Auckland District Health Board

Statement of Intent

For the year ending 30 June 2005

August 2005

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1. Introduction

1.1 Public Finance Requirements

This Auckland DHB Statement of Intent sets out the organisation's intentions and objectives for the year ending 30 June 2005. Some of these intentions and objectives will be ongoing for the next three to five years. The Statement of Intent sets the broad parameters under which the Auckland DHB is managed and has been prepared in terms of section 41C and 41D of the Public Finance Act 1989 and section 42 of the New Zealand Public Health and Disability Act 2000.

The Auckland District Health Board (Auckland DHB) is a major funder and provider of healthcare services. The organisation funds and provides community based and secondary services to central Auckland, tertiary services to the Auckland region and national tertiary services nationally. Auckland DHB is responsible for improving the Auckland District population's health by focusing on those factors that most influence health. We fulfil our Treaty of Waitangi obligations by working in partnership with manawhenua and with the participation of other iwi. We also retain a focus on reducing inequalities to ensure Maori and other groups where health status is below that of non-Maori are assisted to improve health status and address problem areas.

1.2 The Auckland DHB Population

Although Auckland DHB is the biggest DHB by turnover, its population all living within the Auckland City council area is fourth biggest. As well as providing health services for Auckland City, Auckland DHB has to manage the flow of people into our area for treatment. Approximately half the work carried out in the provider arm is for people out of the city but most of these are within greater Auckland.

Approximately 367,400 people (March 2001) are usually living in the Auckland DHB area. Of these: 56 percent are European, 8 percent are Maori, 12 percent are Pacific people, and 17.2 percent are Asian. Twenty percent of the population are children under 14 years of age, 15.3 percent are between 15 and 24 years, and 10 percent are aged 65 years and over.

There has been considerable population growth in Auckland, particularly between June 2002 and June 2003. For Auckland city the estimated populations since the census were: 388,800 (June 2001 adjusted census figures) 401,500 (June 2002), 415,100 (June 2003) and 420,700 (June 2004). Between June 2003 and June 2004 the DHB population increased by 5,400

people. It is expected that there will be 561,500 people living in the district by 2026, about 172,700 more people or a 40 percent increase from 2001.

The ethnic composition of the population is expected to change over time, with growth expected in the proportion of Asian peoples in the population, and a reduction in the proportion of European peoples. In the period to 2016, the proportion of Asian peoples is projected to increase by 123%. By 2016, it is projected that approximately half (51%) of the Auckland DHB population will identify as European (64% in 2001); 34% as Asian (20% in 2001); 8% as Maori (8% in 2001); and 13% as Pacific peoples (14% in 2001).

The percentage of people under 14 years is expected to decrease from 20 percent in 2001 to 16.3 percent, while the proportion of people aged 65 years and over in this district will increase from 10 percent to 13.6 percent in the year 2026. The biggest increase in the over 65s is expected in the over 85s group. Nationally it is expected that this group will increase six fold by 2051. The over 85s will go from 9% to 22% of the over 65s during this period.

1.3 Health Inequalities within the District

Funding and planning activities are informed by the Population Health Needs Assessment completed in 2001 that highlighted the burden of disease and disability for the Auckland population and inequalities in health status between population groups:

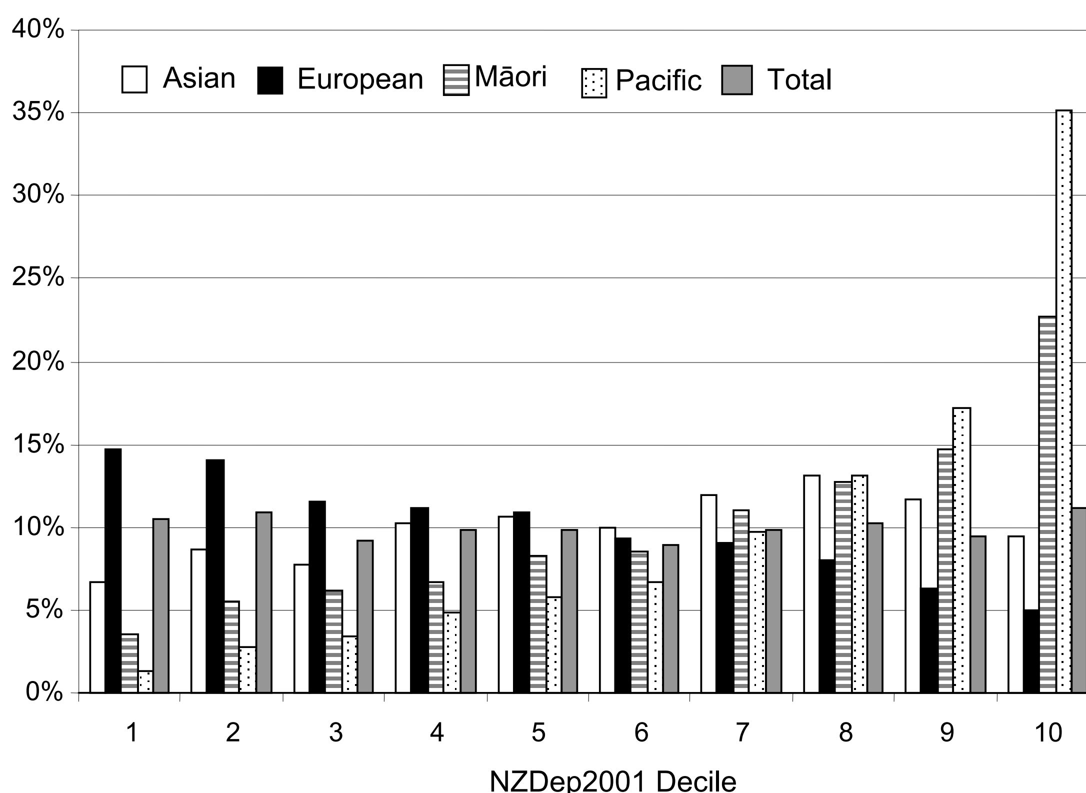
- Cardiovascular disease and cancer are the leading causes of death.
- Diabetes is predicted to increase markedly over the next ten years, especially among Maori and Pacific peoples.
- Maori and Pacific children within the district have poor oral health compared to others.
- There are increases in the incidence of communicable disease among young children (tuberculosis, rheumatic fever, meningitis, cellulitis and gastro-enteritis) especially among Maori, Pacific peoples and people from refugee backgrounds.
- About 20 percent of our population have a disability, and 3 percent have a severe disability.
- Alcohol and illicit drug use is increasing with concerns about the use of these substances among young people, Maori and Pacific peoples.
- There is a high youth suicide rate among males, particularly young Maori men.
- Family violence (including domestic violence and child abuse) is recognised as a key social and health issue in society.

Cancer and ischaemic heart disease are leading causes of death for all ethnic groups in Auckland. There are however, significant variations in other leading causes of deaths

between ethnic groups (e.g. injury and poisoning, perinatal conditions and diabetes featured more strongly in Maori and Pacific people than for other groups). Maori in New Zealand have higher perinatal mortality rates of than non-Maori but this disparity appears to be more pronounced for Auckland Maori. Auckland DHB has identified diabetes as a special focus area in the District Strategic Plan.

Maori and Pacific all-cause mortality rates are high in comparison to the rates for other groups in Auckland and the total New Zealand population. The overall health status for Pacific people in Auckland is however similar to that of Pacific people living in other parts of the country, while the all-cause mortality rate for Maori in Auckland is substantially less than the national rate for Maori. While the health status of Maori is not as high as other cultures in Auckland, local Maori do appear to have better health than Maori living in other districts.

Evidence links lower socio-economic status to inequalities in health status. The scale of deprivation is important in health planning and indicates areas of priority focus. This acknowledges the influence deprivation and other significant and related health determinants have on health status and on health seeking behaviour. Approximately thirty percent of the Auckland DHB population lives in highly deprived areas (deciles 8–10) of the district. When compared by ethnic groups, approximately 65% of Pacific peoples and about 50% of Maori live in deciles 8-10, compared with 34% of Asian peoples and 19% of European. There has been a slight decrease in the percentage of the population living in the high deprived areas defined as deprivation decile 10 (31 percent of the local population in 1996 lived in areas of high deprivation compared with 30 percent in 2001).



The new migrant and refugee populations also have high unmet needs that span health and other service areas. Specific plans exist in this area as well as a range of intersectoral initiatives via Strengthening Families that ensure local agencies responses and resources are well coordinated. The Asian population similarly, has distinct health needs are being increasingly incorporated into planning. A regional Plan for Asian Public Health has been completed with some of the health service planning and intersectoral recommendations underway.

1.4 Obligations to Maori

Auckland DHB recognises the Treaty of Waitangi as the founding document of New Zealand. The Treaty of Waitangi is the fundamental relationship between the Crown and Iwi and as such, provides the framework for Maori development, health and wellbeing. The NZ Public Health and Disability Act 2000 requires a DHB to establish and maintain processes to enable Maori to participate in and contribute towards strategies for Maori Health improvement. This recognises and respects the principles of the Treaty of Waitangi with a view to improving health outcomes for Maori. General references to the Treaty of Waitangi in this document derive from and should therefore be understood in this legislative context.

As a Crown Agency, Auckland DHB demonstrates that Treaty responsibilities are managed via our commitment to the principles of Partnership, Participation and Protection. These principles have been outlined by the Ministry of Health in order to provide direction specific to the health sector. Similarly, some of the processes that we have established are in the form of Partnership agreements and relationships with local Iwi. These relationships and agreements support the overarching and ongoing Crown relationships with Maori that have been established by the Treaty.

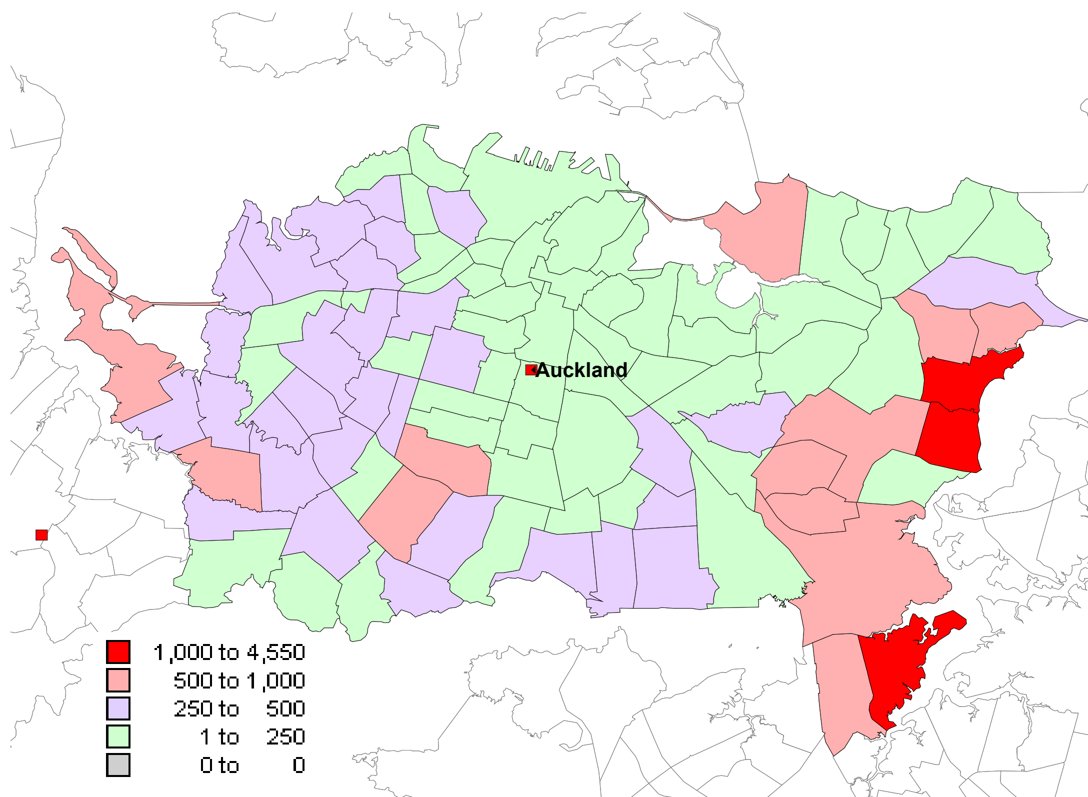
Each principle contains a significant provision that relates to health. Our commitment is consistent with the Ministry of Health, He Korowai Oranga - Maori Health Strategy and the Memorandum of Understanding we hold with Te Runanga o Ngati Whatua and its operational arm Tihi Ora MAPO. This Memorandum of Understanding outlines key principles, processes and protocols for working together at both governance and operational levels.

Alongside our relationship with Ngati Whatua as manawhenua is our responsibility to the Maori communities in our district and those who use our services. Auckland DHB works together with iwi, hapu, whanau and Maori communities to develop strategies for Maori health gain and appropriate health and disability services.

Partnership	Working in accordance with our Memorandum of Understanding with Te Runanga o Ngati Whatua to ensure that Ngati Whatua, as manawhenua, are partners with the Auckland DHB at the governance level. This health partnership ensures that we actively protect Maori interests in our health planning and funding activities.
Participation	Involving Maori at all levels of the sector in planning, development and delivery of health and disability services.
Protection	Auckland DHB will aim to ensure that Maori enjoy the same level of health as non-Maori and will safeguard Maori cultural concepts, values and practices. This includes the right of equity between Maori and other New Zealanders to health services and the expectation that these services will meet the rights/rites, needs, interests and aspirations of Maori.

Auckland DHB continues to develop relationships with key Maori stakeholders and Maori providers to ensure the health needs of the Auckland DHB Maori community are identified and addressed with a view to reducing health inequalities. This will provide opportunities to foster Maori capacity and provider development so Maori can provide for their own health needs and assist in addressing barriers to access for Maori.

The majority of Maori living in the Auckland district are located in the eastern part of the city.



He Kamaka Oranga (the Maori Health team) within Auckland DHB will ensure it is responsible for all aspects of policy development, planning and funding, provider management, quality, clinical leadership and Tikanga Maori.

Maori Health will consolidate current Maori health initiatives within the secondary and tertiary sector of the Auckland DHB while building on the functions of a district health board such as service integration strategies, developing Maori population health strategies and funding. In particular, planning (needs analysis, prioritisation, strategic and annual planning) will involve Tihi Ora MAPO, the Maori Health Advisory Committee and other Maori stakeholders in collaboration with Maori Health and the Chief Advisor Tikanga.

1.5 Organisational Activities and Capabilities

Auckland DHB is a major funder and provider of healthcare services; funding and providing community based and secondary services to central Auckland, tertiary services to the Auckland region and national tertiary services nationally. The Board is responsible for improving the Auckland District population's health by focusing on those factors that most

influence health. The Board also has responsibility for collaborating and planning across a wide range of health and non-health sectors in order to influence the broader determinants of health. This is achieved through the following activities:

- Population health needs analysis
- Planning and funding for services that meet the principles and priorities of the NZ Health Strategy and the NZ Disability Strategy
- Collaboration with other DHBs, Government agencies and non-Government entities
- Contribution to the development of good public health policy
- Strengthening community participation in health
- Building capability within the Auckland DHB and community
- Improving service provision with regard to access, appropriateness and effectiveness of the services for Maori and Pacific people so as to reduce health inequalities
- Provision of public health services in collaboration with other Auckland DHBs through the Auckland Regional Public Health Service.

2. Nature and Scope of Activities

2.1 Governance and Management

The management structure has evolved to meet the needs of the new environment with three key functional groups: Planning and Funding, Shared Services and Provider Services. The organisation is completing changes to ensure that the administrative and clinical systems and processes of the Auckland DHB are efficient and cost effective.

A restructure of our senior management occurred in early 2004 in an effort to achieve savings through reduced management costs and concentrate our activities on health service delivery. The structure also incorporates key relationships with Treaty partners and the Hospital and Primary care Clinical Boards. The Executive Team comprises senior managers and clinical heads who assist the CEO with leadership on major organisational issues. The Executive Team ensures that matters requiring input from governance or that require formal sign off are taken to the Board.

Auckland DHB works with the other two District Health Boards in the greater Auckland region, Counties Manukau and Waitemata. We also work at a wider level through national bodies such as joint working committees with the Ministry of Health and the various District Health Boards New Zealand (DHBNZ) committees and projects.

Auckland DHB also works in conjunction with a wide range of educational facilities and third parties in relation to research and training.

Statement of Output Objectives: Output 1: Governance and Management
DHB governance and funding administration – this output class has a funding value of approximately $2 million. Objectives and initiatives in this Statement of Intent are aligned to this output class.

2.2 Funding and Planning

Auckland DHB is responsible for funding health services for its resident population as well as a number of regional and national services. This involves funding for almost 1,000 providers for primary and mental health services. This figure has been extended further with the devolution of disability services for older people. The funding and planning team is responsible for assessing population health need and ensuring that services are planned for the future to meet these needs and make best use of available resources.

Services provided to the rest of the country necessarily involve some trade offs that may impact on the local population and our locally determined priorities. We endeavour to balance the demand for specialist services against our aim to contribute to healthy communities and provide quality healthcare to all the people in our area, with a special focus on the reduction of inequalities in health status.

To help us prioritise resources, Auckland DHB uses the recently developed national prioritisation framework. This framework includes a set of principles that help us assess the relative priority of services or interventions.

Statement of Output Objectives Output 2 – Funding and Planning
This output class has a funding value of approximately $311 million. Objectives and initiatives in this Statement of Intent are aligned to this output class.

2.3 Provider Arm/Hospital Services

Auckland DHB operates New Zealand's largest public hospital providing hospital and outpatient services provide services for more than 350,000 people in central and tertiary services for a population of about 1.3 million in the northern region. Auckland DHB also supports other tertiary hospitals, as the patient profile treated is wider than that seen in other areas. For example, the intensive care unit has received referrals for critically ill patients from every other hospital in the country.

Auckland DHB also has a number of tertiary services, such as neurosurgery, clinical genetics and paediatric oncology for patients in the northern and midland regions. Paediatric oncology is based on a shared care and an outreach model, which reduces the need for patients to travel. There are a number of national services that include major organ transplants such as lungs and livers. Auckland DHB has the only paediatric intensive care unit in the country that is used by all hospitals.

Within the immediate Auckland region, Auckland DHB provides a tertiary support service for the other two hospitals in the Auckland region.

Auckland DHB also provides disability services for Assessment, Treatment and Rehabilitation services, Community services, Needs Assessment and Service Co-ordination services (65+ years), Child Development services, and Therapy services.

Auckland DHB provides over 55 percent of its provider arm services to people outside of the district. Project work continues on inter district flows in order to gauge the volume of work flowing between DHBs and the costing for these.

The provision of national tertiary services exposes Auckland DHB to risks associated with high cost treatments that are not fully covered within the funding envelope. Transplant work (Kidney in particular), blood products associated with haemophilia treatment, and some high cost pharmaceuticals are adequately covered by “top-sliced” funding but a number of high cost, low volume procedures continue to expose the organisation to ongoing losses that cannot be retrieved through the population based funding or inter district flows projects.

Statement of Output Objectives Output 3 – Provider Arm

The output class relating to the provision of personal and family health services, plus mental health services has a funding value of approximately $733 million including all sources of revenue. Objectives and initiatives in this Statement of Intent are aligned to this output class.

3. DHB Objectives

Auckland DHB objectives set out in this Statement of Intent are consistent with our District Strategic Plan and District Annual Plan for 2004-05, Government priorities and the Minister of Health's "Start Here" list. Auckland DHB has defined four goals to provide the strategic focus for these plans:

Get control of our finances	Get control of our finance and reduce the current level of deficit and improve business performance
Improve performance	Standardise, consolidate, and integrate our services Coordinate across all health services to streamline care and to secure more cost effective health gain So gains from the change programme can work to maximum effect in our new and efficient hospital
Auckland city's population receive their fair share	Interdistrict flow patients managed to contract Gain appropriate funding for older people's health Focus on health gain for the Auckland DHB population
Lift the health of people living in Auckland city	Service planning and provision based on need Focus on population health Reduce inequalities Coordinated health services Strengthen the primary care sector Improve quality and safety of services Reflect our Treaty of Waitangi responsibilities within the framework of the NZPHD Act·

3.1 Get control of our finances

The financial year 2004-05 will be a difficult, complex and tough period for the Auckland DHB. As well as completing initiatives related to the building programme there will be considerable focus on reducing the deficit. This will be a considerable stretch for the organisation. Sections four and six contain further detail on our financial position.

3.2 Improve performance

The organisation has undergone a period of extensive change with a $447 million building redevelopment involving the construction of the new Auckland City Hospital and related buildings and services. It is now time to get back to basics and to both improve operational performance and become a true DHB.

3.3 Auckland's population receive their fair share

In order to ensure that the population of Auckland City receive their fair share of health services, the organisation has to carefully manage the flow of patients into Auckland DHB services from other DHBs.

We are aiming to provide the level of service that has been contracted for and all our costs being managed within budget. Improvements in this area will require a high level of accuracy of coding into categories of Auckland DHB population, referrals from other DHBs, patients funded under Accident Compensation, and Overseas Patients. Systems for tracking cost savings are also required so we can understand the costs associated with work for other DHBs. A particular focus will be to ensure that ADHB receives adequate funding for the older people occupying the disproportionately high number of rest homes in its areas.

3.4 Lift the health of people living in Auckland City

The work programmes planned to achieve these goals reflect a commitment to pursuing the best health outcomes for the central Auckland population within the available funding. While focusing on the workout plan developed to address the deficit we will also progress initiatives that are aimed at health gain for the Auckland DHB population.

Auckland DHB identified diabetes as a special focus area in the District Strategic Plan. The continued development of Primary Healthcare Organisations is also a priority.

The Auckland DHB work programmes planned to lift the health of Aucklanders are complemented by health protection and promotion services provided by the Auckland Regional Public Health Service. This service covers the three Auckland districts.

3.5 Organisational Goals and Objectives for 2004-05

Below is a summary of goals and objectives taken from the 2004-05 District Annual Plan.

2004-05 Goals	Area	2004-05 Objective
Get our Finances in Order	Meet Financial targets	Manage costs within agreed budgets to ensure ADHB meets all its financial targets.
	Manage FTEs	Manage staff numbers to ensure ADHB does not exceed budgeted FTE levels.
	Savings Initiatives	Attain the financial benefits planned in the District Annual Plan
Performance Improvement	Management and Administration	Organisation wide project to reduce Management and Administration costs to 10.5% target.
	Patient Satisfaction	Improve patient satisfaction in the Provider Arm to meet or exceed the average for all DHBs.
	Performance Improvement Project	Achieve key implementation goals for the year
	Migration Completed	On time, within budget, successful commissioning
	Operating Rooms and Sterile Supply Services	Organisation wide projects to improve/restore targeted performance and clinical safety of Operating Room and SSS.
	Outpatient and Administration Services	Organisation wide projects to improve/restore targeted performance of Outpatient and Administration services.
	Turnover	Retain and develop key staff plus organisational knowledge.
	Health and Safety	Improve management of health and safety for all our staff, contractors and visitors and reduce the Lost Time Injury Frequency Rate (LTIFR) by 10% from the previous year.
	Sick Leave	Promote wellness and reduce over-use of sick leave within ADHB.
Auckland's population receive their fair share	Patient Volumes	Patient volumes up to 10% above contract for Auckland's population, and costs within budget. Inter-district flow volumes within 1% variation of contract and costs within budget. 100% Accuracy of Coding into ADHB population, DHB Referrers, ACC and Overseas Patients
Lift the health of people living in Auckland	Elective Surgery	Target and support elective services initiatives to improve performance to targets
	Diabetes Management	Meet the "Get Checked" contract targets (60%) and other

2004-05 Goals	Area	2004-05 Objective
City		targets set for case management and eye screening
	Reduce Inequalities Health Disparities	Enrolments in PHOs exceed 90% of ADHB population. PHO immunisation rates for Maori and Pacific population improves by 25% from previous year Service areas to identify one measurable service specific objective to reduce inequalities
	Clinical Indicators	Focus on areas for clinical quality improvement work using Clinical Indicators.
	National Immunisation Register and Meningococcal Vaccination	Undertake the work associated with the National Immunisation Register and MeNZB vaccination strategy and meet Crown Funding Agreement obligations

4. Analysis of the Cost Pressures

4.1 Strategy to manage the deficit

Auckland DHB has been operating with a large deficit for several years. The deficit will increase from $44.7 million in the 2003-04 financial year to $66.5 million (plus two abnormal items; mental health under spend of $5.5 million and asbestos removal of 11.4 million) in the 2004-05 financial year. Developing a greater understanding of the root causes of the financial problems facing the organisation has been an important first step in managing the problem. These issues have been detailed in the District Annual Plan.

In general the following principles will be applied in the management of all services;

- Build accurate, reliable budgets
- Understand the problem areas, internal and external, and address the root causes
- Take the price component of new funding directly to the bottom line to reduce the deficit
- Tight management of FTE numbers
- Aim to set service volumes to no more than historical levels and with the intention of absorbing growth in demand, except in critical areas such as oncology, renal and diabetes
- Manage the impact of regional service planning changes including any associated cost reductions
- Recognise the maximum potential for property sales
- Review productivity of all services progressively

The majority of the efficiency issues that need to be addressed are in the provider arm and predominantly these are within Auckland City Hospital. These changes will require continued effort to instil a culture of management accountability in the organisation. Auckland DHB is committed to achieving efficiencies and costs where we can have an impact and hold managers and clinicians accountable. These initiatives are detailed in the 2004-05 District Annual Plan.

5. Performance Targets

5.1 Indicators of Auckland DHB Performance

The following performance targets and measures reflect objectives from the Auckland DHB 2004-05 District Annual Plan.

Contracted outputs

In the year to 30 June 2005 Auckland DHB will provide a wide range of secondary and tertiary hospital services that fulfil contractual obligations to the Crown. The table below summarises the planned contract outputs.

Contracted Output	Measure/Unit	Target	Contract	Actual	Actual
		12 months to 30 June 2004	**12 months to 30 June 2004**	**12 months to 30 June 2004**	**12 months to 30 June 2003**
Personal Health					
Total WIES (Inpatients)					
Medical Services	CWDs*	19,623	18,455	19,150	18,538
Surgical Services	CWDs	22,886	23,223	23,661	23,029
Cardiac Services	CWDs	23,755	23,618	23,103	23,418
Ambulatory Services	CWDs	3,623	3,623	3,533	3,545
Women's Services	CWDs	8,875	8,286	7,564	8,555
Children's Services	CWDs	19,705	19,705	19,651	19,726
	Total:	***98,467***	***96,910***	***96,661***	***96,811***
Total Attendances (Outpatients)					
Medical Services	Attendances1	168,771	168,771	162,785	162,031
Surgical Services	Attendances2	40,413	40,263	42,687	50,575
Cardiac Services	Attendances3	28,383	28,383	29,912	28,769
Ambulatory Services	Attendances4	82,587	82,587	79,104	83,178
Clinical Support Services	Attendances5	18,326	22,400	17,875	2,0086
Women' s Services	Attendances	20,228	20,228	19,404	22,227
Children's Services	Attendances[7]	79,482	79,279	78,617	86,265

1 Includes Adult ED attendances and A+ Links but not programmes

2 Does not include programmes

3 Does not include programmes

4 Does not include programmes

5 Does not include programmes

6 Less services under this HBO for 02/03

Contracted Output	Measure/Unit	Target	Contract	Actual	Actual
		12 months to 30 June 2004	12 months to 30 June 2004	12 months to 30 June 2004	12 months to 30 June 2003
	Total:	***438,190***	***441,911***	***430,384***	***433,045***
Emergency Department					
Adults	Attendances[8]	42,406	42,406	47,023	42,503
Children	Attendances[9]	31,068	31,068	28,760	28,359
	Total:	***73,474***	***73,474***	***75,783***	***70,862***
Maternity					
Total Births	Births	***7,580***	***7,580***	***7,667***	***7,803***
Mental Health					
Inpatient services	Available bed days	***58,947***	***58,947***	***56,453***	***59,130***
Outpatient services	Clinical FTEs	***310***	***285***	***281***	***273***

Financial Measures

Financial performance for June 05	Target	Actual	Actual
Measure	**12 months to 30 June 2005**	**12 months to 30 June 2004**	**12 months to 30 June 2003**
Return on Net Funds Employed (Operating Margin/Net Funds Employed x 100)	-45.36%	-25.21%	-31.26%
Operating Deficit to Revenue (Operating Deficit /Total Operating Revenue x 100)	-7.14%	-3.96%	-5.54%
Interest Cover * (Calculation as per bank covenant requirements)	≥ 2.00	1.56	-3.52
Debt to Debt plus Equity Ratio (Total Borrowings/Total Borrowings plus Equity x 100)	65.00%	64.07%	60.55%

7 Includes Child ED attendances and DSS but not programmes

8 Subset of Medical figures above

9 Subset of Child figures above

* Cost Weighted Discharges

* *Interest cover*: This is calculated based on the published interest figures and the deficit for the year adjusted for the Auckland DHB share of associated company profits, profit on sale of assets, taxation, interest paid and depreciation

Financial Performance Measures: The financial targets are derived from the Budget approved by the Board and the Interest Cover ratio as required by the banking covenants.

Non Financial Measures

Process and Efficiency	Purpose	Target	Actual	Actual	Actual
Measure (output class 3)		**12 mths to 30 June 05**	**12 mths to 30 June 04**	**12 mths to 30 June 03**	**12 mths to 30 June 02**
Occupancy Rate for Resourced Beds	Efficient use of resources	85%	82%	81%	85%
DRG-Based Average Length of Stay (ALOS)	Efficient use of resources	3.00 days	3.10 days	2.99 days	3.04 days
Elective Day of Surgery Admission Rate	Move to more efficient setting for treatment	80%	79%	80%	74.53%

DRG-Based Average Length of Stay: This is based on the total discharges and the length of stay. The source data for this information is the coded information as supplied by Auckland DHB.

Elective Day of Surgery Admission Rate. Auckland DHB has a high percentage of Elective Daycase Surgery. The numerator for this measure is the number of elective surgical discharges, whose surgery was performed on the day of admission (excluding day cases). The denominator: The total number of elective surgical discharges, excluding day cases

Patient and Quality	Purpose	Target	Actual	Actual	Actual
Measure (output class 3)		**12 mths to 30 June 05**	**12 mths to 30 June 04**	**12 mths to 30 June 03**	**12 mths to 30 June 02**
Customer Service Proportion of Satisfied Customer Survey Respondents	Improve quality of service	93%	93.06%	94.06%	92%
Customer Service Proportion of Very Good Customer Survey Respondents	Improve quality of service	52%	51.38%	52.09%	52%
Percentage of Complaints Resolved/Closed	Improve quality of service	60%	42.44%	52.90%	59%
Hospital Acquired Blood Stream Infections (per thousand inpatient admissions)	Manage infection rates	6.65	6.84	6.10	6.47
Diabetes Annual Get Checked rates (case detection)	Improve management of diabetes	60%	44%	29%	25%

Percentage of Complaints: The Quality of Service Unit maintains a policy of communicating the status of complaints to each complainant every 14 days.

Hospital Acquired Blood Stream Infections: This rate has historically run at approximately 8 events per thousand inpatient admissions and the statistic for the last year is therefore lower than would ordinarily be expected. The statistics include patients who are readmitted with a blood stream infection who have previously received care within the Auckland DHB. This produces a higher statistic than would otherwise be the case.

The diabetes rates are based on the annual report and estimates for the following twelve months prepared to 31 December each year rather that 30 June.

Organisational Health and Learning	**Purpose**	**Target**	**Actual**	**Actual**	**Actual**
Measure (output class 3)		**12 mths to 30 June 2005**	**12 mths to 30 June 2004**	**12 mths to 30 June 03**	**12 mths to 30 June 02**
Staff Turnover (total)	Improve staff retention	16.72%	17.6%	15.6%	16.8%
Sick Leave Rate	Manage staff health	2.56%	2.7%	2.6%	2.8%
Workplace Injuries per 1,000,000 worked hours (Lost Time Injury Frequency Rate, or LTIFR)	Manage injury rates	6.91	7.68	6.8	13.5

Sick Leave Rate: is calculated as the total hours sick leave taken during the quarter divided by the total contracted employee hours in accordance with the balanced score card reports.

The definition for *Workplace Injuries or LTIFR* is the number of lost time injuries per million hours worked. A “lost time” injury is any occurrence of injuries that results in the loss of a full working shift, and "hours worked" is the actual number of working hours (i.e. excluding things such as annual leave, sick leave etc).

5.2 DHB Specific Performance Measures

2004-05 Goal 1: Get our Finances in Order	
Objective	**Performance Measure**
Manage costs within agreed budgets to meet all **financial targets**	Costs within budget. • Volumes within contracted levels • Costs recovered from ACC and others • Capital programmes deliver savings • National Prioritisation Framework applied • Population Based Funding managed for Inter-District Flows and pricing deficiencies

	• Referred Services spend managed • Improved costing system and business intelligence systems
Staff numbers do not exceed budgeted **FTE levels**	FTE total within budget.
2004-05 Goal 2: Performance Improvement	
Reduce **Management and Administration** costs to 10.5% target	Achieve targets for management and administration review.
Workforce management plan implemented Implement: • Employment Relations strategy • Learning and Development Plan • Workforce action plan • New HR information systems	All workforce management plans in place Zero variation from planned activities
Occupational Health and Safety policies and procedures integrated into everyday business and benchmarked Manage **health and safety** for staff, contractors and visitors. Reduce the Lost Time Injury Frequency Rate (LTIFR) from 2003-04 figures	LTIFR reduced from 2003-04
Reduced over-use of **sick leave** Management of annual leave.	Reduce sick leave by 5% compared to 2003-04 level
Migration completed on time, within budget, successful commissioning	Zero variance from planned activities
Organisation wide **projects** to: • Improve/restore targeted performance of Operating Room and Sterile Supply Services • Performance of Outpatient and Administration services	Plans in place and implementation progress on target
Improve **patient satisfaction** in the Provider Arm to meet or exceed the average for all DHBs	Patient satisfaction meets or exceeds national DHB average
Competent and qualified Pacific health and disability sector	Workforce development initiatives in place
Regional collaboration. Manage access to secondary and tertiary services within the metro-Auckland Region. Work with the other two Auckland DHBs to: • Develop and implement strategies and monitoring systems to prevent inappropriate access to out-of-DHB hospitals	• By 30 June 2005

• Finalise a detailed Regional Service Planning workplan for 2004-05 (signed off through the Regional Chief Executives Forum) • Complete 5-year volume forecasts by DHB for DRG and non-DRG in 2004-05 • Complete strategies for the provision of Renal services across the region within 2004-05 • Regional (and complementary local DHB) processes for assessing viability of new equipment, procedures and drug technologies in 2004-05 • Initiatives in place to secure efficiencies, improvements in productivity and increased service delivery	• By 31 Dec 2004 • Report quarterly against the Regional Service Planning Workplan • 30 June 2005 • 30 June 2005 • 30 June 2005 • 30 June 2005 Report on the initiatives undertaken and in progress, and the savings achieved, as part of the annual report.
2004-05 Goal 3: Auckland's population receive their fair share	
Patient volumes up to 10% above contract for Auckland's population, and costs within budget Inter-district flow volumes at 100% of contract and costs within budget. 100% Accuracy of Coding into ADHB population, DHB Referrers, ACC and Overseas Patients	Contract volumes for Auckland's population at up to 110%. Costs within budget. Coding 100% Accurate. Interdistrict flow volumes within 1% variance
2004-04 goal 4: Lift the Health of Aucklanders	
4.1 **Reduce inequalities** Progress He Korowai Oranga, ADHB **Maori Health** Strategy and implement: ✓ National Workforce Development Plan ✓ Regional Maori Mental Health Action Plan ✓ Tikanga Best Practice Policy • Monitor Maori health status • Identify the Maori specific spend annually • Develop Maori PHOs and improve mainstream PHO performance for Maori • Complete new initiative projects: Do Not Attend, Discharge Planning, Whare Oranga	Ethnicity data collected Health status trends monitored Systems in place to track spend on Maori health
Reduce health disparity for **Pacific peoples**. Priority areas of diabetes, outreach immunisation services,	Implement the priority areas in the Pacific Health and Disability Action Plan.

parish nursing services • Implement the primary health care strategy and monitor the effectiveness of Pacific PHOs • Models of service delivery for Pacific peoples with complex and chronic conditions	Participation of Pacific people in decision making, the development of strategies and plans for Pacific Health gain.
Reduce Inequalities and Health Disparities: Enrolments in PHOs exceed 90% of ADHB population. PHO immunisation rates for Maori and Pacific population improves by 25%. Services to identify one specific objective to reduce inequalities	90% 60% Service specific objectives set and achieved.
Complete the work associated with the National Immunisation Register	NIR functional to support MeNZ B programme
Meningococcal Vaccination	MeNZ B strategy implemented in the Eastern Corridor and ADHB as required in the Crown Funding Agreement
Equity of access to quality **mental health services** through integrated services • Restructure Regional Mental Health Services • Implement Acute Services Review findings and a quality monitoring framework • Review data management systems • Stakeholder networks participate in planning and service development	Blueprint funding allocated Review recommendations actioned Evidence of stakeholder input
NZ Health of Older People Strategy. Plans developed for: • Managing migration • Home Based Support (regional) • Community rehabilitation	All Health of Older People plans in place Sustainable services in place
NZ Disability Strategy: Implement the NZ Disability Strategy	A project to implement the NZ Disability Strategy at the Greenlane Clinical centre is underway Regional work to get consistent level and type of service for disabled people and families
4.2 **Manage integrated health services**	Free Annual Diabetes Reviews (Get Checks) performed. Target is 60%

Diabetes Management. Meet the "Get Checked" contract targets Work with PHOs to meet case detection, case management and eye screening targets for 2004-05 Access for Maori and Pacific improved Providers have plans including KPIs for monitoring activities Projects underway: • Children and Young People's Diabetes Prevention and Management Project • Develop diabetes Chronic Care Management programmes	Target for good diabetes control (case management) Maori and Pacific 70% All Others - 80% Target for eye screening within the last 2 years - 80% Programme established in conjunction with PHOs Aspects of MoH Healthy Eating Healthy Action Plan Implemented
Reduce the Incidence and Impact of **Cardiac Disease.** Equity of services and health gain cardiac services (cardiology, cardiothoracic and catheter laboratories) for region • Heart Failure Project with cardiac services • Manage growth in acute, elective services and vascular volumes within budget and guidelines • Review cardiac services (cardiology, cardiothoracic and catheter laboratories) for region to inform purchasing, equity of services and health gain. • Implement cardiovascular risk assessment guidelines • Research opportunities into basic mechanisms, novel therapies and clinical trials • Activities for: obesity prevention	Growth in acute and elective CTSU (paediatric/adult) and vascular volumes managed.
Reduce the incidence and impact of **Cancer** through prevention programmes e.g. tobacco regulation enforcement, smoking cessation, prevention of tobacco uptake and promotion of dietary measures • Screening programmes promoted with hard to reach groups • Manage and monitor the capacity for radiotherapy and chemotherapy treatment • Plan and implement radiotherapy and chemotherapy treatment capacity to ensure waiting	Screening programmes in place with improved access figures Improvement in waiting times for radiotherapy and chemotherapy Develop cancer treatment data collection Access for Maori improved

times are within Ministry of Health Guidelines • Contribute to the Cancer Register and development of national cancer data set • Access for Maori and Pacific improved • Implement palliative care services • Identify research opportunities for clinical cancer treatment trials • Plan and implement strategies that develop the cancer treatment workforce • Contribution to the Cancer Register and development of national cancer data set and to the Cancer treatment services working party	
Elective services and radiotherapy waiting times managed within guidelines • Equity and timeliness of access to assessment, diagnostics, tests, procedures and treatments • Improve Elective Service Performance Indicators and elective patient quality of care management. • Monitor contract volume management • GP liaison work including cross boundary liaison work. Get best use of resources and knowledge across the region • Initiatives to circumvent unnecessary elective appointments and treatment	All patients accepted for a first specialist assessment (FSA) seen within 6 months of the date of referral All patients who are given a commitment to treatment, receive it within 6 months No patient in active review fails to receive a review every 6 months
4.3 **Strengthen the primary care sector** **NZ Primary Health Care Strategy**. • Implement Care Plus, Reduced Co-payments for Pharmaceuticals, services to improve access (SIA) and Health Promotion (HP) funding	
A comprehensive and collaborative model of care within the region • Inter-district planning and service development (service shifts and facility planning) • Health Promotion in PHOs • Coordinated case management for children and families. Projects for high and complex needs Maori, Pacific and New Migrant children • Intersectoral response to abuse of children and	Progress on shared services; pricing, mental health; PHOs; referred services; contract management; regional IT for pharmacy, primary health care; DSS older people's care, NZ Disability Strategy; and prioritisation framework Healthy Housing programme in place Cellulitis prevention programme continued to plan

young people • Implement Family Violence Intervention Guidelines	Sustainable cities development System 2 projects completed Intervention guidelines implemented and functional
4.4 **Improve quality and safety of services** **Clinical quality improvement** work using Clinical Indicators. Improve Clinical Governance of Quality and Safety. Maintain Accreditation with Quality Health NZ; certification requirements are met • Quality and safety improvements integrated into all operational activities • "Improving Quality" integrated into Quality Planning	Each service to identify, measure, report and produce an action plan for at least one Clinical Indicator relevant to their population.

6. Financial Information

These financial statements are aligned with the material agreed in the 2004-05 District Annual Plan. The information in this section provides summarised details of capital expenditure plan and the planned disposal of certain land holdings in accordance with the commitments made to the Crown under the building programme business case. All shareholdings shown in the financial statements are held with the approval of the Minister of Health.

6.1 Statement of Accounting Policies

Reporting Entity

The financial statements included in this report are for the reporting entity the Auckland District Health Board and the Group comprising ADHB and the Auckland District Health Board Charitable Trust and associates.

Measurement Base

The accounting principles recognised as appropriate in the measurement and reporting of financial performance and financial position on a historical cost basis are followed by ADHB, with the exception that certain assets specified below have been stated at market value.

Going concern

The financial statements, which comply with the requirements of the Financial Reporting Act 1993 and the Public Finance Act 1989, are prepared on the basis that the ADHB is a going concern. The Minister of Health and the Minister of Finance have provided a Letter of Comfort to the Board that it is appropriate for the financial statements for the year ended 30th June 2005 to be prepared on a going concern basis.

Budget figures

The budget figures are those approved by the Board. The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Board for the preparation of the financial statements.

Specific Accounting Policies

The following particular accounting policies which materially affect the measurement of financial performance and the financial position have been applied.

(a) Goods and Service Tax (GST)

All items in the financial statements are exclusive of GST with the exception of receivables and payables which are stated with GST included. The net amount of GST payable is

included as part of payables in the Statements of Financial Position. In the statements of cash flows, GST on receipts and GST on payments are offset to present a net amount of GST paid and included as an operating expense. Where GST is irrecoverable as an input tax then it is recognised as part of the related asset or expense.

(b) Basis of consolidation

Subsidiary

The consolidated financial statements include those of ADHB and the Auckland District Health Board Charitable Trust. The Auckland District Health Board Charitable Trust is accounted for using the purchase method, which involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis. The ADHB Charitable Trust is consolidated as Auckland DHB has the power to appoint and remove Trustees. All significant inter-entity transactions are eliminated on consolidation.

Associates

Associates are entities in which Auckland DHB holds an interest in the equity and over which ADHB exercises significant influence but does not control. The interest in associates is reflected in the consolidated financial statements on an equity accounting basis, which involves recognising Auckland DHB's share of the associate's surplus or deficit in the consolidated Statement of Financial Performance and ADHB's share of the net assets of the associate in the consolidated Statement of Financial Position. Investments include shares in associates valued at cost, Auckland DHB's share of the retained post-acquisition changes in reserves of associates and loans to associates. Auckland DHB's share of the retained post-acquisition changes in reserves of associates are included in the consolidated financial statements only.

(c) Employee entitlements

Employee entitlements include liabilities for salary and wages, annual leave, long service leave and retirement gratuities accrued to employees for services rendered up to balance date. In determining the value of employee entitlements, salary and wages and annual leave are calculated on an actual entitlement basis whilst the other entitlements are calculated on an actuarial basis at current rates of pay.

(d) Taxation

Auckland DHB is a public authority under New Zealand Public Health and Disabilities Act 2000 and is exempt from Income tax under section CB3 of the Income Tax Act 1994.

(e) Foreign currency

Transactions denominated in foreign currencies (other than forward contracts) are translated at the rate of exchange ruling at the transaction date. Short-term transactions covered by forward exchange contracts are measured and reported at the forward rates specified in the contracts. At balance date foreign monetary assets and liabilities are translated at the closing rate and exchange differences arising from the translations are recognised in the statement of financial performance.

Where a foreign monetary asset is designated as a hedge of a transaction denominated in a foreign currency, the exchange difference arising from their translations is recognised in the statement of financial performance.

(f) Accounts receivable

Accounts receivable are stated at expected realisable value after providing for doubtful and uncollectable debts.

(g) Inventories

Inventories are valued on the basis of the lower of cost, determined on a first-in first-out basis, and net realisable value. This valuation includes allowances for slow moving and obsolete inventories.

(h) Leases

Finance leases, which effectively transfer to the entity substantially all of the risks and benefits incident to ownership of the leased item, are capitalised at the lower of fair value of the leased property, and the present value of the minimum lease payments. The leased assets and corresponding liabilities are recognised in the statement of financial position and the leased assets are depreciated on a straight line basis over the period the entity is expected to benefit from their use.

Operating lease payments, where the lessors effectively retain substantially all the risks and benefits of ownership of the leased items, are charged as expenses in the periods in which they are incurred.

(i) Revenue recognition policy

Ministry of Health contract revenue and interest income are recognised on an accrual basis. Other operating revenue is recognised on invoice or receipt for delivery of service, whichever is earlier.

Donations and bequests received are treated as revenue on receipt, in the statement of financial performance. These funds are administered by the Auckland District Health Board Charitable Trust.

Donations and bequests from third party trusts are recognised as revenue only when actually receipted.

(j) Funds held in trust

Funds held on behalf of patients and the Ngati Whatua Trust Board are treated as a non-current liability “Funds held in trust” and are distributed to them as required.

(k) Research projects

Research costs are recognised in the statements of financial performance as incurred. Grants received in respect of research projects are recognised in the statements of financial performance on an accrual basis, i.e. when research objectives have been met.

(l) Financial instruments

As a guardian of public money, Auckland DHB must be risk averse and seek to minimise exposure arising from its treasury activity. Auckland DHB is not authorised by Treasury policy to enter into any transaction, which is speculative in nature. Financial instruments carried on the Statement of Financial Position includes cash and bank balances, receivables, payables and borrowings. These instruments are generally carried at their estimated fair value.

Investments in bonds are recognised at market value at balance date. Gains or losses on the investments are recognised in the Statement of Financial Performance. Auckland DHB is also party to financial instruments that are not recognised in the financial statements. These include interest rate swaps and forward exchange contracts. Their primary purpose is to reduce exposure to fluctuations in foreign currency exchange rates and interest rates. Any gains or losses arising from exposure to these instruments are offset against the related gains or losses on the assets or liabilities being hedged. The net differential paid or received on interest swaps is recognised as a component of interest expense or interest revenue over the period of the agreement.

(m) Land and Buildings

Land and buildings are recorded at fair value less accumulated depreciation on buildings.

The building assets of Auckland DHB are considered to be specialised assets and accordingly are valued where appropriate based on depreciated replacement cost (fair value) less accumulated depreciation. Valuations have been obtained through an independent valuer.

(n) Property Plant and Equipment

There are eight classes of fixed assets:

Freehold land

Leasehold land

Plant, equipment, computer software, vehicles	Work in progress
Freehold buildings	Leased plant and computer equipment
Building Fitout	Property intended for sale

Items of property, plant and equipment are initially recorded at cost.

Revaluations are carried out for most classes of property, plant and equipment to reflect the service potential or economic benefit obtained through control of the asset. Revaluation is based on the fair value of the asset. Where an asset is recorded using depreciated replacement cost, depreciated replacement cost is based on the estimated present cost of construction, reduced by factors for age and deterioration of the asset.

Classes of property, plant and equipment assets that are revalued, are revalued at least every five years.

For each property, plant and equipment asset project, borrowing costs incurred during the period required to complete and prepare the asset for its intended use are expensed.

Work in progress, which is not depreciated, is the cost of direct material, direct labour and direct overhead of capital works projects unfinished at balance date. When a project is finished the total cost of that project is transferred to buildings and/or plant and equipment.

The carrying amounts of all property, plant and equipment are reviewed on an ongoing basis. Any impairment in value is recognised immediately in the Statement of Financial Performance. If the recoverable amount of an asset is less than the carrying amount, the item is written down to its recoverable amount. The write down of an asset recorded at historical cost is recognised as an expense in the Statement of Financial Performance.

The carrying amount of an asset that has previously been written down to recoverable amount is increased to its current recoverable amount if there has been a reversal of the impairment loss. The increased carrying amount of the item will not exceed the carrying amount that would have been determined if the write down to recoverable amount had not occurred. On assets that are not revalued the reversal is recognised in the Statement of Financial Performance. On revalued assets the reversal is recognised as revenue to the extent that the impairment was recognised as an expense, and the balance is treated as an upward revaluation.

Gains and losses on disposal of property, plant and equipment are recognised as revenues or expenses in the Statement of Financial Performance.

Properties intended for sale are carried at the lower of cost and net realisable value.

(o) Depreciation

Depreciation of property, plant and equipment, other than land and work in progress, is calculated on a straight line basis so as to allocate the cost of the assets, less their estimated residual values, over their useful lives as follows:

Freehold buildings	1 to 89 years
Plant, equipment, computer software and vehicles	2 to 20 years
Building Fitout	1 to 45 years
Leased plant and equipment	4 to 8 years

(p) Changes in accounting policies

There have been no changes in accounting policies during the year.

All accounting policies have been applied on a basis consistent with previous years.

(q) Comparatives

Where necessary, comparative information has been reclassified to achieve consistency in disclosure with the current year.

6.2 Financial Statements

Statement of Financial Performance for the year ended 30 June 2005

	2002-03 Actual $'000	2003-04 Actual $'000	2004-05 Budget $'000
REVENUE			
Ministry of Health			
Base - Provider	546,502	596,644	636,876
Base - Governance	2,129	2,648	2,824
Base - Funder	220,478	379,510	407,843
Other Contracts	46,328	48,012	38,389
	815,437	1,026,814	1,085,932
Other Revenue			
Inter Provider Revenue	1,417	1,988	1,709
Other Patient Care Revenue	21,093	23,145	21,135
External Revenue	55,708	59,171	48,429
	78,218	84,304	71,273
TOTAL REVENUE	893,655	1,111,118	1,157,205

OPERATING COSTS			
Employee Costs	469,363	492,061	493,798
Treatment Costs	144,559	164,852	153,610
Funder Payments	220,719	362,082	422,901
Property & Equipment Maintenance	40,931	50,508	53,177
Administration	20,542	21,575	16,813
TOTAL OPERATING COSTS	896,114	1,091,078	1,140,299
OPERATING SURPLUS/(DEFICIT)	(2,459)	20,040	16,906
Depreciation, interest & capital charge			
Depreciation	29,725	44,095	54,700
Interest	4,662	13,513	20,037
Capital Charge	13,869	17,353	17,900
	48,256	74,961	92,636
Other Contributions			
Associates	660	132	-
Charitable Trust	558	1,403	2,200
Surplus on Sale of Assets	(208)	8,723	6,975
	1,010	10,258	9,175
NET DEFICIT FOR THE YEAR	(49,705)	(44,663)	(66,556)
Other Costs			
Asbestos Removal			11,395
Mental Health Underspend			5,30
TOTAL DEFICIT FOR THE YEAR	(49,705	(44,663)	(83,251)

Statement of Financial Position as at 30 June 2005

	2002-03 Actual $'000	2003-04 Actual $'000	2004-05 Budget $'000
Current Assets			
Cash and bank balances	24,780	28,910	140
Receivables and Prepayments	86,117	91,191	95,018
Inventories	5,912	7,793	7,800
	116,809	127,894	102,958
Non Current Assets			
Cash, bank balances and investment bonds	8,148	9,711	11,911
Property, Plant and Equipment	469,846	544,303	614,916
Investment in associates	122	254	253
	478,116	554,268	627,080

Total Assets	594,925	682,162	730,038
Current Liabilities			
Payables and accruals	178,562	176,573	187,190
Borrowings	123,133	41,656	32,106
Funds held in trust	710	743	743
	302,405	218,972	220,039
Non-Current Liabilities			
Payables and accruals	12,614	11,825	11,450
Borrowings	120,889	274,233	315,000
	133,503	286,058	326,450
Total Liabilities	435,908	505,030	546,489
Equity			
Public Equity	461,068	523,846	613,518
Accumulated deficit	(309,655)	(355,721)	(438,976)
Donations and bequests	7,604	9,007	9,007
	159,017	177,132	183,549
Net Assets	594,925	682,162	730,038

Statement of Cash Flows for the year ended 30 June 2005

	2002-03 Actual $'000	**2003-04 Actual $'000**	**2004-05 Budget $'000**
CASH FLOW FROM OPERATING ACTIVITIES			
Cash was provided from			
Provision of health services	872,895	1,118,298	1,156,158
Interest received	2,837	1,898	710
	875,732	1,120,196	1,156,868
Cash was applied to			
Employee costs	465,779	491,486	464,877
Other operating costs	413,116	647,291	708,294
Interest paid	4,526	12,820	19,965
	883,421	1,151,597	1,193,136
Net cash inflow/(outflow) from operating activities	(7,689)	(31,401)	(36,268)
CASH FLOW FROM INVESTING ACTIVITIES			
Cash was provided from			

Proceeds from sale of fixed assets	36	19,023	6,975
Payments received from associates	2,560		
	2,596	19,023	6,975
Cash was applied to			
Purchase of fixed assets	189,121	112,600	118,162
Interest capitalised on purchase of fixed assets	7,432	3,974	-
	196,553	116,574	118,162
Net cash inflow/(outflow) from investing activities	(193,957)	(97,551)	(111,187)
CASH FLOW FROM FINANCING ACTIVITIES			
Cash was provided from			
Proceeds from capital contributed	123,180	62,778	89,668
Proceeds from loans raised	91,582	71,867	31,217
	214,762	134,645	120,885
Net cash inflow/(outflow) from financing activities	214,762	134,645	120,885
MOVEMENT IN CASH AND BANK BALANCES			
Add opening balance	19,812	32,928	38,621
Net cash inflow/(outflow)	13,116	5,693	(26,570)
CLOSING BANK BALANCE	32,928	38,621	12,051

6.3 Key assumptions included in the budget

Revenue

Ministry of Health - Base contract

Revenue from the base contract, inclusive of inter-district flows, has been built into the Annual Plan based on advice from the Ministry of Health.

Ministry of Health - Other contracts

Other major contracts outside the base contract include Public Health Funding and Disability Support Directorate Funding and have been built into the plan based on advice from the Ministry of Health.

Other patient care revenue

The major components of this category are non resident patient revenue and ACC revenue. The main reason for the fall in this revenue is a decline in non resident revenue caused by a fall in volumes within children’s and women’s health.

External revenue

The major components of this category are sales to external parties, donations and clinical training and education revenue. The major reasons for the fall in this revenue is a decline in donations following the completion of the building programme, the loss of car park revenue following the sale of the licence, and the non recurrence of provision releases.

Operating costs

Employee costs

Employee costs account for approximately 68 percent of our operating costs exclusive of the funder payments. Auckland DHB has attempted to stay within the Ministry guidelines of a 3 percent increase in employee costs.

Budgets have been set using cost of living allowances of 2 percent. Additional allowance for wage creep has been made ranging between 0.5% and 2.6% depending on the staff group.

As is set out in the table below there will be little movement in FTE numbers at a provider arm level after due allowance has been made for temporary staff, overtime and medical fees for service.

Auckland DHB FTE analysis (including temp staff, overtime and medical fees for service)

By staff group	Adjusted Mar 02	Jun 04 Actual	Jun 05 Budget
Medical	857	880	946
Nursing	2,566	2,517	2,564
Technical	1,187	1,173	1,283
Hotel Services	360	281	281
Administration	1,380	1,496	1,372
Vacancy assumption			(109)
Total Provider Division (excl. mental and public health)	6,350	6,347	6,337
Mental Health	576	572	623
Public Health	153	165	172
Total ADHB	7,079	7,084	7,132

FTEs included in the above figures	Adjusted Mar 02	Jun 04 Actual	Jun 05 Budget
Temporary staff	67	164	40
Medical Fees for Service	-	2	3
Overtime	80	60	-
Total	147	226	43

Notes
Temp Staff FTEs have been calculated on a monthly cost of $5,000 per FTE
Medical Fees for Service FTEs have been calculated on a monthly cost of $16,000 per FTE
Equivalent Overtime FTEs have been taken from the monthly reports provided by Payroll Services for ACH
Temp Staff FTEs for June 2004 appear to be inflated by 50 FTEs approx due to accruals for financial year end. This would have a large impact on the Support Services figure for this month.

Auckland DHB will however face significant challenges in containing its employee costs given the following factors:

- Passing of the Holidays Act 2003
- Settlements of Collective Agreements above budget

Auckland DHB has set itself a number of challenging savings targets in terms of:

- Management of vacancies
- Staff efficiency initiatives
- A review of Management and Administration roles
- A continuing search for efficiencies

Allowance has been made for these elements and has been factored into the employee cost line.

Treatment costs

At face value the 2004-05 budget for treatment costs shows a reduction of $11.2 million relative to the 2003-04 result. Realistically the scale of the saving is significant as typically the underlying price, quality and technology cost increases run between 5 and 10 percent across the sector. Managing this risk is a considerable risk to the Auckland DHB deficit. Management has focused its monthly reporting on this area of risk and has mitigation strategies in place to reduce its impact.

Funder Payments

Based on an analysis of prior year trends plus an allowance of 3%. In addition allowance has been made for the spending of the Mental Health surplus carried forward from the 2003-04 year of $5.374 million.

Property and Equipment Maintenance

a) Utility costs associated with new buildings

Allowance has been made in the budget for the increased cost of utilities in operating the new facilities. These include allowances for additional cleaning, security, electricity, gas and maintenance.

b) Asbestos

During refurbishment loose asbestos fibres have been found in the general dust collected on the ceilings tiles of the Support Building (old Auckland Hospital) and the Building 4 (old Green Lane Hospital). These residues are remnants of asbestos removal efforts in the 1980s and early 90s and are mixed in with dust collection deposited over decades.

The full cost of the removal of asbestos totalling some $11.395 million will be written off during the 2004-05 year in accordance with generally accepted accounting principles, as it is a known liability.

Administration

Based on prior year trends plus an allowance of 3%, but also allowing for savings opportunities. The main driver of the decrease between 2003-04 and 2004-05 is lower consulting fees as a result of the wind down of the Building and Change Programmes.

Depreciation

The primary driver of the increase in depreciation is the impact of the completion and capitalisation of the new facilities and associated clinical equipment.

Interest

The policy of interest capitalisation is to be discontinued in the 2004-05 year in accordance with Treasury instructions. Details of the interest capitalisation policy and the effect of the change of policy are detailed in 12.3.

Capital charge

Allowance has been made for the capital charge at the rate of 11 percent per annum on the Crown equity balance for each year.

Charitable Trust Contribution

An assumption has been made for the receipt of donations from the A+ Charitable Trust of $2.2 million. The main donations allowed for are:

	$'000
Clinical Education Centre	$1,000
Consumer Health Information Centre	$500
Other donations	$100
	$1,600

The balance of the contribution by the trust 0.6 million will come from interest earned on deposits held by the Trust.

6.4 Issues associated with the budget

Valuation of assets

The Board commissioned a valuation of the freehold land and buildings and fit out set out above by Teifer Young as at 30 June 2003. The Board has used this valuation as a basis for assessing the fair value of those assets as $396 million (2003: $133 million). The valuation exercise is indicative as there are issues to be resolved surrounding restrictive covenants over key parcels of land which affect Auckland DHB's ability to sell that land.

The valuation exercise is not complete as there are issues to be resolved surrounding these restrictive covenants.

Capitalisation of interest

It is Auckland DHB's policy to capitalise borrowing costs as part of the cost of an asset. It does this by applying a capitalisation rate to expenditure on the acquisition, construction or production of assets that require a substantial period of time to get them ready for their use. DHB defines a major project to be one of $5 million or more in value.

Treasury has instructed Crown entities to expense interest rather than capitalise interest costs with effect from 1 July 2003. If this policy was implemented then the Financial Reporting Standard & (FRS7) would require Auckland DHB to expense in the 2004-05 year, all interest capitalised to 30 June 2004. This amounts to $15,143,000. This one impact would increase the deficit in the 2004-05 year and impact on banking covenant ratios in that year and would necessitate further equity from the Crown in order to maintain banking covenant compliance.

The Auckland DHB has made a submission to the Ministry of Health and Treasury that it be permitted to continue with its existing treatment until the building programme is completed to keep consistency with its financial treatment. At this stage in view of the impending revaluation of assets this one off impact will not occur.

Capital

Capital expenditure for the period of this Annual Plan, including the Building Programme comprises the following.

Asset class	2004-05 budget $'000
Building Programme - Buildings	57,540
Building Programme - Equipment	21,333
Baseline - National Women's Refurbishment	3,000
Baseline - Plant & Equipment	10,720
Baseline - Prior Year's Commitments	12,900
Oncology - Linear Accelerator	3,210
Information Systems	16,291
	124,994

Oncology equipment

Auckland DHB has the regional contract for the provision of oncology services. Due to the demand for oncology services there has become a need to replace equipment and purchase new equipment to meet the volumes. This equipment will be funded from free cash flow.

Assets to be sold

Approval will be required from the Ministry to ensure that the planned sale of the Greenlane land and buildings in 2004–05 will eventuate. Provision for a one time gain of $6.975 million has been made in the budget.

Other assets

The majority of the vehicle fleet are covered by operating leases. The small number of vehicles that are owned will be placed on operating leases at the end of their useful life. No renewals are planned for 2004–05. The majority of IT hardware is covered by an operating lease. The cost benefit analysis of owning versus leasing has been completed and there will be a gradual move over time back to a position of owning IT hardware.

6.5 Treasury

Debt profile

The debt profile is within total facilities of $380 million comprising bonds issued of $120 million, Crown Financing Agency facilities of $195 million and a working capital of $65 million. With the completion of the building programme and associated equipment fit out, capital

expenditure will reduce and free cash flows in excess of the depreciation change will provide funds to commence repayment of borrowings.

Equity support

The Crown provided a Letter of Comfort in October 2004, undertaking to provide sufficient equity support to ensure that the Auckland DHB complies with covenants constrained in present debt funding arrangements. It is assumed that similar undertakings will be provided by the Crown in future years.

Funding structure

The equity and debt required to sustain the Auckland DHB plan over the three years of the forecast has been included in the three-year plan.

Statement of Movement in Equity for the year ended 30 June 2005

	2002-03 Actual $'000	2003-04 Actual $'000	2004-05 Budget $'000
Equity at beginning of the period	85,542	159,017	177,132
Net deficit for the year	(49,705)	(44,663)	(83,251)
Equity Injections			
Deficit Support	56,300	35,000	71,250
Building Programme	66,880	27,778	18,418
	123,180	62,778	89,668
Equity at end of year	159,017	177,132	183,549

There have been changes in lenders, limits and borrowing arrangements. The following banking covenants and ratios apply.

Lender	Covenant	Ratio
The covenants and ratios apply to all of the following funders: MBIA and the bondholders Crown Financing Agency Term Debt ASB Bank working capital facility.	Interest cover Debt: debt and equity ADHB total assets to total group assets Annual and six-monthly reporting requirements	>2. < = 65% >95% N/A

The balance sheet and interest cover ratios have been calculated for the period of this plan. The final equity injections required to sustain Auckland DHB's financial viability are a matter of negotiation with the Crown as owner.

Balance Sheet Ratio

	2002-03 Actual $'000	2003-04 Actual $'000	2004-05 Budget $'000
Current Portion	123,133	41,656	32,106
Non Current Portion	120,889	274,233	315,000
Total Debt	244,022	315,889	347,106
Equity	159,017	177,132	183,549
Total Debt plus Equity	403,039	493,021	530,655
Ratio of Total Debt to Debt plus Equity	60.55%	64.07%	65.41%

Interest Cover for Banking Compliance

	2002-03 Actual $'000	2003-04 Actual $'000	2004-05 Budget $'000
Net deficit for the year	(49,705)	(44,663)	(83,251)
Trustee's Income - A+ Charitable Trust	(558)	(1,403)	(2,200)
Depreciation	29,725	44,095	54,700
Capital Charge	13,869	17,353	17,900
Interest Paid after Capitalised Interest	4,662	13,513	20,037
Earnings Before Interest, Tax & Depreciation - EBITD	(2,007)	28,895	7,185
Interest Paid	4,662	13,513	20,037
Ratio of EBITD to Interest Paid	(0.43)	2.14	0.36
EBITD Required	9,324	27,026	40,074
EBITD Actual	(2,007)	28,895	7,185
Surplus/(Shortfall)	(11,331)	1,869	(32,888)
Subsequent Equity Introduced	26,194	17,027	33,000
	14,863	18,896	112

6.6 Disposal of Land

In accordance with the provisions of the New Zealand Public Health and Disability Act, Auckland DHB will not dispose of any land without having first consulted with the Minister and obtained her consent to do so.

In keeping with previous agreements with the Crown, the Auckland DHB will release funds from the sale of a number of properties in the 2003-04 period. It is also proposed to licence the Auckland DHB car parks for a 20-year period with an expected realisation of $15 million. This licence agreement will reduce future income. This reduced income has been reflected in

the forecast for outer years. The sale of the surplus land at Greenlane is planned for 2004-05.

6.7 Procedure for buying shares

Auckland DHB will seek the consent of the Minister of Health before acquiring any shares or interest in a body corporate or association of persons as required by s28 of the New Zealand Public Health and Disability Act 2000 and using the process set out in CAB(00)M 32/2A(1).

Auckland DHB plans to establish a retail pharmacy in its facilities. This will require the establishment of a company that will be at least 75 percent owned by a pharmacist to meet the requirements of the Pharmacy Act. We will contract with this company to provide the dispensing services. Approval for this investment is being sought from the Minister.