MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth St
PO Box 5013
Wellington 6145
New Zealand
T+64 4 496 2000

23 NOV 2018

Thai Quoc Khanh
fyi-request-9012-a25bb356@requests.fyi.org.nz

Ref: H201807449

Dear Thai Quoc Khanh

Response to your request for official information

I refer to your email of 19 October 2018 to the Ministry of Health (the Ministry) requesting information under the Official Information Act 1982 (the Act). A copy of your request is attached as Appendix One

I will address the matters you raised separately.

Question 1: Could you please explain more details on the differences among Funder, Provider and Governance. Also, could you please give me your opinion on which net result should be used when measuring efficiency of hospital services that provided by DHB provider arm. Besides, I found that most of the DHBs were in deficit over the period from 20013 to 2016. Especially, most of DHB providers underperformed the plan and made up the largest proportion in the total deficit. Could you please provide me brief causes for the pervasive deficits and whether Ministry of Health have any policies to subsidise or encourage DHBs to reduce their losses.

Attached as Appendix Two is an extract from the district health board (DHB) / Ministry Common Chart of Accounts.

The reason why DHBs are not achieving budget plans are outlined in the report "District Health Board Sector Financial Performance Reports" and can be found at: www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/summary-financial-reports/dhb-sector-financial-reports-2017-18.

Question 2: By collating the Revenue of Provider arm in Schedule 2 and Schedule 3, I found that there exist differences. Take Auckland DHB (2016/17) for example, Revenue in Schedule 1 is 1,882,759; this figure in Schedule 3 is 1,430,735. Likewise, the revenue reported in the Auckland DHB Annual Report 2016/17 (page 39) is 2,079,133. Please kindly explain the variance in the revenue figures of DHB provider.

The table below shows how the revenue is made up for the two arms and the consolidated position:

($ Billions)	Funder	Provider	Consolidated
Devolved Funding (Population Based Funding)	1,292	1,234	1,292
Non Devolved Funding (side contracts)		56	56
Other Government funding		39	39
Other income		87	87
IDF Income	590	14	604
Total	**1,882**	**1,430**	**2,078**

Question 3: ***The Full Time Equivalent (FTEs) staff in the Schedule 4 are not similar to the FTEs reflected in the District Health Board clinical staffing numbers (https://www.health.govt.nz/our-work/health-workforce/dhb-clinical-staffing-numbers). Take Auckland DHB for example, the FTE at 20 Sep 2016 was 4,714 (including Health Assistant); the total FTEs is Schedule 4 at 30 June 2016 was 8,380. Again, please kindly disentangle this difference.***

The clinical staffing numbers report clinical FTEs only (medical & nursing staff only) whereas schedule 4 reports FTEs for medical, nursing, allied, support and administration/management staff. The June 2016 total FTE count of 8,380 includes all staff.

The September 2016 clinical staff report shows Medical & Nursing staff FTEs at 4,714 and the September 2016 schedule 4 shows FTEs Medical and Nursing Staff at 5,844. The difference between these 2 numbers relates to the way each report calculates FTEs.

The clinical staffing report calculates FTEs as follows:

Reports on the increase in medical and nursing full-time equivalents (FTE) in DHBs use the Employed FTE methodology, which is based on the contracted hours of employees. One FTE is based on a person who works a 40 hour week (eg, a worker contracted for 30 hours a week is 0.75 FTE). However, a person working more than 40 hours a week is only counted as one FTE (eg, a Senior Medical Officer contracted for 60 hours a week is 1.0 FTE, not 1.5). Table One below illustrates how this works:

Table One: Employed FTE counts:

Contracted hours	Employed FTE count
30 hours per week	0.75 FTE
40 hours per week	1.0 FTE
60 hours per week	1.0 FTE

Schedule 4 on the other hand reports FTEs on the hours worked in the week. Therefore, if medical or nursing staff worked a 60 hours per week the total FTE would be reported as 1.5 FTE. Schedule 4 will therefore, typically report a higher number of equivalent FTEs compared to the clinical staff report.

Question 4: ***The Balance sheet reflect the financial figures of each DHB, in which the non-current assets are clearly specified. However, I have no understanding on the scope of these assets. Although DHBs have a variety of functions, I thought the Balance sheet might only capture the assets used at DHB provider. Could you please explain more on this issue?***

The attached Appendix Three lists the items that make up non-current assets.

I trust this information fulfils your request. Please note that the Ministry may publish this response (with your personal details removed) and any attachments on the Ministry of Health website.

Yours sincerely

Tina Wakefield
Acting Deputy Director-General
Corporate Services

Appendix One

"1. Schedule 1
Could you please explain more details on the differences among Funder, Provider and Governance. Also, could you please give me your opinion on which net result should be used when measuring efficiency of hospital services that provided by DHB provider arm.

Besides, I found that most of the DHBs were in deficit over the period from 20013 to 2016. Especially, most of DHB providers underperformed the plan and made up the largest proportion in the total deficit. Could you please provide me brief causes for the pervasive deficits and wether Ministry of Health have any policies to subsidise or encourage DHBs to reduce their losses?

2. Schedule 2
By collating the Revenue of Provider arm in Schedule 2 and Schedule 3, I found that there exist differences. Take Auckland DHB (2016/17) for example, Revenue in Schedule 1 is 1,882,759; this figure in Schedule 3 is 1,430,735. Likewise, the revenue reported in the Auckland DHB Annual Report 2016/17 (page 39) is 2,079,133. Please kindly explain the variance in the revenue figures of DHB provider.

3. Schedule 4
The Full Time Equivalent (FTEs) staff in the Schedule 4 are not similar to the FTEs reflected in the District Health Board clinical staffing numbers (https://www.health.govt.nz/our-work/health-workforce/dhb-clinical-staffing-numbers). Take Auckland DHB for example, the FTE at 20 Sep 2016 was 4,714 (including Health Assistant); the total FTEs is Schedule 4 at 30 June 2016 was 8,380. Again, please kindly disentangle this difference.

4. Schedule 6
The Balance sheet reflect the financial figures of each DHB, in which the non-current assets are clearly specified. However, I have no understanding on the scope of these assets. Although DHBs have a variety of functions, I thought the Balance sheet might only capture the assets used at DHB provider. Could you please explain more on this issue?."

Appendix Two

The Cabinet Minutes of 18 May 2000 state that the DHBs shall produce financial statements detailing the performance of three dimensions (arms) of DHBs, as set out below. The rationale behind this policy is to maintain the transparency and accountability in the allocation of funds towards DHB Provider and non-hospital service providers.

DHB Funder – responsible for the funding of health and disability services. In this arm DHBs report on the receipt of funds from the Crown and the allocation of funds to providers, including to their own hospitals. This excludes governance, management and administration activities relating to allocation of funds.

DHB Provider – responsible for governance and management of Crown owned hospital and associated health services. Reports on the provision of health and disability services and associated fringe activities such as renting surplus properties etc.

DHB Governance & Funding Administration - refers to the governance, management and administration activities relating to the allocation of funds. This includes:

- DHB Board costs, such as payments to Board members, meeting expenses, etc.
- all costs relating to the advisory committees to the Board, such as the Community and Public Health Advisory Committee, Disability Support Advisory Committee and Hospital Advisory Committee. The Hospital Advisory Committee could fit in DHB Provider, but the funding for the committee is included in the overall funding for DHB Governance and Funding Administration
- the corporate costs of servicing the Board (Board secretariat function)
- the share of the CEO costs relating to DHB Funder
- the corporate costs of working on DHB accountability requirements
- specific costs of managing DHB Funder, such as needs assessment, contracting with providers and monitoring the providers
- the share of corporate costs in managing DHB Funder, such as share of Finance, IT, etc.
- costs relating to shared services agencies
- the cost of internal audit which works at the Board's behest.

This excludes:

- the share of CEO costs relating to DHB Provider
- the share of corporate costs relating to DHB Provider.

From a financial view the DHB's consolidated net result (surplus or deficit) is one of the performance measures of the DHB.

Non Current Assets

Land - Owned

Land - Leased

Non Residential Buildings, Improvements & Plant -Owned

Non Residential Buildings, Improvements & Plant - Leased

Residential Buildings, Improvements & Plant - Owned

Residential Buildings, Improvements & Plant - Leased

Clinical Equipment - Owned

Clinical Equipment - Leased

Other Equipment - Owned

Other Equipment - Leased

Information Technology - Owned

Information Technology - Leased

Intangible Assets **(Software)** Owned

Intangible Assets **(Software)** Leased

Motor Vehicles - Owned

Motor Vehicles - Leased

Trust Properties - Owned

Trust Properties - Leased

Investment Property

Provision Depreciation - Owned Non Residential Buildings, Improvements & Plant

Provision Depreciation - Owned Residential Buildings, Improvements and Plant

Provision Depreciation - Owned Clinical Equipment

Provision Depreciation - Owned Other Equipment

Provision Depreciation - Owned Information Technology

Provision Depreciation - Owned Intangibles (Software)

Provision Depreciation - Owned Motor Vehicles

Provision Impairment - Land

Provision Depreciation - Owned Trust Properties

Provision Depreciation - Leased Non Residential Buildings, Improvements & Plant

Provision Depreciation - Leased Residential Buildings

Provision Depreciation - Leased Clinical Equipment

Provision Depreciation - Leased Other Equipment

Provision Depreciation - Leased Information Technology

Provision Depreciation - Leased Intangibles (Software)

Provision Depreciation - Leased Motor Vehicles

Provision Depreciation - Leased Trust Properties

WIP

Investment in NZ Health Partnerships Limited

Investment in Subsidiaries

Investment in Associates

Long Term Investments (> 12 months)

Long Term Investments – Trusts (> 12 months)

Other Investments (Loans)

Inventory - Non Current

Prepayments - Non Current

Derivatives in Gain

*The balance sheet is calculated at a consolidated level.