potential and proven COVID-19 vaccines and other therapeutics

This was a new MCA category established during 2020/21 for obtaining potential and proven vaccines and therapeutics as part of minimising the health impacts of COVID-19.

2.9 National response to COVID-19 across the Health Sector MCA

COVID-19 public health response

This was a new MCA established during 2020/21 for providing national response to the COVID-19 pandemic across the health sector.

2.10 Health capital envelope 2020–2025 (MYA)

The capital envelope multi-year appropriation (MYA) was established in Budget 2020 for purchasing of health sector assets, providing capital to health sector Crown entities or agencies for new investments, and reconfiguring DHB's balance sheets. The increase of \$383.203 million in actual expenditure against the budget was mainly due to the transfer of the completed Christchurch Hospital to the Canterbury DHB and Grey Base Hospital to the West Coast DHB.

3 COVID-19 response expenditure for the year ended 30 June 2021

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 \$5.014 billion has been appropriated to Vote Health for 2019/20 and outyears.

Total expenditure for the year ended 30 June 2021 across the Ministry is \$1.219 billion against a budget of \$2.440 billion. The total spend is made up of \$1.093 billion in non-departmental expenditure, \$96.789 million in departmental expenditure and \$29.224 million in capital expenditure. Joint Ministers have approved in-principle expense transfers of unspent COVID-19 related 2020/21 funding to 2021/22, reflecting the uncertainty of when costs would be incurred. The final transfer amount of \$763.884 million will be confirmed and approved by the Joint Ministers in the 2021 October Baseline Update.

Key spending on initiatives during 2020/21 includes:

- \$122.932 million – Personal Protection Equipment (PPE): For the purchase and use of additional PPE, including protective masks, face shields, gloves and other protective clothing, for frontline health care workforce and essential services workforce. This cost includes the \$56.391 million impairment of inventory after an assessment was performed at year end on the quality of PPE in accordance with PBE IPSAS 12. Refer to note 2.1 above for inventory balance at year end.
- \$192.848 million – Enhanced border measures – managed isolation and quarantine: To provide health services in our managed isolation or quarantine facilities.
- \$280.305 million – COVID-19 testing and laboratory capacity: For purchase of testing equipment, consumables associated with processing tests and the delivery of testing services within the community to detect the presence of COVID-19.
- \$40.791 million in DHB support to respond to the COVID-19 pandemic including costs for incident management, regional coordination services, additional cleaning, and security services as well as other activities associated with the response.
- \$50 million – Increase in combine Pharmaceutical Budget and PHARMAC operating costs: To meet the increase in the price of medicines procured by PHARMAC resulting from the disruption to supply.



- \$90.014 million on our contact tracing services including telehealth and boosting Public Health capacity to invest in surge capacity, and to support contact tracing.
- \$266.754 million for the COVID-19 Vaccine and Immunisation programme including the cost of purchasing vaccine supply and COVAX agreements.

As the lead agency for the response to COVID-19, the main impacts on the Ministry's departmental financial performance:

- received funding of \$38.223 million from the Crown to lead the response
- incurred \$31.005 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 \$56.391 million as a result of quality standard concerns.

Statement of budgeted and actual expenses and capital expenditure incurred against appropriations for the year ended 30 June 2021

Transfers under section 26A of the PFA for Vote Health

The Ministers of Finance and Health as Joint Ministers agreed to support a fiscally neutral adjustment between appropriations in Vote Health under section 26A of the Public Finance Act 1989 for the 2020/21 financial year only, to avoid the risk of unappropriated expenditure at year end. The section 26A transfer is approved by way of an Order in Council prior to 30 June under section 26A of the Public Finance Act.

The approved appropriation includes adjustments made in the Supplementary Estimates and the following transfers under section 26A of the Public Finance Act were made:

	Supplementary estimates 2021 \$000	Section 26A transfers 2021 \$000	Approved appropriation 2021 \$000
Departmental output expenses			
Sector planning and performance	81,798	(917)	80,881
Payment services	18,710	917	19,627



Statement of expenses and capital expenditure incurred without, or in excess of, appropriation or other authority for the year ended 30 June 2021

The Ministry has no expenses and capital expenditure incurred without, or in excess of, appropriation or other authority for the year ended 30 June 2021.

Expenses and capital expenditure incurred in excess of appropriation

Nil.

Expenses and capital expenditure incurred without appropriation or outside scope or period of appropriation

Nil.

Statement of departmental capital injections for the year ended 30 June 2021

Actual capital injections 2020 \$000		Actual capital injections 2021 \$000	Approved appropriation 2021 \$000
	Vote Health		
3,144	Ministry of Health – Capital injection	12,509	12,509

Statement of departmental capital injections without, or in excess of, authority for the year ended 30 June 2021

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



Appendices

Ngā āpitihanga





Appendix 1:

2017–21 Statement of Strategic Intention

measure results

Outcome measures

Table 1: Outcome measure results¹¹

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 expectancy¹²

	2019 ¹³	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

¹¹ The outcome measure 'independent life expectancy' has not been reported because results are dependent on data gathered in the Disability Survey which was last undertaken in 2013.

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.

¹² Prior years 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>

¹³ These are the latest results available and are the same as reported in our 2019/20 Annual Report.



Life expectancy increases over time

Measure

Life expectancy at birth as an indicator of the number of years a person can expect to live, based on population mortality rates at each age in a given year/period

Target

Improved results for male/female and Māori/non-Māori

Result

Life expectancy is a summary measure of mortality and the trend shows New Zealanders are living longer than ever before.

Improvements in Māori life expectancy at birth since 1995–97 have narrowed the gap between Māori and non-Māori.

Life expectancy at birth¹⁴

	2018–20 ¹⁵	2017–19	2012–14	2005–07 ¹⁶	2000–02	1995–97
Female	83.9	83.5	83.2	82.2	81.1	79.7
Male	80.3	80.0	79.5	78.0	76.3	74.4

Ethnicity and sex

	2018–20 ¹⁷	2017–19	2012–14 ¹⁸	2005–07 ¹⁹	2000–02	1995–97
Māori females	N/A	77.1	77.1	75.1	73.2	71.3
Māori males	N/A	73.4	73.0	70.4	69.0	66.6
Non-Māori females	N/A	84.4	83.9	83.0	81.9	80.6
Non-Māori males	N/A	80.9	80.3	79.0	77.2	75.4

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

¹⁴ These are the median results produced for the New Zealand period life tables.

URL 1995–97 to 2017–19: <https://www.stats.govt.nz/information-releases/national-and-subnational-period-life-tables-2017-2019>. Published 20 April 2021, accessed 2 July 2021; and URL 2018–20: <https://www.stats.govt.nz/information-releases/births-and-deaths-year-ended-december-2020-including-abridged-period-life-table>. Published 18 February 2021, accessed 2 July 2021.

¹⁵ Life expectancy figures for 2018–20 are an interim indication of trends from abridged period life tables. All other figures are based on complete period life tables.

¹⁶ 2005–2007 results are those published in 2008.

¹⁷ Definitive results for the 2018–20 period will be available when complete period life tables, using 2019-base population estimates, are published in the next year. This will include Māori and non-Māori life expectancy tables.

¹⁸ Caution should be taken in making comparisons with 2012–2014 period life tables, particularly for the Māori ethnic group because the revised Māori population estimates suggest an under-estimation of the size of the Māori ethnic group.

¹⁹ 2005–2007 results are those published in 2008.



Result

Age-standardised DALY rates per 1,000 decreased from 1990 until 2019. As the population is growing and ageing, the absolute number of DALYs has slowly increased from 1,039,768 in 1990 to 1,215,774 in 2019.

Disability-adjusted life years (DALYs) per 1,000 people²⁰

	2019 ²¹	2018	2017	2016	2015	2010	2000	1990
Female	198	197	197	196	198	204	224	257
Male	217	217	215	215	217	227	267	319
Total	207	207	205	205	207	215	244	286

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

Measure

New Zealand maintains its position within the Organisation for Economic Co-operation and Development (OECD), balancing relatively high life expectancy outcomes with relatively modest health expenditure.

Target

Maintain OECD position.

Result

New Zealand has maintained its position within the OECD as having relatively high life expectancy for relatively modest expenditure on health. New Zealand performs well internationally with the 15th-highest life expectancy out of 38 OECD countries while expenditure was only 19th highest in 2019.

OECD life expectancy and health expenditure – position out of OECD countries²²

	2019	2018	2017	2015	2010	2005
Life expectancy	15th of 38	17th of 38	15th of 38	14th of 38	13th of 38	12th of 38
Health expenditure	19th of 38	19th of 38	19th of 38	19th of 38	20th of 36	23rd of 36

20 Prior years 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>

21 These are the latest results available and are the same as reported in our 2019/20 Annual Report.

22 The life expectancy ranking has reduced slightly since 2005 as New Zealand has been overtaken by Ireland, Luxembourg, South Korea 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 21 July 2021).

This information comes directly from the OECD. The OECD updates prior year results as the estimates are recalibrated and re-estimated based on new information, data and methods each year. Therefore, prior results change as the source data is updated. The OECD updates data historically for the full set of 38 countries as countries join the organisation and/or when it receives information. The differences in the number of countries in the denominator can be because some member countries have not provided data.

System level measures

Table 2: System level measure results

Ambulatory sensitive hospitalisations rates per 100,000 children aged 0–4 years

Measure

Ambulatory sensitive hospitalisations (ASH) 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.

Expected trend: Equitable ASH rates for Māori, Pacific, and non-Māori, non-Pacific

Result

The 12-month rolling average to March 2021 showed that COVID-19 had a large impact on 'normal' services, resulting in a statistically significant reduction in child ASH rates for Māori, Pacific peoples and the total population. The equity gap for Māori (5,057) persists when compared with the non-Māori, non-Pacific rate (3,796). The top four conditions contributing to ASH rates continue to be two respiratory conditions (upper and ear, nose and throat respiratory infections), asthma, gastroenteritis and dental.

	2021	2020	2019 ²³	2018	2017
Ambulatory sensitive hospitalisations (ASH) rates per 100,000 children aged 0–4 years	4,432	6,425	6,930	6,770	6,494

Total acute hospital bed days per capita per 1,000 (standardised)

Measure

This measure can be used to manage the demand for acute inpatient services on the health system. The intent of the measure is to reflect integration between community, primary, and secondary care and it supports maximising the use of health resources for planned care rather than acute care.

Expected trend: Downward

Result

The 12-month rolling average showed a statistically significant reduction in hospital bed day rate, reflecting the impact COVID-19 had on 'normal' services. The rate for Māori (523/1,000) and for the Pacific population (604/1,000) remained significantly higher than the non-Māori, non-Pacific rate (326/1,000).

	2021 ²⁴	2020 ²⁵	2019 ²⁶	2018	2017
Total acute hospital bed days per capita	364	404	413	426	420

23 The national total includes all ethnicities. We have made minor adjustments to results published in previous Annual Reports to provide the latest available results, which include any additional records and updates from hospitals across New Zealand in the live database.

24 South Canterbury DHB data for the January to March 2021 quarter was not available at the time of publication. However, the addition of this data is not expected to increase rates at the national level.

25 The national total includes all ethnicities. We have made minor adjustments to results published in previous Annual Reports to provide the latest available results, which include any additional records and updates from hospitals across New Zealand in the live database.

26 Ibid.



Amenable mortality

Measure

The amenable mortality rate measures premature deaths (deaths of people aged under 75 years) from causes that the health system could potentially have prevented, reflecting variation in the coverage and quality of health care (preventative or therapeutic services) delivered to individuals.

Expected trend: Downward

Result

Amenable mortality rates have been declining and we expect this trend to continue. The rates for Māori and Pacific populations have also reduced. However, the equity gap between rates for Māori and Pacific peoples and the rate of the total population has remained. Both the Māori rate (206.5) and Pacific rate (172.7) are more than twice the non-Māori, non-Pacific rate (72.4).

	2017 ²⁷	2016	2015	2010	2005	2000
Amenable mortality (per 100,000 national mean)	91.5	87.8	90.7	103.7	120.0	146.0

Patient experience of care²⁸ (August 2020 – May 2021 survey results)

The patient experience of care system level measure is comprised of the adult primary care and adult inpatient experience surveys. Both surveys aim to improve the quality of health services in New Zealand Aotearoa by enabling patients to give feedback that can be used to monitor and improve the quality and safety of health services. The surveys provide consistent tools that can be used for national measures as well as for local assessment and improvement.

The table below first shows results from two of the highest scoring questions that are common across both survey; and then presents results from priority questions in each survey.

August 2020	May 2021
Percentage of people who say they were definitely treated with respect by their healthcare professional (national mean)	
Results	
Adult inpatient = 91	Adult inpatient = 91
Adult primary care = 96	Adult primary care = 97
Percentage of people who say they did not feel they were treated unfairly (discrimination) (national mean)	
Results	
Adult inpatient = 93	Adult inpatient = 92
Adult primary care = 97	Adult primary care = 97
Priority question: Adult inpatient experience survey	
Percentage of people who say they were definitely told the possible side effects of the medicine they left hospital with, in a way they could understand (national mean)	
Result	Result
Adult inpatient = 62	Adult inpatient = 62

27 The time lag before data is available occurs because it is necessary to wait for the outcome of coronial inquiries. We have made minor adjustments to results published in previous Annual Reports to provide the latest available results.

28 In 2020, the national patient experience survey programme was refreshed. This included a change of survey provider, a review of both the primary care and inpatient survey questionnaires, stakeholder engagement and cognitive pre-testing in priority populations. As part of the refresh, it was agreed to move away from reporting domain scores and focus instead on priority questions.



Priority questions: Adult primary care survey**Percentage of people who say they receive care from a GP or nurse when they need it (national mean)****Result**

Adult primary care = 83

Adult primary care = 83

Percentage of people who say they feel involved in their own care and treatment with their GP or nurse (national mean)**Result**

Adult primary care = 87

Adult primary care = 89

Comment**Adult inpatient survey**

- The inpatient survey has been running quarterly in all DHBs since 2014. A selection of adult patients (aged 15 years and over) who spend at least one night in hospital during each survey sample period are invited to take part.
- At the national level, survey responses have remained broadly consistent. The national response rate is 25 percent.

Adult primary care survey

- The primary care survey has been running quarterly since 2016. It 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.
- 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 response rate is 16 percent. The use of paired invitations (SMS and email) for Māori and Pacific peoples is showing promising results in increasing response rates.
- An ongoing priority of the survey programme is to increase participation for Māori and Pacific populations.



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 2020/21.

Health targets

The Minister of Health announced the new Health System Indicators Framework in August 2021, replacing the national health targets. For more information on the Health System Indicators framework, and results, see the Health Quality & Safety Commission New Zealand website at <https://reports.hqsc.govt.nz/HSI>.

In 2020/21 DHBs continued to report to the Ministry against the existing national health targets and the results are presented below.

Table 3: National health target results

Target area	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Shorter stays in emergency departments ²⁹	95%	86.6%	85.1%	83.6%	83.1% (note 1)TBC
Faster cancer treatment ³⁰	90%	89.3%	88.8%	85.1%	84.2%TBC
Increased immunisation ³¹	95%	89.4%	89.3%	87.7%	87.3%TBC
Better help for smokers to quit ³²	90%	78.4%	78.0%	77.0%	76.1%TBC
Raising healthy kids ³³	95%	93.3%	93.4%	93.5%	93.4%TBC

Note 1: The national result does not include data for Waikato DHB due to the impact of the cyberattack on DHB systems

- 29 Patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.
- 30 Patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
- 31 Age eight months will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.
- 32 PHO-enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months and pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.
- 33 Obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.



Appendix 2:

Legal and regulatory framework

Additional statutory reporting requirements

The Minister of Finance has not specified any additional reporting requirements.

Health Act 1956

The Health Act 1956 requires the Director-General of Health to report annually on the current state of public health. 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 Health Act also requires the Director-General to report before 1 July each year on the quality of drinking-water in New Zealand. The public can access the most recent report 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 2021, 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.

The *Border Executive Board* was established under the Public Service Act 2020, as an Interdepartmental Executive Board, to deliver an integrated and effective border system. The Ministry of Health is a member of the board which Board is hosted by the New Zealand Customs Service.³⁴ The Board is required to produce an Annual Report under the Public Finance Act 1989 and this is made available on their website: <https://www.customs.govt.nz/about-us/border-executive-board/>.

³⁴ New Zealand Customs Service (Chair), Ministry of Business, Innovation and Employment, Ministry of Foreign Affairs and Trade, Ministry of Health, Ministry for Primary Industries and Ministry of Transport.



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
- Contraception, Sterilisation, and Abortion Act 1977
- Education and Training Act 2020
- Food Act 2014
- Gambling Act 2003
- Hazardous Substances and New Organisms Act 1996
- Local Government Act 1974
- Local Government Act 2002
- Maritime Security Act 2004
- Prostitution Reform Act 2003
- 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 Aotearoa 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 3:

Asset performance indicators

Cabinet Office Circular CO(19)6 requires investment intensive government agencies to report against their asset performance indicators in annual reports.

Table 4: Asset performance indicator results

Indicator	Indicator type	Actual 2019/20	Target 2020/21	Actual 2020/21
Property				
Percentage of buildings with a Property Council of NZ Grade ³⁵ of C or better	Condition	89%	>80%	91%
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%	100%
Average occupancy m ² per head	Utilisation	14.62	<14 m ²	11.33
Percentage of buildings with a functionality rating ³⁷ of 3 or better	Functionality	100%	100%	100%
Average power used kWh/m ²	Functionality	73 kWh/m ²	<80 kWh/m ²	84.78 kWh/m ²
Information and communications technology (ICT)				
Availability of five key ICT applications including internal Ministry and sector systems (note 1)	Availability	99.87%	99%	97.4%
Availability of key sector- and public-facing systems (note 1)	Availability	99.46%	99%	97%
The number of active sector user logins to national systems (note 2)	Utilisation	5,069	15,000	16,436

35 Property Council New Zealand's quality grading matrix includes the following grades: Grade D: Office space with lower poor-quality finish. Services fall below the minimum set for a C grade; Grade C: Good-quality space with a reasonable standard of finish and maintenance. Tenant car parking facilities should be available; Grade B: High-quality space including good views and outlook, quality lobby finish, on-site undercover parking, quality access to and from an attractive street setting, and quality presentation and maintenance. Grade A: A landmark office building located in major CBD office markets which are pacesetters in establishing rents and include ample natural lighting, good views and outlook, prestige lobby finish, on-site undercover parking, quality access to and from an attractive street setting, and premium presentation and maintenance.

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.



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 reflected the number of active sector user logins that are registered in the national system. For 2020/21 the result reflects the number of actual individuals with access to the national system.



Appendix 4:

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.

Pharmac Review Committee

The Pharmac Review Committee was established in March 2021. This Review will help to ensure that the public can have confidence in the work of PHARMAC by examining:

- how well Pharmac performs against its current objectives and whether and how its performance against these could be improved.
- whether Pharmac's current objectives maximise its potential to improve health outcomes for all New Zealanders as part of the wider health system, and whether and how these objectives should be changed.

Membership

Sue Chetwin (Chair)	Heather Simpson	Professor Sue Crengle
Frank McLaughlin	Leanne Te Karu	Dr Tristram Ingham

Mental Health and Wellbeing Commission

The Initial Mental Health and Wellbeing Commission was established in November 2019 and was in operation until February 2021. The Initial Mental Health and Wellbeing Commission was set up to maintain the momentum of He Ara Oranga, the Government inquiry into mental health and addiction, and the work to transform New Zealand Aotearoa's mental health and wellbeing system while the Mental Health and Wellbeing Commission was being established.

Membership

Hayden Wano (Chair)	Kevin Hague	Dr Julie Wharewera-Mika
Kendall Flutey	Kelly Pope	

COVID-19 Surveillance and Testing Strategy Group

The Group was established to oversee the Ministry of Health's implementation of the COVID-19 Surveillance Plan and Testing Strategy. The Group was set up in August 2020 for a four-week period.

Membership

Sir Brian Roche (co-chair)	Heather Simpson (co-chair)	Dr Api Talemaitoga
Dr Rawiri Jansen	Professor Philip Hill	



Contact Tracing Assurance Committee

The Contact Tracing Assurance Committee was established to provide the Minister of Health with independent advice on the Ministry of Health's improvements to the contact tracing system recommended in the *Interim Report on the Contact Tracing System* by Dr Ayesha Verrall. The Committee was established in May 2020 and was closed in October 2020.

Membership

Sir Brian Roche (chair)	Dr Marion Poore	Professor Philip Hill
Warren Moetara	Liz Read	

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, prioritising of capital investment, delivering 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 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 New Zealand Public Health and Disability Act.

Membership

Professor Judith McGregor (chair)	Lorraine Hetaraka	
Associate Professor Andrew Connolly	Alisa Claire	Karl Metzler
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 Sotera Catapang	Dr Michael Meyer
Rochelle Style	Dr Karen Bartholomew	Catherine Garvey
Dr Kate Parker		



Membership: Northern B Health and Disability Ethics Committee

Kate O'Connor (chair)	Stephanie Pollard	Susan Sherrard
John Hancock	Leesa Russell	

Resigned between 1 July 2020 and 30 June 2021:

Dr Nora Lynch	Tangihaere Macfarlane	Jane Wylie
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Membership: Central Health and Disability Ethics Committee

Helen Walker (chair)	Dr Ptries Herst	Helen Davidson
Dr Peter Gallagher	Dr Cordelia Thomas	Sandy Gill
Julie Jones		

Resigned between 1 July 2020 and 30 June 2021:

Dr Jillian Wilkinson

Membership: Southern Health and Disability Ethics Committee

Helen Walker (chair)	Dominic Fitchett	Dr Devonie Eglinton (nee Waaka)
Dr Paul Chin	Associate Professor Mira Harrison-Woolrych	
Dr Sarah Gunningham		

Resigned between 1 July 2020 and 30 June 2021:

Dr Pauline Boyles	Professor Jean Hay-Smith
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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)	Rosemary de Luca	Dr Karen Reader
Karaitiana Taiuru	Dr Sarah Wakeman	Calum Barrett
Seth Fraser	Catherine Ryan	Dr Analosa Veukiso-Ulugia

Resigned between 1 July 2020 and 30 June 2021:

Tim Barnett	Colin Gavaghan
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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)	Mania Maniapoto-Ngaia	Michèle Stanton
Judith Charlton	Dr Mary Birdsall	Dr Tepora Emery
Associate Professor Michael Legge		Dr Paul Copland



Appendix 5:

Delegation of functions or powers

The Public Service Act 2020 requires departments to state in their annual report where their chief executive's functions or powers have been delegated under the Act to a person outside the public service. We must include a description of an assessment of how effectively the delegated function or power was performed or exercised.

Table 5: Delegation of functions or powers

Function or power delegated	Person delegated to	Assessment of how effectively the delegated function or power was performed or exercised
Power to appoint enforcement officers at section 18 of the COVID-19 Public Health Response Act 2020. Only for the purpose of authorising enforcement officers to assist with the enforcement of any alert level boundary mandated by Order made under the Act	Police Commissioner	Delegated power not used in 2020/21.

Appendix 6:

Substance Addiction (Compulsory Assessment and Treatment) Act 2017

In February 2018, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act) came into force, replacing the Alcoholism and Drug Addiction Act 1966. The Substance Addiction Act is designed to help people with a severe substance addiction and impaired capacity to make decisions about engaging in voluntary or compulsory treatment. This new legislation is better equipped to protect the human rights and cultural needs of patients and whānau and places greater emphasis on a mana-enhancing and health-based approach.

The Ministry is required under section 119 of the Substance Addiction Act to disclose matters relating to the Act in its Annual Report. The data below was extracted from PRIMHD³⁸ in August 2021 and covers activities that occurred from 1 July 2020 to 30 June 2021.³⁹

In this period, 37 people were detained under the Substance Addiction Act. 28 compulsory treatment orders were made during this period. The courts extended 20 compulsory treatment orders.

The average length of detention for those who had compulsory treatment orders made or extended was 12 weeks and four days (89 days).

Among these patients, 33 percent were detained for up to eight weeks, which is within the first period of compulsory treatment set out in the Act. 67 percent of patients were detained for a period of between 8 and 16 weeks, requiring a compulsory treatment order extension.

38 PRIMHD is a Ministry of Health single national mental health and addiction information collection of service activity and outcomes data for health consumers. PRIMHD data was extracted in August 2021. Data from PRIMHD is only able to measure mental health and addiction outcomes, so these results may not fully encompass other sources of support for people recovering from severe substance addiction – for example, support for access to housing.

39 There may be cases where a person started the early stages of the Substance Addiction Act at the end of June 2020 and continued through 2021, or first came under the Act in June 2021. Due to this, there are discrepancies in reporting, where a higher number of people had compulsory treatment orders made or extended than were detained under the Substance Addiction Act.



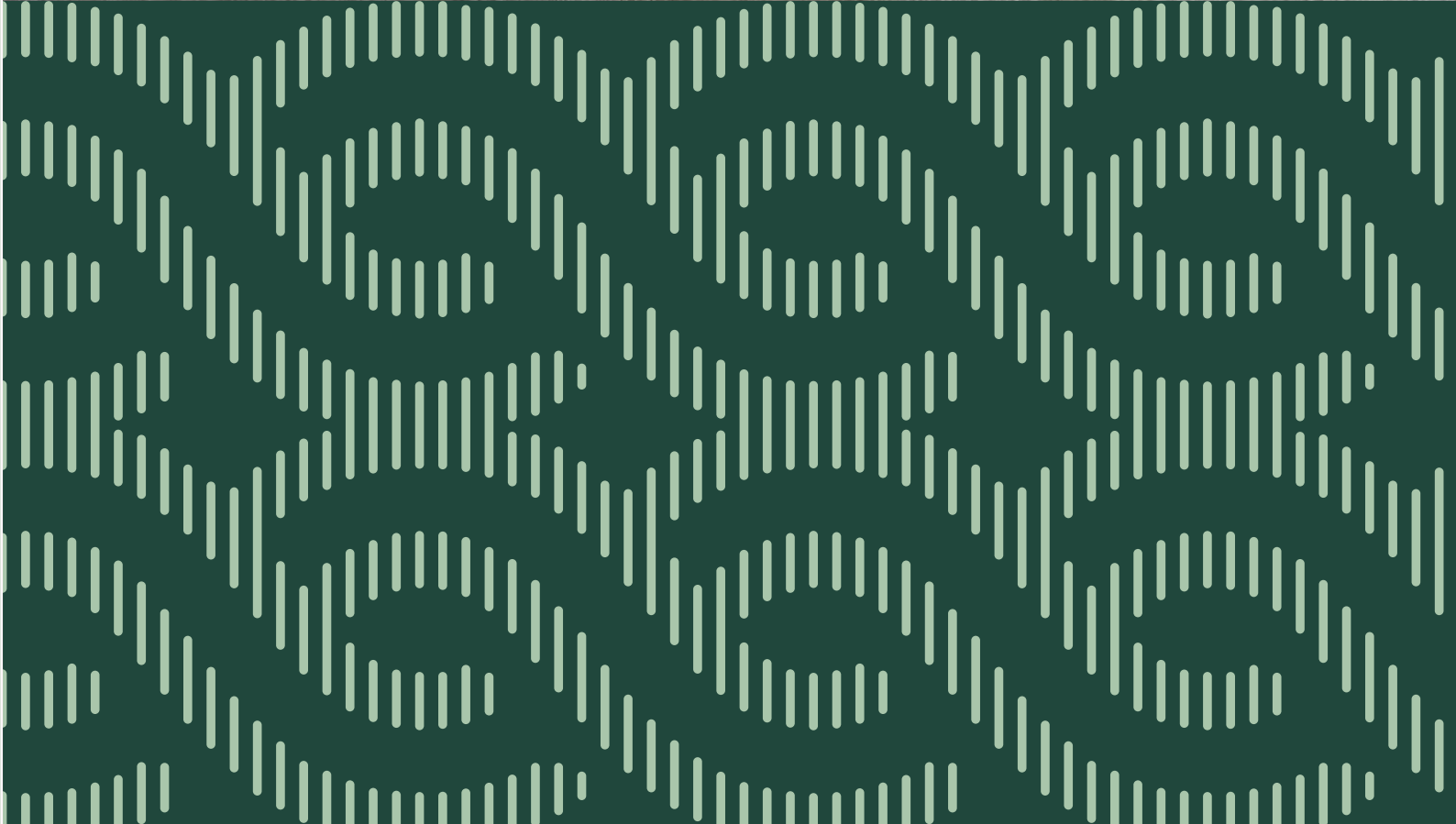
PRIMHD records show that among service users who were discharged from the Substance Addiction Act during this period:

- 30.2 percent received additional inpatient care
- 74.4 percent engaged with individual treatments in outpatient services
- 46.5 percent had family meetings arranged
- 67.4 percent had Supplementary Consumer Records
- 62.8 percent had wellness plans.
- If a service user was discharged in late June 2021, they are unlikely to have had enough time to engage with outpatient services during the reporting period. For this reason, it may be difficult to draw meaningful conclusions about a service user's recovery journey from the information above.



TE AHO
O TE KAHU
CANCER
CONTROL
AGENCY

Annual Report 2020/21



**Mā te whiritahi, ka
whakatutuki ai ngā
pūmanawa ā tāngata**

**Together weaving the
realisation of potential**

Our purpose

We provide strong central leadership and oversight of cancer control. We lead and unite efforts to deliver better cancer outcomes for Aotearoa New Zealand.

Our work is

- equity-led
- knowledge-driven
- outcomes-focused
- person and whānau-centred.



TE AHO
O TE KAHU
CANCER
CONTROL
AGENCY

We have a system that delivers consistent and modern cancer care to achieve:

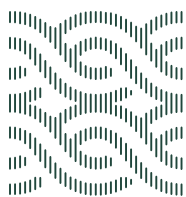
Fewer cancers
He iti iho te mate
pukupuku

Better survival
He hiki ake i te oranga

Equity for all
He taurite ngā huanga

Who we are

Te Aho o Te Kahu, the Cancer Control Agency is a departmental agency reporting directly to the Minister of Health and hosted by the Ministry of Health. The agency was created in recognition of the impact cancer has on the lives of New Zealanders and provides a sharp focus on this important health issue. We have 50 people working for us across six Wellington-based teams and four regional hubs.



He Mihi

Chief Executive Foreword

I am pleased to present the second Annual Report for Te Aho o Te Kahu, the Cancer Control Agency.

I'm delighted to take this opportunity to reflect on our progress and achievements over the last year. I am extremely proud of my team, the relationships we are building, the work we are doing and our growth as an agency over the last 12 months.

I am excited to illustrate how we have improved outcomes for whānau living with cancer right now, while at the same time progressing a wide range of projects that deliver on our vision of:

- Fewer Cancers.
Kia whakaiti iho te mate pukupuku
- Better Survival.
Kia runga noa ake te mataora
- Equity for All.
Kia taurite ngā huanga.

Our work this year has been set against a backdrop of immense uncertainty and change with both COVID-19 and the Health and Disability System Reforms providing significant challenges and opportunities for the cancer sector and Te Aho o Te Kahu.

We have continued the establishment activity necessary to ensure our Agency can deliver on our vision.

Relationships are the key to delivering on our purpose of leading and uniting efforts to deliver better cancer outcomes. To that end, we have worked at all levels of the organisation to connect with, and listen to, our stakeholders – from whānau living with cancer to clinicians, non-governmental



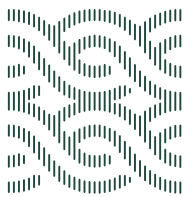
organisations (NGOs) to district health boards (DHBs), advocacy groups to advisory groups, local service providers to international cancer leaders. We are now using their shared insights to shape our work.

We have significant projects underway that put equity front and centre. Te Aho o Te Kahu hosted a series of community hui across the motu, enabling us to hear the voice of over 2,500 whānau Māori. Their humbling kōrero has already made an impact on our work programme.

Finally, I would like to acknowledge all those who are affected by cancer – we have you at the centre of our thinking – and thank the skilled and dedicated people who work in the cancer sector making a real difference every day.

Ngā mihi

Professor Diana Sarfati
Tumuaki, Chief Executive and National
Director of Cancer



Anei Mātou Who We Are

Te Aho o Te Kahu, the Cancer Control Agency (the Agency) is a departmental agency reporting directly to the Minister of Health and hosted by the Ministry of Health. The Agency was created in recognition of the impact cancer has on the lives of New Zealanders and provides a sharp focus on this important health issue.

Tō mātou aronga Our purpose: an agency focused on cancer

Te Aho o Te Kahu provides strong central leadership and oversight of cancer control. We lead and unite efforts to deliver better cancer outcomes for Aotearoa New Zealand. We are also accountable for ensuring transparency of progress towards the goals and outcomes in the National Cancer Action Plan.

In practice, this leadership and oversight is delivered through:

- providing advice to Government about the future design and function of cancer services and options for resolving operational issues
- bringing stakeholders together to progress and achieve shared objectives
- undertaking national initiatives to improve cancer outcomes for New Zealanders
- assembling and disseminating cancer data and information to inform decision making and service delivery

- providing support for cancer service providers when service is, or is likely to be, disrupted or is not meeting demand or expectations.

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 pace of change present major challenges for our systems and services.
- Māori and Pacific peoples have worse cancer survival rates than other New Zealanders.
- Cancer survival is improving in Aotearoa New Zealand, but our rate of improvement is slower than rates in other comparable countries, so we are at risk of falling behind.

Tō mātou whāinga Our vision

We strive to achieve:

- Fewer cancers
- Better survival
- Equity for all.

We are also driven to achieve a work programme that is:

- equity-led
- knowledge-driven
- outcomes-focused
- person- and whānau-centred.

Our strong commitment to the goal of achieving equity is embedded in all our processes and work.

Te taonga me te kupu taurangi o te ingoa

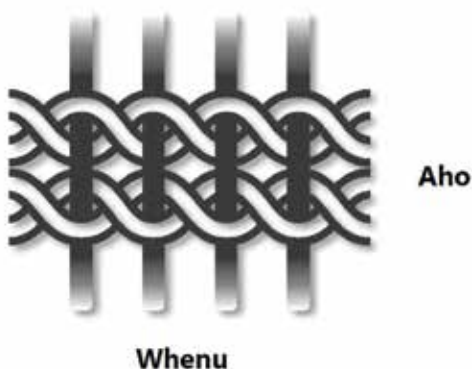
Our name: Te Aho o Te Kahu

Our te reo Māori name is a taonga that was gifted to us by Hei Āhuru Mōwai, the Māori Cancer Leadership Group in June 2020. This name is a core part of who we are and how we work.

Te Aho o Te Kahu means 'the central thread of the cloak: This thread (aho) binds the many strands (whenu) into one cloak (kahu) that provides protection to people and their whānau.

Te Aho: the central thread symbolises our Agency and our role as a leader and connector across the cancer control continuum.

Te Kahu: the cloak symbolises all the services, organisations, people and communities that work with those affected by cancer.



Equity is not only the priority of the Agency in its role as 'Te Aho'; it is also central and is embedded into our architecture, processes, systems and tikanga.

Ngā roopu tūhono Our partners

This year we have continued to work with our partner groups to strengthen external advice and input into the operation of Te Aho o Te Kahu. The role and function of these groups have been continuously reviewed to make best use of the valuable time and expertise provided by the members of these groups.

Te Aho o Te Kahu, Cancer Control Agency Advisory Council

Te Aho o Te Kahu Advisory Council supports the Chief Executive to ensure a whole-of-system focus on preventing, treating and managing cancer. The Council supports the Chief Executive to oversee system-wide prioritisation and coordination of cancer care in New Zealand. It considers and provides advice on how to get the best value from existing cancer prevention and care investment.

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.

Te Aho o Te Kahu supports the Hei Āhuru Mōwai leadership and rangatiratanga through operational and project funding, and Hei Āhuru Mōwai works closely with Te Aho o Te Kahu and provides expertise and support for negotiated strategic work and projects centred on improving Māori cancer outcomes.

Clinical Assembly

The Clinical Assembly provides clinical advice to support Te Aho o Te Kahu with the long-term strategic direction for reducing cancer incidence and improving cancer services across the cancer continuum. The Clinical Assembly includes clinicians from a broad range of cancer-related medical, nursing and allied health specialities.

He Ara Tangata, Consumer Reference Group

He Ara Tangata, the Consumer Reference Group, provides Te Aho o Te Kahu with advice on whānau-centred solutions for people affected by cancer. He Ara Tangata ensures the work of Te Aho o Te Kahu focuses on the needs of people across the continuum of cancer care.



Other partners

One of our key functions is to liaise with 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 DHBs. 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, we have developed strong active links with Māori and Pacific health leaders, consumer-led groups, clinical leadership groups, NGOs and primary care practitioners. In the last year, these relationships have been established, embedded and strengthened.

Pūmau ki Te Tiriti

Our commitment to Te Tiriti o Waitangi

Te Aho o Te Kahu strives to achieve the following four goals of Te Tiriti, each expressed in terms of mana.

Mana whakahaere:

Effective and appropriate stewardship or kaitiakitanga over the health and disability system. This goes beyond the management of assets or resources.

Mana motuhake:

Enabling the right for Māori to be Māori; to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori.

Mana tangata:

Achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.

Mana Māori:

Enabling ritenga Māori (Māori customary rituals) which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy and customary practices) and encapsulated within mātauranga Māori (Māori knowledge).



The principles of Te Tiriti o Waitangi provide the framework for how we will meet our obligations under Te Tiriti in our day-to-day work:

Tino rangatiratanga:

The assurance of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.

Equity:

The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.

Active protection:

The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori.

Options:

The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way.

Partnership:

The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of health and disability

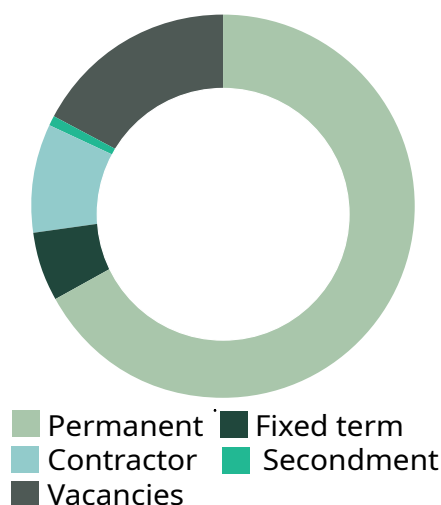
services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

Tō mātou whānau **Our people**

As at 30 June 2021, Te Aho o Te Kahu employs 50 people or 47.6 FTE, supported by an additional contracted 5.9 FTE.

Two staff (4%) resigned from Te Aho o Te Kahu during 2020/21.

Personnel (FTE)



We have 44 FTE employed on permanent contracts, with 3.6FTE fixed term and 5.9FTE contractors. Twenty percent of our staff work part-time.

Head count (full/part time)

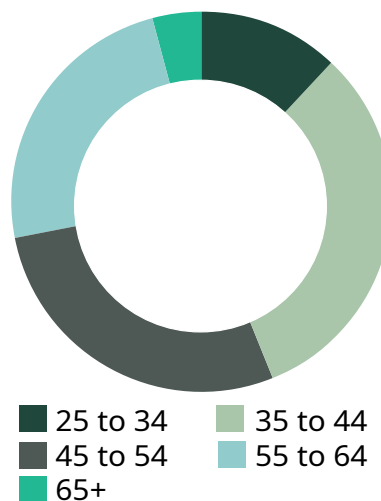


The majority of our staff are female (78%).

Gender (All staff)

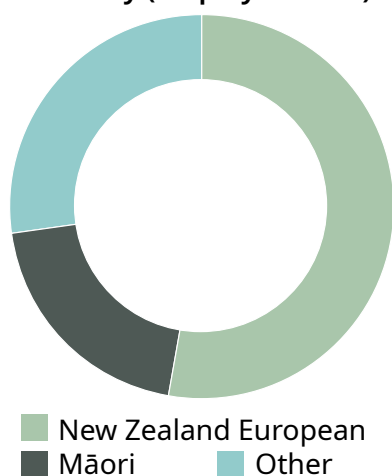


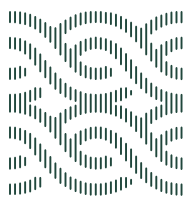
Age group



While we have employed a deliberate strategy to attract and recruit staff who identify as Māori, our proportion of Māori staff (to 8%) has dropped this year.

Ethnicity (Employed staff)



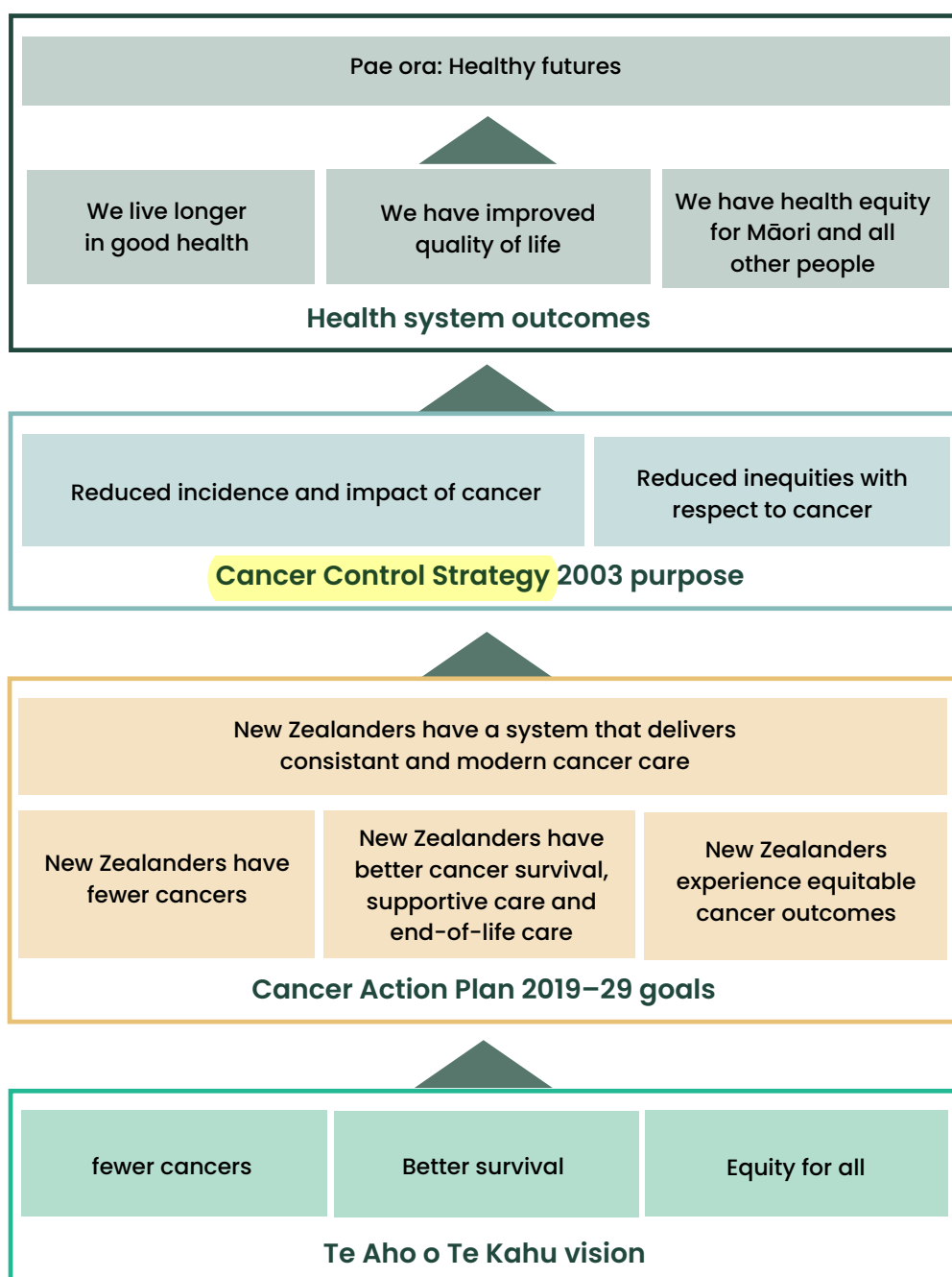


Tō Mātou Takune

Our Intentions for 2020/21

The strategic direction of Te Aho o Te Kahu is articulated through the New Zealand **Cancer Control Strategy** 2003 and the New Zealand Cancer Action Plan 2019–2029. Our work is focused on achieving the New Zealand health system goal of Pae

Ora: Healthy Futures and the three system outcomes – living longer in good health, improved quality of life and equity for all, through delivering our vision of fewer cancers, better survival and equity for all.

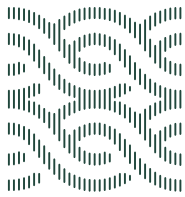


In 2020/21 Te Aho o Te Kahu developed a work programme to progress these goals. All aspects of the Te Aho o Te Kahu work programme include consideration of the likely or intended impact on improving equity in access, quality and outcomes. In particular our work programme has focused on:

Supporting a system that delivers consistent and modern care
Strong leadership and governance
Building a high performing Cancer Control Agency
A new model for delivery of cancer services
Guidance and advice related to cancer during the COVID-19 pandemic
Better quality and more connected data and information
Nationally agreed chemotherapy protocols
National standard for cancer-related pathology
National cancer data intelligence
A system to monitor national radiation oncology practice
He Pūrongo Mate Pukupuku o Aotearoa 2020, The State of Cancer in New Zealand 2020
Better and more focused research and innovation
Supporting improved research that is better aligned to priorities
Improving access to clinical trials
Supporting innovation
Helping New Zealanders to have fewer cancers
Cancer prevention
Achieving fewer cancers through a focus on prevention
Improving cancer survival
Diagnosis and treatment
National clinical quality improvement indicators, reports and plans
Clinical working and advisory groups
Regional clinical pathway and Multi-Disciplinary Meeting (MDM) projects
Quality of cancer treatment in regions
Replacement of Linear Accelerators (LINACs)

Faster Cancer Treatment measures
Response to service delivery disruption
Cancer medicines availability analysis
Support and information

Increasing capacity and capability to improve equity in cancer care and outcomes
Māori Affairs Select Committee Inquiry into Māori Health inequities
Māori community hui
Māori leadership and engagement



Tō Mātou Tutuki

What We Have Achieved

He Pūnaha manaaki

Supporting a system that delivers consistent and modern care

Strong leadership and governance



Building a high performing Cancer Control Agency

In 2020/21 Te Aho o Te Kahu has continued to focus on building the necessary foundations of a high performing organisation, providing value to our stakeholders and maintaining a strong reputation for responsiveness and delivery. Building our Agency while also delivering on an ambitious work programme has not been without its challenges, and it has been critical to our success that we also have a strong focus on supporting staff wellbeing.

Our work programme and direction for 2020/21 were heavily influenced by the advice from our leadership and working groups. Our relationship with Hei Āhuru Mōwai has been particularly important, and it has provided Te Aho o Te Kahu with invaluable insights and guidance across our work programme, most notably for our cancer service planning work and our series of Māori community hui. The 2020/21 year also saw the significant step of the establishment of He Ara Tangata, our national cancer consumer reference group. This group consists of 16 cancer consumers (8 of whom are Māori and 2 are Pacific) who meet regularly to

provide input into our work and share their experiences so that our Agency can better meet people's needs.

Across all our workstreams, Te Aho o Te Kahu is fully committed to upholding our collective obligations to Te Tiriti o Waitangi and making an enduring contribution to being equity-led and whānau-centred in everything we do. These values are embedded in our Agency's karakia and waiata. Our data and information work contributes to the work underway by Te Aho o Te Kahu and across the sector to drive equity-led decisions and better inform the measurement of health gain for Māori, Pacific peoples and other population groups that experience inequities. We require equity impact assessments for our projects to ensure equity is embedded in our approach and actions and we are growing the capability of our people to deliver against our Te Tiriti and equity obligations. Our approach is in its early stages and will evolve as we build our collective understanding and grow in confidence in 2021/22 and beyond.

Our Agency results in the 2020/21 staff satisfaction survey undertaken by the Ministry of Health (see the Our Performance section, page 172) were pleasing and provided a useful reaffirmation that we are on the right track. We have actively worked to address the

areas that our staff rated lowest including improving our project management processes and documentation.

We have continued to develop our core policies and processes, such as risk management, conflicts of interest, financial management, business continuity and reducing our emissions. Many of these processes were formally agreed with the Ministry of Health through our shared work to develop our Departmental Agency Agreement, which was signed by the Chief Executives of both agencies in July 2021.

We have undertaken a significant amount of recruitment during the past year, successfully filling 39 roles. We have been very pleased with the capability and calibre of our new staff, who have a shared passion for our vision and making a difference for people affected by cancer.

Te Aho o Te Kahu has retained a key focus on building staff capability through 2020/21. First and foremost, this has been centred on building our capability with respect to te ao Māori, Te Tiriti o Waitangi and equity. We published E Tipu E Tipu, our Māori Language Plan, on our website in June 2021 and have developed a comprehensive Whāinga Amorangi Phase One Plan to empower Te Aho o Te Kahu staff through capability-building in Māori Crown relations. As an agency we are committed to making progress in all six competency areas highlighted in this plan. We will monitor our progress against the plan over the next 12 months. Our staff have also provided us with their aspirations to embed te ao Māori within our work, from an individual level up to an organisational level.

We have worked hard to provide the Government with evidence-based, robust advice to build trust and confidence. In 2020/21 Te Aho o Te Kahu contributed to

236 ministerials, Official Information Act requests and formal public queries, with all responded to within expected timelines.

On 1 July 2020 the Southern, Central and Te Manawa Taki Cancer Networks transitioned into our Te Aho o Te Kahu Regional Hubs. The Northern Hub joined us on 1 January 2021. These hubs are a critical part of the Agency, supporting the delivery of system improvement in the regional context and giving voice to the unique perspectives and diverse needs of local and regional communities in the development of national priorities.



A new model for delivery of cancer services

In 2020/21 Te Aho o Te Kahu worked alongside the Health and Disability System Transition Unit to determine how cancer services could be delivered in the future. The Cancer Services Planning project has a single goal of providing evidence-based recommendations to the new health entities (Health New Zealand and the Māori Health Authority) on how cancer treatment services in Aotearoa New Zealand should be organised and distributed to achieve optimal and equitable cancer outcomes.

Work on this project began in October 2020 and continues at pace. Each of the six workstreams within the project (surgery, radiation oncology, systemic treatments, clinical services, supportive care and

equity) has been required to undertake extensive sector stakeholder engagement, equity analysis and to work closely with Hei Āhuru Mōwai and He Ara Tangata. We have applied a Te Tiriti principles-based framework to guide this work.

The project will deliver a recommendations document to inform the Transition Unit, Health New Zealand and the Māori Health Authority on how to create whānau-centred, equitable, high-quality and sustainable cancer services.



Guidance and advice related to cancer during the COVID-19 pandemic

Te Aho o Te Kahu worked with the cancer sector during the COVID-19 community outbreak in Auckland in August 2020 to ensure cancer patients continued to have access to cancer treatments. This outbreak presented new challenges – notably as it was the first time that regions had been at different alert levels – which caused initial disruption to people travelling to receive cancer care. Te Aho o Te Kahu reissued guidance outlining treatment delivery expectations at different hospital alert levels and responded to issues raised by the sector. This included working with the Ministry of Health, Auckland DHB and PHARMAC to resolve the issue whereby Aotearoa patients were unable to fly to Melbourne to receive Peptide Receptor Radionuclide Therapy (PRRT) a potentially lifesaving neuroendocrine tumour treatment. This led to the establishment of a temporary treatment service in Auckland, followed by a permanent service being stood up in July 2021. During the Auckland outbreak, the Agency also secured additional funding for the Cancer Society to address

the increased accommodation, transport and support service needs during the COVID-19 lockdown.

Te Aho o Te Kahu continued to release regular reports on the impact of COVID-19 on cancer services until the end of December 2020 (<https://teaho.govt.nz/reports/cancer-care>). This included specific reports focused on the Auckland COVID-19 lockdown (report released October 2020) and lung cancer (report released December 2020). The Agency also led two peer-reviewed articles published in Lancet Regional Health – Western Pacific Region outlining the response of the New Zealand cancer sector to COVID-19 and the impact COVID-19 had on cancer diagnoses and treatment. The Agency linked with international agencies and colleagues to share experiences of COVID-19.

In the context of COVID-19 and the move to deliver cancer care via virtual means, Te Aho o Te Kahu developed a report to look at the current state of telehealth for medical oncology, barriers to implementation and opportunities that may affect implementation of future systems. This work will inform an ongoing project to look at the role of digital and telehealth in future cancer care.

In 2021 the focus shifted to the COVID-19 vaccine. Te Aho o Te Kahu worked with clinical experts to develop advice on vaccination for cancer patients, releasing guidance in March 2021 (<https://teaho.govt.nz/reports/cancer-care>). The Agency connected with the Ministry of Health and the Immunisation Advisory Centre at the University of Auckland to ensure consistent advice for cancer patients and cancer clinicians.

Better quality and more connected data and information



Nationally agreed chemotherapy protocols

Te Aho o Te Kahu has continued the development of Anti-Cancer Therapy – Nationally Organised Workstreams (ACT-NOW). This programme produces clinically agreed, evidence-based anti-cancer drug regimens to support the national standardisation of treatment, equity of access to therapy, improved planning and efficient use of resource. In early 2021, Te Aho o Te Kahu launched the Systemic Anti-Cancer Therapy New Zealand (SACT) Regimen Library, which is an online repository of chemotherapy treatment definitions intended to support the harmonisation of practice within medical oncology and malignant haematology.

In 2020/21 over 160 regimens have been published in the SACT Regimen Library and 12 of the 20 tumour type regimen harmonisation sector workshops have been completed. Development of a SNOMED CT based Health Information Standards Organisation (HISO) standard for the description of chemotherapy regimens and a standard based implementation guide for the exchange of regimen data between systems has also been progressed. To support these other data improvement activities, we have progressed development of a draft national data standard, outlining key data items for collection from electronic prescribing systems to be used to support equity analysis, quality improvement and resource planning.

The ACT-NOW programme has been supported by Te Aho o Te Kahu Regional Hubs, with Te Manawa Taki and Southern Hubs testing implementation aspects of the new regimens.

National standard for cancer related pathology

At the start of 2021, Te Aho o Te Kahu commenced a project to develop structured pathology reporting to support national consistency in the data collected by clinicians requesting pathology services and pathologists reporting back the findings on a patient's treatment pathway. This data will have a range of benefits from facilitating consistent clinical decision-making to strengthening our ability to monitor cancer outcomes nationally. This project involves the development of HISO data specifications for all cancers that outline the individual data items and their concise definitions using SNOMED CT to codify recorded data for enhanced accuracy and consistency in laboratory systems.

A proof of concept for lung cancer was undertaken to better understand requirements and test benefits in the first half of 2021. We are on track to deliver priority data specifications for lung, colorectal, prostate and breast cancers by the end of calendar year 2021 to support implementation planning with laboratory providers in late 2021 and into 2022. An ongoing partnership with the sector is required to ensure the data specifications remain clinically relevant and are implemented consistently across all providers.



National cancer data intelligence

Work has commenced with the Ministry of Health to create the infrastructure to collect, store and disseminate cancer information within the health sector. The CanShare programme will work with a range of stakeholders to provide complete, accurate, timely and shareable data to support clinical decision-making, services planning, cancer monitoring and quality

improvement. This programme will provide guidance and direction for the national collection and sharing of cancer information. It will integrate with the other work of Te Aho o Te Kahu on ACT-NOW, structured pathology reporting and the Radiation Oncology Collection (ROC).

Te Aho o Te Kahu is also supporting the ongoing data quality improvement of Faster Cancer Treatment (FCT) reporting by DHBs. This data provides insights into whether care is being provided within set timeframes. To achieve this improvement, enhancements are being made to the transactional data business rules and we are working with DHBs and the Ministry of Health on data quality queries.

Te Aho o Te Kahu has continued to coordinate FCT data collection, reporting and dissemination and has responded to Official Information Act requests, Parliamentary Questions and ad hoc requests related to FCT reporting. Te Aho o Te Kahu Te Manawa Taki Regional Hub has also provided regional narrative reports for the DHBs in that region.



A system to monitor national radiation oncology practice

Te Aho o Te Kahu has used the ROC to progress several projects including:

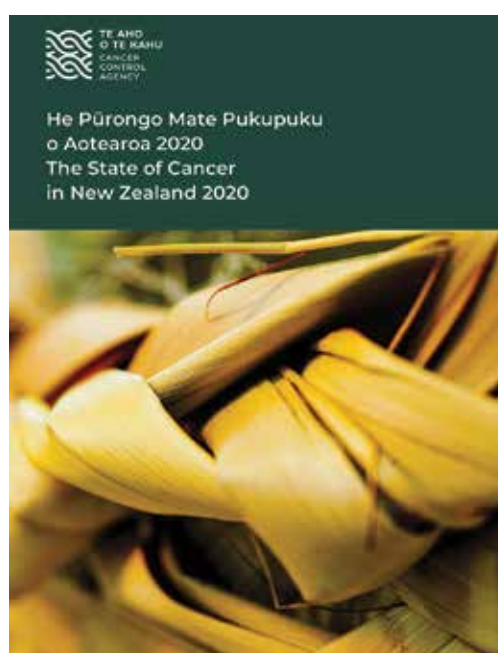
- the development of an improved Radiation Oncology workforce demand model, which has been endorsed by the Royal Australian and New Zealand College of Radiologists (RANZCR)
- provision of key data for the He Pūrongo Mate Pukupuku o Aotearoa 2020, The State of Cancer in New Zealand 2020 report and the Cancer Services Planning programme
- the Northern region LINAC capacity planning project

- development of a prototype methodology to improve the completeness of the New Zealand Cancer Registry (NZCR) by identifying clinically diagnosed cancers that had not been notified to the NZCR.

In addition, Te Aho o Te Kahu is working with the Radiation Oncology Work Group (ROWG) on enhancements to the ROC system. This includes additional fields to be collected at a national level to better inform equitable access and outcome improvement efforts for radiation oncology treatment. A project was also established to develop the ROC DataMart and work with all private and public providers to collect the new data elements from June 2021. Currently Te Aho o Te Kahu is testing data files from all cancer centres for inclusion by December 2021, to be followed by a focus on data quality improvement in 2022.

He Pūrongo Mate Pukupuku o Aotearoa 2020, The State of Cancer in New Zealand 2020

In February 2021, Te Aho o Te Kahu released our inaugural report He Pūrongo Mate Pukupuku o Aotearoa 2020, The State of Cancer in New Zealand 2020 (<https://teaho.govt.nz/reports/cancer-state>).



This report provides a summary of the state of cancer from across the cancer continuum and identifies where issues and inequities exist along the cancer pathway. The report was the result of a huge collaborative effort across Te Aho o Te Kahu and with external stakeholders.

The report is a snapshot of a point in time – it does not make recommendations. It provides a baseline that can be used to measure the effectiveness of cancer control programmes, identify work priorities and inform funding proposals. It highlights the gaps in our knowledge – areas where more research is needed – and challenges the health sector to provide equitable, effective care for all who are affected by cancer.

He Pūrongo Mate Pukupuku o Aotearoa 2020, The State of Cancer in New Zealand 2020 represents the first stage in our ongoing critical analysis of the cancer care system. We intend to review the state of cancer in Aotearoa regularly to provide a benchmark for monitoring action and measuring improvement. This report was well received in Aotearoa New Zealand and internationally. We regularly see statistics from the report being used in external presentations, on websites, in funding applications, in research proposals and quoted in the media.

Better and more focused research and innovation



Supporting improved research that is better aligned to priorities

Alongside the Ministry of Health and the Health Research Council (HRC), Te Aho o Te Kahu contributed to a \$6 million request for proposals (RFP) for research to drive equitable cancer outcomes. This RFP was announced in December 2020 with a

clear focus on lung cancer and patient experience across the cancer journey for Māori and Pacific peoples. The Assessing Committee for this research met on 3 September 2021, with a strong group of proposals recommended for funding. They will be going through HRC Council approval process in late 2021.

Te Manawa Taki regional hub has supported a regional three-year Lung Cancer Research project which was completed and a report published in 2021. This research will help inform quality improvement and decision-making around lung cancer initiatives across Te Manawa Taki region.

Te Aho o Te Kahu is part of the advisory group for the WHIRI project, which is an HRC-funded pilot in the Waikato region led by Hei Āhuru Mōwai. This project aims to test a wraparound approach to secondary and tertiary care for whānau Māori with cancer.



Improving access to clinical trials

Clinical trials are an important part of cancer research and care; however, there are large inequities in access to clinical trials in New Zealand, with smaller hospitals and rural areas having particularly poor access. Te Aho o Te Kahu is pleased to be supporting Cancer Trials New Zealand to undertake work to develop core infrastructure to initiate cancer teletrials in New Zealand.



Supporting innovation

A year ago, New Zealand patients with neuroendocrine cancers who would benefit from a treatment known as Peptide Receptor Radionuclide Therapy (PRRT), had to travel to Australia for this treatment.

PRRT is a type of radiation treatment where a radioactive medicine is attached to a special protein and injected into the bloodstream. This compound then delivers a high dose of radiation to neuroendocrine cancer cells in a targeted way. PRRT is an effective treatment option for people with metastatic neuroendocrine cancers. It can prolong survival, improve quality of life and manage symptoms where there are limited options.

The Ministry of Health was previously paying for urgent patients to receive PRRT in Melbourne, through the High Cost Treatment Pool. COVID-19 travel restrictions made this increasingly difficult. In September 2020, a collaboration

between Auckland DHB, Te Aho o Te Kahu, Ministry of Health, PHARMAC, Mercy Radiology, the Cancer Society and the Unicorn Foundation NZ enabled patients needing urgent PRRT treatment during the COVID-19 pandemic to receive it in Auckland. In 2021, Te Aho o Te Kahu worked with these partners to create a permanent Auckland-based PRRT service, which was officially launched in July 2021.

Te Aho o Te Kahu has also commenced work on providing advice on a consistent national approach to cancer molecular testing and improving consistency of access to PET-CT scans by standardising national indications for publicly funded PET-CT.

Kia whakaiti iho te mate pukupuku

Achieving fewer cancers through a focus on prevention

Cancer prevention

Cancer is the leading cause of death in Aotearoa and is a significant contributor to inequities in mortality and life expectancy for Māori, Pacific and low socioeconomic communities. Cancer prevention is the ideal in cancer control, as the predicted increase in demand for cancer services over the next 20 years will likely be unsustainable. Up to 50% of cancers are caused by modifiable cancer risk factors, so are potentially preventable.

The majority of actions to reduce the incidence of cancer are led by other parts of the public health sector, particularly the Population Health and Prevention Directorate of the Ministry of Health, including the National Screening Unit, and DHBs. Te Aho o Te Kahu has engaged closely with these agencies to support their efforts.



Cancer Prevention report

To inform and support the initiatives of the partners noted above, in 2021 Te Aho o Te Kahu commenced work on a report that assesses cancer prevention activities in Aotearoa New Zealand compared with evidence-based best practice for a range of cancer risk factors including tobacco, alcohol and nutrition. This report, which is being developed in collaboration with Te Hīringa Hauora, the Health Promotion Agency, the University of Otago, Wellington and relevant Ministry of Health teams, will include options for what we could consider doing to strengthen cancer prevention. The report is scheduled to be completed in October 2021.

Kia runga noa ake te mataora

Improving cancer survival

Diagnosis and treatment

National clinical quality improvement indicators, reports and plans

In 2020/2021 Te Aho o Te Kahu has continued to progress the Quality Performance Indicators (QPI) programme to improve the quality of cancer services and deliver better outcomes for people diagnosed with cancer. QPIs are selected by an expert cancer working group with consumer representation and a range of clinical experts involved in providing patient care. QPIs enable DHBs to compare their performance with other DHBs.

Once appropriate QPIs are selected and reviewed in consultation with the relevant cancer sector, a quality performance monitoring report is drafted and published by Te Aho o Te Kahu. These reports also compare our Aotearoa results with those of other countries where equivalent data is available.

Te Aho o Te Kahu uses the monitoring report to work with the sector to identify areas where there is unwarranted variation between DHBs and develop a quality plan with actions to improve services and outcomes. The expectation is that DHBs with poor performance or unwarranted variation will undertake quality improvement work that will improve outcomes for those who are diagnosed with cancer.

Following extensive consultation with sector experts, a *Lung Cancer Quality Improvement Monitoring Report* was published in March 2021 and a *Prostate Cancer Quality Improvement Monitoring Report* was drafted and published in

September 2021. In March 2021, in addition to the publication of the *Lung Cancer Quality Improvement Monitoring Report*, an online interactive cancer data explorer tool went live on our website. This tool enables public access to information by each DHB on bowel and lung indicator performance. Filters can be applied giving access to more detailed demographic information including ethnicity.

On 8 April 2021, Te Aho o Te Kahu held a Lung and Prostate Cancer Quality Improvement Forum with key stakeholders from each DHB to collaborate and facilitate improvements for those diagnosed with lung and prostate cancers. This forum informed the development of quality improvement plans for lung and prostate cancers. These plans will include agreed actions for DHBs, Te Aho o Te Kahu and other relevant organisations to ensure improvements in care and outcomes for these cancers. Feedback from the forum was positive, with over 90 clinicians and stakeholders in attendance.



Ongoing work includes a review of the QPI programme to ensure it is being delivered efficiently and appropriately, supporting the recalculation of prostate and bowel QPIs and commencing the development of QPIs for pancreatic and breast cancer. In addition

we are continuing to work with BPAC and clinical groups to produce primary care guidance based on QPI reports and producing clinical guidance as required for areas where significant variation in care is suspected or demonstrated.

Te Aho o Te Kahu regional hubs play a crucial role in the development and implementation of the QPI programme. In 2020/21, the hubs have supported DHBs to implement bowel and lung cancer quality improvement plans and take actions to resolve unwanted variation.



Clinical working and advisory groups

Clinical working and advisory groups are an important channel through which Te Aho o Te Kahu gains clinical insight and understanding, addresses identified variation in access and outcomes, becomes aware of systemic issues and progresses key elements of our work programme such as the QPI programme. Supporting these groups, including the Radiation Oncology Work Group (ROWG), Medical Oncology Work Group (MOWG), Haematology Work Group (Haem) and the Clinical Assembly, forms a substantial proportion of the work programme of the Treatment Quality and Standardisation Team of Te Aho o Te Kahu.

Te Aho o Te Kahu regional hubs also support and engage with valuable regional clinical and stakeholder groups. The Northern regional hub has taken on the secretariat tasks for head and neck, bowel, lung and Northern/Te Manawa Taki gynaecology tumour stream groups. This function may be reviewed in 2021/22. In 2020/21 the Southern regional hub strengthened the South Island cancer consumer group (including people living with cancer or beyond cancer, and their whānau carers) to better support our work

and give insight into consumers in that region.

Te Aho o Te Kahu intends to review the role, function and distribution of its various national and regional working and advisory groups. We took the first step in 2020/21 with the completion of a review of the terms of reference of national working groups.



Regional clinical pathway and Multi-Disciplinary Meeting (MDM) projects

In 2020/21 Te Aho o Te Kahu regional hubs supported their regional DHBs to design effective, consistent and reliable approaches to information collection through MDMs. By supporting DHBs to meet the Cancer Multidisciplinary Meeting Data Standard, the regional hubs are enabling MDMs to be an activity that produces a rich source of significant clinical information and a starting point for improving the collection of cancer information to support the delivery of care across the cancer pathway.

This year, the Manawa Taki Hub has contributed to implementation of Phase Two of the regional Clinical Pathway and MDM Management System project. The system went live for colorectal and lung cancers and requirements have been agreed for breast, head and neck, and gynaecological cancers. Work is underway on requirements for urological and upper gastrointestinal cancers and lymphoma.

The Southern Regional Hub has completed the addition of the first two tumour streams (gynae oncology and hepatobiliary) on to its MDM reporting dashboard, enabling key outputs from the MDM to be measured along with patient outcomes.



Quality of cancer treatment in the regions

Te Aho o Te Kahu Regional Hubs have continued to progress a number of quality improvement initiatives in 2020/21.

Te Manawa Taki Hub have facilitated and supported its regional DHBs with initiatives to improve lung cancer access and outcomes. Working alongside Te Manawa Taki lung cancer work group, the Hub has completed a feasibility report into endobronchial ultrasound (EBUS) in Lakes and/or Waikato DHBs. Implementation of multi-speciality, one-stop rapid access clinics to improve timeliness to lung cancer surgery and management of follow-up for regional curative patients is in progress.



Replacement of Linear Accelerators (LINACs)

While one in two people with cancer would benefit from receiving radiation therapy, only one in three receives it. Barriers to treatment include workforce challenges, inequitable distribution of services and machine capacity. Ensuring equitable access to radiation therapy is one of the ways that we influence cancer outcomes in New Zealand. DHBs rely on LINACs to meet demand for radiation therapy, so we need to ensure that there is adequate provision across the system.

Through Budget 19 the Government invested \$25 million to replace ageing LINACs in New Zealand hospitals. This replacement programme has been led by the Ministry of Health but is supported by Te Aho o Te Kahu.

In 2020/21 the Central Regional Hub worked with its regional DHBs to plan for the replacement of LINACs across the region. The Southern Regional Hub has facilitated the collection of information and advice to inform Nelson Marlborough

DHB about the delivery of a local radiation oncology service.



Faster Cancer treatment measures

Faster cancer treatment (FCT) indicators were introduced by the Government in 2012, requiring DHBs to collect standardised information on patients who had been referred urgently with a high suspicion of cancer. There are two indicators:

- 31-day indicator – patients with a confirmed cancer diagnosis receive their first cancer treatment (or other management) within 31 days of a decision to treat
- 62-day indicator – patients referred urgently with a high suspicion of cancer receive their first treatment (or other management) within 62 days of the referral being received by the hospital.

Te Aho o Te Kahu is encouraging and supporting ongoing FCT data quality improvement through enhancing transactional data business rules and working with DHBs and the Ministry of Health on data quality queries. Te Aho o Te Kahu also coordinates FCT data collection, reporting and dissemination.

Through 2020/21 Te Aho o Te Kahu Regional Hubs have continued to support regional DHBs to improve their performance against FCT measures. Different regions have experienced differing needs and challenges, and therefore the support provided by each hub has varied. Collectively, the regional hubs have supported their DHBs with regional FCT analysis including provision of equity-focused reporting, contributing to local DHB cancer service improvement work groups, collating regional narrative reports and assisting with specific improvement initiatives.



Response to service delivery disruption

Waikato DHB cyber-attack

In May 2021, provision of cancer treatment at Waikato DHB was compromised as a result of a cyber-attack. Because Waikato DHB provides cancer treatment for patients residing in other DHBs in the region, this attack also had wider ramifications across the region.

Te Aho o Te Kahu worked with Waikato DHB to respond to the impact of the cyber-attack. Radiation therapy services were particularly impacted by the attack, with no radiotherapy able to be provided by the DHB for two to three weeks. Te Aho o Te Kahu supported the Waikato Regional Cancer Centre to coordinate a national response for radiotherapy. This included rapidly modelling national capacity to deliver radiotherapy with changes to different variables – for example, extending delivery hours and changing the way care is delivered. Te Aho o Te Kahu provided national leadership to support the coordination of radiotherapy provision, with patients treated in Auckland, Tauranga and Wellington.

Te Manawa Taki Regional Hub played an important role through this challenging period, providing extra resource to assist the DHB to identify patients in urgent need of treatment and co-ordinate their care. This issue is not entirely resolved and the Hub is continuing to provide the DHB with some resource to assist with this task.

Supporting service delivery challenges in DHBs

In early 2021, Southern DHB identified a significant increase in waiting times for patient access to radiation and medical oncology. Te Aho o Te Kahu has been actively working with the DHB to support it to address this issue.

In May 2021, the Chief Executive and Southern Hub Manager of Te Aho o Te Kahu met with clinical staff, clinical and service leadership, and executive management of Southern DHB. Since that meeting the Southern Regional Hub has supported Southern DHB to actively grow the workforce, including medical, nursing and allied health staff and further invest in nonsurgical cancer services. Te Aho o Te Kahu continues to reinforce the need for a strong focus on the impact of delays on the health and wellbeing of patients. While short term measures to address this impact are crucial, a robust approach to ensure services are sustainable on an ongoing basis is also required.

Te Aho o Te Kahu has also worked with Health Workforce NZ to understand capacity issues and think about initiatives to enhance recruitment and retention across Aotearoa New Zealand.



Cancer medicines availability analysis

Te Aho o Te Kahu has commenced work to assess the availability of cancer medicines in Aotearoa New Zealand. The goal of this analysis is to objectively assess the breadth of cancer medicines available in New Zealand and identify if and where there are substantial gaps between medicines with clear clinical benefit that are available in other comparable countries and those available here.



Support and information

The Southern Regional Hub has commenced a project to improve transition support for people who have recently completed treatment.

Improving equity of cancer outcomes



Support Government Response to Māori Affairs Select Committee Inquiry into Māori Health Inequities

The Māori Affairs Committee Inquiry into Health Inequities for Māori was initiated on 16 March 2019 in response to letters from Māori users of the health system expressing concern and identifying shortcomings for Māori seeking cancer care. Te Aho o Te Kahu worked closely with Manatū Hauora (Population Health and Prevention and Health Workforce), Mō Te Pātaka Whaioranga, Mana Tohu Mātauranga o Aotearoa and Te Hiringa Hauora to provide advice to inform the Government's response to this Inquiry, with that response tabled in Parliament on 14 April 2021. The Government's response agreed, or agreed in principle, with 14 of the 19 Inquiry recommendations.

Māori community hui

In February 2021 Te Aho o Te Kahu embarked on a series of Māori Cancer Community Hui around the motu. Working alongside local DHBs, cancer service providers, Māori leaders, stakeholders and communities, we delivered 13 hui from Kaikohe to Invercargill – reaching over 2,500 whānau Māori.

The purpose of the hui was to hear the voice of whānau Māori as they shared their insights and experiences of cancer and cancer care in Aotearoa. At each hui we worked collaboratively with whānau Māori to codesign solutions to issues identified

during workshop sessions. We also supported whānau Māori with free health checks, health promotional activities, primary care enrolment, and screening enrolment and delivery. Rongoā Māori (traditional Māori healing) and a focus on hauora (holistic wellbeing) were also important elements of the hui.

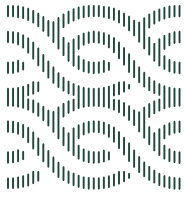


The hui had the additional benefit of raising the visibility of Te Aho o Te Kahu as a leader, and an agent for change, in the health system and the hui have solidified our relationships with many Māori providers, leaders and stakeholders.



Māori leadership and engagement

Alongside Hei Āhuru Mōwai, Te Aho o Te Kahu has been considering the best approach to engage genuinely with Māori leaders and communities at national and regional level to gain their insights and advice. This work is ongoing.



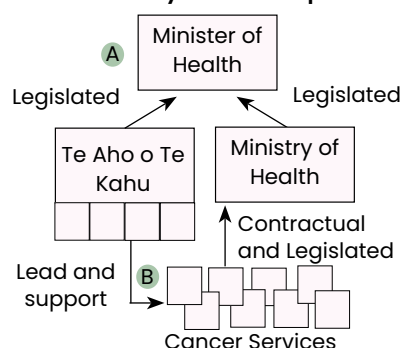
Tō Mātou Whakahaere

Our Performance

Te Aho o Te Kahu is currently developing its approach to better understanding what is happening in the sector and our own performance. As an interim step, we intend to communicate our performance through the approach and measures outlined below, which will be regularly reviewed and improved to make sure we are focusing on the things that matter.

Tō mātou ahu Our approach

Accountability relationships



Why?

It is important that Te Aho o Te Kahu delivers on the government's expectations

There are some key questions we need to answer to support these relationships:

- how can we best demonstrate our performance to fulfil accountability requirements? (A)
- how can we gain the best understanding of challenges being experienced in the sector in order to lead and support? (B)

How?

Our intended approach is to develop five monitoring processes from which a selection of key indicators and information will be drawn and reported to the Minister.

Outcome and intervention tracking

This will provide a view of whether Te Aho o Te Kahu is delivering on its purpose and meeting its goals of fewer cancers, better survival and equity for all. These indicators will likely be slow moving, and will require care with interpretation.

Delivery of the Cancer Action Plan

A framework is being developed to track progress with delivering the actions described in the National Cancer Action Plan. This will likely consist of a mixture of indicators and project milestones.

Early identification of service challenges

Our regional hubs have developed a framework for identifying service issues in their region in order to provide appropriate action and support. This builds on existing reporting mechanisms and relationships.

Acknowledging achievements and challenges

Te Aho o Te Kahu has developed a more formal mechanism for identifying and reporting on our achievements, risks and challenges.

Te Aho o Te Kahu corporate performance

Te Aho o Te Kahu has identified key metrics which can be used to track our internal performance as an agency. This consists of a mixture of throughput and people-related indicators.

Effectiveness

Efficiency

What?

The products to be delivered from this approach are still in development. They may include:

- a quarterly dashboard provided to the Minister, and shared with the advisory council covering a selection of key indicators, progress reporting and risks
- monthly reporting collated by the Te Aho o Te Kahu regional hubs showing service performance and challenges in their region
- a tracking tool for each action described in the National Cancer Action Plan.

Yet to be determined is whether any of this reporting is appropriate to be shared publicly, eg, on the Te Aho o Te Kahu website, or with stakeholders.

Ngā aronui mo tēnei wā

Our interim performance measures

Outcome measures

These measures tell us if we are heading in the right direction and remind us of our purpose – they are the things that really matter to us. However, they are not solely attributable to Te Aho o Te Kahu and will likely shift slowly.

Fewer cancers

Cancer incidence rate¹ **345.9** ▼ Trend

NZ Health System Indicator

Access to primary care **84%** ▼

Better survival

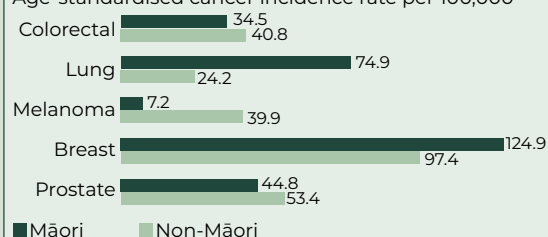
Cancer mortality rate¹ **114** ▼ Trend

NZ Health System Indicators

Bowel screening participation* –

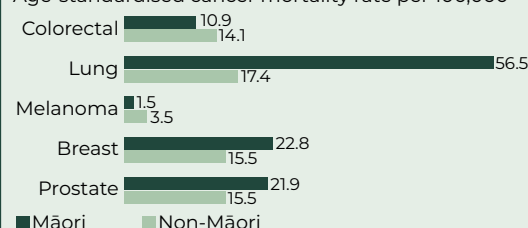
Involved in care **84%** ▲

Age-standardised cancer incidence rate per 100,000



Age- and sex-standardised cancer rates 2008–2017

Age-standardised cancer mortality rate per 100,000



Age- and sex-standardised cancer-related mortality 2007–2017

If Te Aho o Te Kahu has a positive impact on equity, over time we would expect the difference in Māori and non-Māori incidence rates and mortality to reduce.

Better survival – service indicators

These indicators are drawn from regular monitoring to understand what is happening in the system.

CT/MRI wait times target	80% met	Wait for first specialist appointment	14% over time
Colonoscopy wait times target	55% met	Wait for treatment time	25% over time
Breast and cervical screening rates for Māori target	58% met	Patient experience*	
Access to travel support*		% workforce Māori*	

Te Aho o Te Kahu agency indicators

These indicators provide insight into how Te Aho o Te Kahu is functioning as a public service agency

		Trend			Trend
Staff satisfaction	7.3/10	–	OIA timeliness	100%	▲
Sick leave taken	3.1 days	–	% Māori staff	8%	▼
Staff turnover	4%	▲			

¹ Per 100,000 population * In development

Explanation of measures

Measure	Explanation
Cancer incidence rate	<p>The number of people diagnosed with a new cancer per 100,000 people in the population. Most recent data is 2018.</p> <p>Numerator: the number of new cancers diagnosed in that year.</p> <p>Denominator: Aotearoa New Zealand population.</p>
Access to primary care	<p>NZ Health System Indicator.</p> <p>People report they can get primary care when they need it.</p> <p>Sourced from the Health Quality & Safety Commission (HQSC) adult primary care experience survey.</p> <p>Numerator: The number of people answering 'no' to the question: In the past 12 months was there a time when you wanted healthcare from a GP or nurse but you could not get it?</p> <p>Denominator: The number of people who answered the question: In the past 12 months was there a time when you wanted healthcare from a GP or nurse but you could not get it?</p>
Cancer mortality rate	<p>The number of deaths, with cancer as the underlying cause of death, occurring during the year. Cancer mortality is usually expressed as the number of deaths due to cancer per 100,000 population. Most recent data is 2018.</p> <p>Numerator: The number of deaths with cancer as the underlying cause of death.</p> <p>Denominator: Aotearoa New Zealand population.</p>
Bowel screening participation	<p>NZ Health System Indicator.</p> <p>This measure is yet to be developed.</p>

Involved in care	<p>NZ Health System Indicator.</p> <p>The number of people who report they can get primary care when they need it.</p> <p>Sourced from the Health Quality & Safety Commission (HQSC) adult primary care experience survey.</p> <p>Numerator: The number of people answering 'yes' to the question: Did the GP or nurse involve you as much as you wanted to be in making decisions about your treatment and care?</p> <p>Denominator: The number of people who answered the question: Did the GP or nurse involve you as much as you wanted to be in making decisions about your treatment and care?</p>
CT/MRI wait times	<p>The number of people accepted for a CT scan receive their scan within 42 days or less (target 95%).</p> <p>The number of people accepted for a MRI scan receive their scan within 42 days or less (target 90%).</p> <p>Numerator: The number of people who receive the diagnostic within the identified timeframe and people waiting for the diagnostic at the end of the period who have waited less than the indicated timeframe.</p> <p>Denominator: The number of people who have received the diagnostic and people waiting for the diagnostic at the end of the period.</p>

Colonoscopy wait times	<p>The number of people accepted for an urgent colonoscopy receive this in 14 days or less (target 90%).</p> <p>The number of people accepted for a non urgent colonoscopy receive this in 42 days or less (target 90%).</p> <p>The number of people accepted for a surveillance colonoscopy whose procedure is due prior to or within the month of reporting receive this in 84 days or less (target 90%).</p> <p>Numerator: The number of people who receive the diagnostic within the identified timeframe and people waiting for the diagnostic at the end of the period who have waited less than the indicated timeframe.</p> <p>Denominator: The number of people who have received the diagnostic and people waiting for the diagnostic at the end of the period.</p>
Breast and cervical screening rates for Māori	Percentage of eligible women screened in the most recent 24-month period (target 70%).
Access to travel support	This measure is yet to be developed.
Wait for first specialist appointment	<p>ESPI 2: All patients accepted for an first specialist appointment (FSA) should be seen within four months of the date of referral. The goal is to have no patients waiting more than four months for an FSA.</p> <p>Numerator: the number of patients waiting longer than four calendar months for an FSA.</p> <p>Denominator: total number of patients waiting at month end for an FSA.</p>

Wait for treatment	<p>ESPI 5: All patients given a commitment to treatment should receive it within four months. The goal is to ensure no patients with this status remain untreated after four months.</p> <p>Numerator: the number of patients with an assured status waiting longer than 120 days.</p> <p>Denominator: the total number of patients waiting with an assured status.</p>
Patient experience	This measure is yet to be developed.
% workforce Māori	This measure is yet to be developed.
Staff satisfaction	Overall agency score in 'Korero Mai' staff satisfaction survey (out of 10).
Sick leave taken	The average number of sick leave days applied for and approved per permanent or fixed term employee in that financial year.
Staff turnover	<p>The proportion of staff who resigned from Te Aho o Te Kahu in the financial year.</p> <p>Numerator: The number of people who resigned.</p> <p>Denominator: The number of permanent and fixed term staff.</p>
OIA timeliness	The proportion of Official Information Act 1982 (OIA) responses that are sent to requestors within legislated timelines.
% staff Māori	<p>The proportion of Te Aho o Te Kahu staff who identify as Māori.</p> <p>Numerator: The number of people who identify as Māori.</p> <p>Denominator: The number of permanent and fixed term staff.</p>

Haepapa Tauākī

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

23 November 2021

