



Auckland District Health Board

Statement of Intent

For the year ending 30 June 2006

February 2006

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The 2005–06 Statement of Intent for the Auckland District Health Board

Signatories

This 2005–06 Statement of Intent is signed for and on behalf of the
AUCKLAND DISTRICT HEALTH BOARD

Wayne Brown
Chairman

Date

Ross Keenan
Deputy Chair

Date

1. Introduction

1.1 Legal Requirements

This Auckland DHB Statement of Intent sets out the organisation's intentions and objectives for the year ending 30 June 2006. 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 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 Strengthening the population based approach

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.

The local population is characterised by a great diversity of cultures, including people from 181 different ethnic groups. Of these approximately 8% are Maori; 12% Pacific; and 80% New Zealand European/other ethnic groups.

From 2001 (the last census) the Auckland DHB population has continued to grow at approximately 2% per year. Compared to other District Health Boards in the Auckland region, Auckland DHB experienced the greatest relative growth in the period to June 2003 and the second greatest relative growth to June 2004.

The majority of people living in the Auckland DHB area (70%) are working age adults (15-64 years). When examined by ethnicity, Maori and Pacific peoples have a very young population with about 50% aged under 24 years and less than 5% aged 65 years and older.

Evidence links lower socio-economic status to inequalities in health status. Dep2001 is an index of deprivation, combining nine census variables from the 2001 census that reflect aspects of material and social deprivation. This index applies to an area, rather than to individual people. The scale of deprivation ranges from one to 10, where one represents the least deprived areas, and 10 the most deprived areas in New Zealand.

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.

Auckland DHB will need to exercise innovation and flexibility in future planning to address socio-economic differences in health status and to meet the future needs of the changing population.

It is anticipated that the Auckland DHB population will be 585,100 by 2016. From 2001-2016, the ethnic composition of the population is also expected to change over time. Statistics New Zealand population projections indicate that growth is expected in the proportion of Asian peoples in the population, and a reduction in the proportions of European, Maori and Pacific peoples.

Reflecting the high level population projections, in the period to 2016, the proportion of Asian peoples is projected to increase by 154%. By 2016, it is projected that approximately half (48%) of the Auckland DHB population will identify as European (64% in 2001); 33% as Asian (18% in 2001); 7% as Maori (8% in 2001); and 12% as Pacific peoples (13% in 2001).

During the period 2001- 2016, the greatest increase in numbers will be among those aged 40-64 years, resulting in approximately an extra 54,000 people. There will be smaller increases in the number of those aged over 65, under 15 years, and between 15-39 years. The greatest proportion of the population will be aged 40-64 years. However, the Auckland DHB population will experience a reduction in the overall proportion of 15-39 year olds and those aged under 15 years. In contrast to other parts of the Auckland region and the rest of New Zealand where the proportion of those aged over 65 is growing, the proportion of older adults in the Auckland DHB area remains relatively constant.

An investigation of the Auckland DHB population health needs will be undertaken during 2005, and further information about health needs, health service use, and opportunities to address health inequalities will be disseminated during 2005.

1.3 Implementing the Treaty of Waitangi

Auckland DHB recognises and respects 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 improvement¹. This is in order to recognise and respect the principles of the Treaty of Waitangi in order to improve health outcomes for Maori. References to the Treaty of Waitangi in this document derive from, and should therefore be understood, in this context.

As a Crown Entity Auckland DHB will demonstrate how Treaty responsibilities are managed within the health sector by our commitment to the principles of Partnership, Participation and Protection. These principles are outlined by the Ministry of Health to provide direction to the health sector and form the basis of the Auckland DHB Bicultural policy². Some of the processes we have established are in the form of Partnership agreements and relationships with manawhenua including the formation of the Maori Health Advisory Committee³. 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 and these are incorporated in all aspects of this plan. 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

1 NZ Public Health and Disability Act 2000 provisions: Sec 29(4) requirement that a certain proportion of any DHB board shall be Maori. Sec 29 (4) Maori representation on advisory committees. Sec 23 (1) (d) establishment of processes to enable Maori contribution to strategies for health improvement. Sec 22(1) (e) reduce health disparities by improving health outcomes for Maori. Sec 23 (1) (e) fostering the development of Maori capacity in health and disability sector. Sec 23 (1) (f) to provide relevant info to Maori for these purposes.

2 Auckland DHB Bicultural policy reviewed May 1999.

3 Auckland DHB Maori Health Advisory Committee Established in 2003 comprises of 3 members from Ngati Whatua and 3 members from the Auckland DHB. The committee reports to the Auckland DHB Community and Public Health Advisory Committee.

Memorandum of Understanding outlines key principles, processes and protocols for working together at both governance and operational levels.

The role of Tihi Ora MAPO is to support and uphold the kotahitanga, the tino rangatiratanga and manaakitanga responsibilities for the rohe of Ngati Whatua. Tihi Ora will provide, definition and precision specific to the needs of Maori and will ensure that the Auckland District Health Board delivers a fair share of health resources to meet these needs.

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.

The table below shows how we implement the principles of the Treaty.

<p>Partnership</p> <p>Manawhenua, are partners with ADHB at the governance level</p>	<p>Memorandum of Understanding with Te Runanga o Ngati Whatua and its health operational arm Tihi Ora MAPO.</p> <p>Formation of the Auckland DHB Maori Health Advisory Committee.</p> <p>Ensure that Ngati Whatua, as manawhenua, is partners with ADHB at the governance level. This health partnership ensures the active protection of Maori interests in health planning and funding.</p> <p>Meaningful consultation with Maori and involvement in planning health and disability services. ADHB as an agent of the Crown will continue to engage with Maori regarding the impact service changes may have on Maori communities and organisations.</p>
<p>Participation</p> <p>Maori engagement in planning, development and delivery of health and disability services</p>	<p>Responsible and responsive to Maori communities in our district and those who use our services.</p> <p>Active involvement of manawhenua and mataawaka communities in identifying health needs, in providing health services and in our plans to improve health and disability services.</p> <p>Maori provider development.</p>
<p>Protection</p> <p>Maori enjoy the same level of health as non-Maori</p> <p>Safeguard Maori cultural concepts, values and practices</p> <p>Services will meet the</p>	<p>Commitment to the Maori Health Strategy, He Korowai Oranga and other national policy.</p> <p>Inequalities framework and the health inequalities impact assessment tool.</p> <p>The national prioritisation framework which brings Treaty principles into a decision making tool.</p> <p>We recognise the need for equity of participation, access and outcomes for all Maori.</p>

rights/rites, needs, interests and aspirations of Maori	Adhere to the Auckland DHB Tikanga Best Practice Policy to protect the rites of Maori, respect the tikanga of manawhenua and practically contribute to providing services that are responsive to Maori needs and interests.
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He Kamaka Oranga, the Maori Health team is responsible for policy development, planning and funding, provider management, quality, clinical leadership and Tikanga Maori. The team also provides assistance in managing Treaty of Waitangi risks as a result of its monitoring and evaluation processes. All Auckland DHB services are expected to implement their responsibilities towards Maori in our district via performance objectives listed in this plan.

A Memorandum of Understanding has been agreed between Hapai Te Hauora Tapui and Auckland Regional Public Health Service. Both parties are committed to enhancing an environment of responsiveness to the Treaty of Waitangi partnership locally, regionally and nationally. The Memorandum of Understanding provides the guiding relationship principles between the two parties, in the intention to achieve improved public health outcomes of all Maori who reside in the Auckland Region.

2. Nature and Scope of Activities

2.1 Governance and Management

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.

The NZ Public Health and Disability Act 2000 established District Health Boards and statutory advisory committees to ensure that the community has a voice in health and disability service planning and funding. Boards have eleven members, seven of which are elected during the three-yearly local body elections. The Minister of Health appoints four additional members and the Board's Chair. Boards are required to have two Maori representatives and in general should reflect the diversity of people and interests within the Auckland DHB area.

Wayne Brown (Chair)

Ross Keenan (Deputy Chair)

Tony Bierre*

Jackie Blue*

Harry Burkhardt

Barry De Geest*

Virginia Hope*

Di Nash*

John Retimana

Chris Chambers*

Ian Scott*

* Elected members October 2004.

The Board is responsible for funding health and disability support services and for reducing health disparities by improving health outcomes for Maori. The Minister of Health approves these activities and approaches through DHB Strategic and Annual Plans, the Statement of Intent and Crown Funding Agreement.

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 access, appropriateness and effectiveness of the services for Maori and Pacific people in order to reduce health inequalities
- Provision of public health services in collaboration with other Auckland DHBs through the Auckland Regional Public Health Service.

The Board is required to have three permanent advisory committees, each of which must provide for Maori representation.

Community and Public Health Advisory Committee	<p>This committee (CPHAC) provides advice on health gains and how to manage the interface between primary and secondary care. It advises on service option issues focused on 'what is best for the community'. The role of the committee is to provide advice to the Board:</p> <ul style="list-style-type: none"> • on the health status of the Auckland DHB population • to prioritise the use of health funding provided • to ensure the overall health gain of the population is maximised <p>This advice must be consistent with the NZ Health Strategy.</p>
Disability Support Advisory Committee	<p>This committee (DiSAC) advises the Board on issues facing people with disabilities and the priorities for use of disability support funding provided.</p>

Hospital Advisory Committee	The role of the Hospital Advisory Committee (HAC) is to assess strategic issues and monitor the financial and operational performance of the hospitals and related services of the Auckland DHB.	
The Board has established other committees to provide advice.	Audit Committee	Monitors the financial performance of the Auckland DHB, liaises with external auditors and receives reports for the internal auditor.
	Quality Committee	Monitors clinical quality, patient satisfaction and accreditation of services
	Maori Health Advisory Committee	Consists of Board and Ngati Whatua representatives and monitors Auckland DHB obligations under the Treaty of Waitangi and the delivery of health services to Maori as well as tikanga best practice within services.

Board and Statutory committee meetings are open to the public and are notified in the New Zealand Herald. Meeting details are listed on the website www.adhb.govt.nz or are available on request from Ian Bell, Board Administrator (630 9943 extension 8077, or ibell@adhb.govt.nz).

Management

The organisational chart shows the basic structure with the funding and hospital (and related services) arms of the organisation and key relationships with Treaty partners and providers.

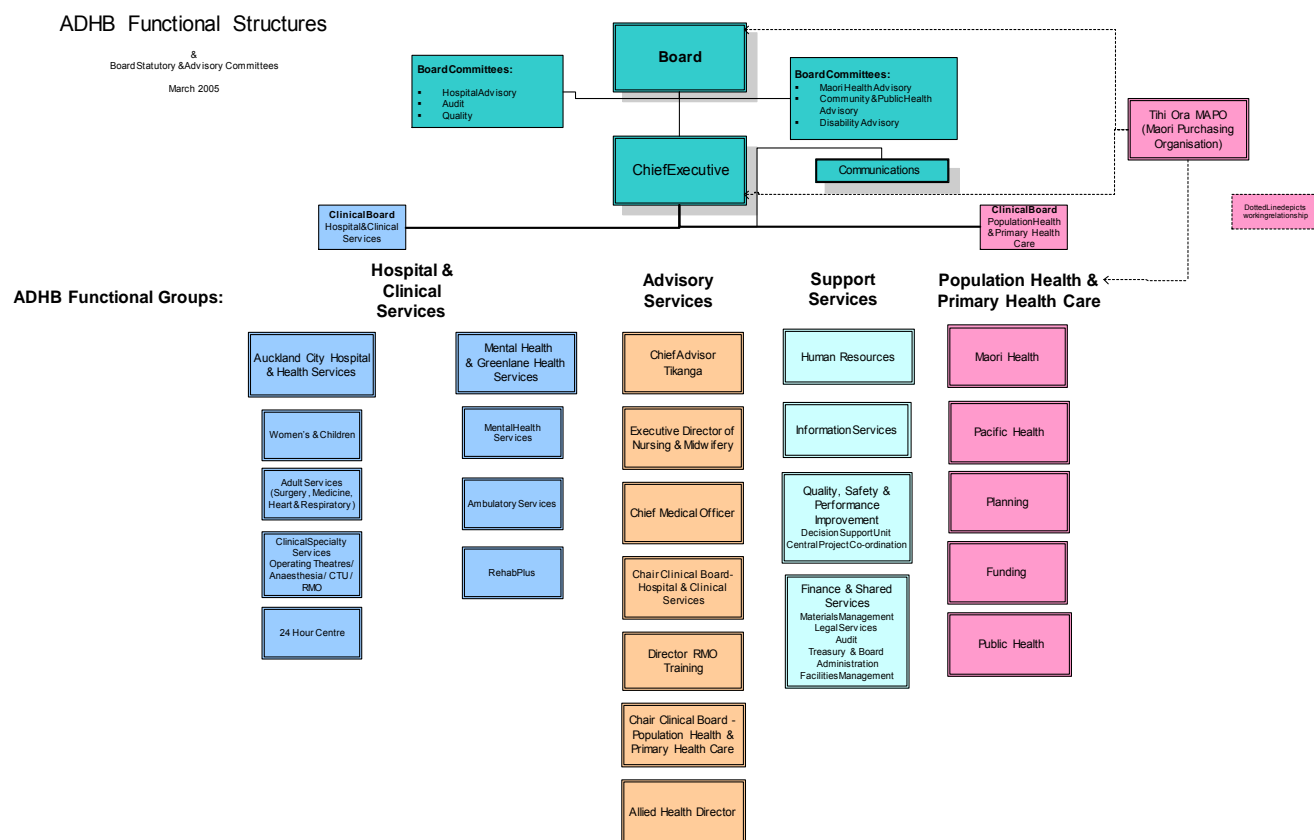
The hospitals (and related services) arm of Auckland DHB includes the Auckland DHB owned hospitals. The Auckland DHB hospital system has an arrangement with government to provide specialist services to people from other DHB areas and from other parts of New Zealand.

Funding for health services has been devolved across to the Auckland DHB although public health and disability services are currently funded directly from the Ministry of Health. Funding for the people of the district must comply with the Crown Funding Agreement, Ministry of Health national strategic plans (see Appendix 3), the NZ Health Strategy and the NZ Disability Strategy.

Auckland DHB works with the other two District Health Boards in the greater Auckland region, Counties Manukau and Waitemata. We also collaborate at a wider level through participation in national bodies such as joint working committees with the Ministry of Health and the various District Health Boards New Zealand (DHBNZ) committees and projects. This develops a regionally and nationally consistent approach to issues such as Population Based Funding, Inter District Flows, prioritisation approaches and the National Service Framework. It also ensures that developments in one area of health do not create problems for others.

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

The following organisational chart shows the functional structure of Auckland DHB and the basic structure which provides for a new way of working. It covers the basic funding and hospital (and related services) arms of the organisation and key relationships with Treaty partners, Clinical Board and some areas of service provision. Not represented in the chart is the Executive Team which 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.



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 a programme of change to ensure that the administrative and clinical systems and processes of the Auckland DHB are efficient and cost effective.

The structure outlined does not show the full organisational chart for hospital and community-based services. The business support roles are not shown in detail on this structure and are referred to as support services in the diagram above.

The Executive Team

Garry Smith	Chief Executive
Dr Nigel Murray	General Manager Auckland City Hospital
Dr Denis Jury	Chief Planning and Funding Officer
Warwick Russell	Interim Chief Financial Officer
Kay Hyman	General Manager Starship and National Women's Health
Fiona Ritsma	General Manager Clinical Specialty Services
Fionnagh Dougan	General Manager Greenlane Health Services and Mental Health Services
Andrew Norton	General Manager Human Resources
Trish Langridge	General Manager Quality and Performance Improvement
Taima Campbell	Executive Director of Nursing & Midwifery
Dr David Sage	Chief Medical Officer
Janice Mueller	Director Allied Health
Dr Allan Pelkowitz	Clinical Leader, Planning and Funding
Dr Stephen Child	Director Clinical Training
Margaret Dotchin	Nurse Director Adult Health Services
Aseta Redican	General Manager Pacific Health
Kris MacDonald	General Manager Maori Health
Steve Mayo-Smith	Chief Information Officer
Dr Margaret Wilsher	Medical Director Adult Health Services Auckland City Hospital

2.2 Funding and Planning**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.

Auckland DHB is funded on a population-based funding formula that is based on where people were living on census night. Adjustments are made for age, ethnicity and also for the amount of specialist work provided to people outside the area. Auckland DHB has a total revenue of approximately \$1.3 billion per year and funding of \$733 million for the Auckland DHB population.

Twenty four percent of total revenue is associated with non hospital services, the bulk of which is made up from Primary Health Organisations, pharmaceuticals and laboratory testing. There are over 1,000 contracts for privately owned services which also include residential services for older people and for people with a mental illness. There are a number of

Kaupapa services run by and for Maori and similar culturally based services for Pacific people. Dental services and palliative care are also provided in the community under contract to the DHB.

Other providers	ADHB hospital and community services	
Primary Health Organisations, GP services and nursing services Community-based health services Kaupapa Maori services Pacific health services Laboratories Community based pharmacies Dental health services Midwives/maternity services Residential care for mental health Rest homes Palliative care	Auckland City Hospital (Acute medical and surgical services) <ul style="list-style-type: none"> • Children and young people's services • Women's health • Surgical services • Cardiothoracic • Medical services • Nutrition Services • Emergency services • Acute mental health • Laboratory • Radiology • Pharmacy • Allied health • Clinical support • Clinical Genetics • Anaesthesia & OR • Clinical Engineering 	Greenlane Clinical Centre (Community, ambulatory & mental health services) <ul style="list-style-type: none"> • Rheumatology • Pain services • Sexual health • Diabetes management • Dermatology • Oral health • Immunology • Audiology • Mental health
	Regional Public Health services are owned by ADHB	

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.

The provider arm of the Auckland DHB provides over 55 percent of its 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 continue to expose the organisation to ongoing losses that cannot be retrieved through the population based funding or inter district flows projects.

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 constantly balance the demand for specialist services against our aim to contribute to health 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. Although the organisation is trying to manage a large deficit, the Board are committed to managing this through finding efficiencies and will only consider service cuts as a last resort. The prioritisation framework is therefore applied in situations where there is new money (the primary investment fund) or where we wish to reallocate resources from one area to another.

The three regional DHBs work closely together given the issues in common and the mobility of the greater Auckland population. Regional projects of high importance for the 2005–06 year include:

- Population based funding
- PHO development and investigation of cross boundary PHO development where this serves community interest
- Implementation of the national prioritisation process
- Participation in the regional public health steering group
- The impact of varying DHB capital structures on pricing
- Inter district flows – the working group continues on regional issues and links to the national work underway
- Regional provider configuration/Regional Service Planning – since 1996 the three DHBs have been planning on the basis of the delivery of secondary services locally and regional services by one provider
- ACC revenue – a project is underway to manage the costs associated with services provided to clients under ACC

- Community pharmacy and laboratory growth – continued growth in pharmaceuticals including wastage from non-compliance. The demographic adjuster for the district is used to absorb the overspend on demand driven laboratory and pharmaceutical services. Pharmacy project underway to reconfigure the spend in this area. The large private sector market in Auckland drives up laboratory and initial pharmaceutical costs.
- Regional standardisation of payroll and process for junior doctors.
- Non-resident bad debts.

2.3 Provider Arm/Hospital Services

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 \$733 million including all sources of revenue. Objectives and initiatives in this Statement of Intent are aligned to this output class.

Auckland DHB owns a provider arm which is made up of the Auckland City Hospital and the Greenlane Clinical Centre and their related community-based services. Hospital and related services owned by the Auckland DHB receive approximately 76 percent of the total budget. Sixty percent of this revenue is associated with staff costs, approximately 20 percent is related to treatment costs, with the remainder linked to equipment, capital, depreciation and administration.

Auckland DHB has completed a \$447 million building redevelopment to create a new hospital on the Grafton site which combines all acute services in one setting. The Auckland City Hospital includes services provided by Starship Children's Health and National Women's Health services (previously located on the Greenlane site).

The Greenlane Clinical Centre provides advanced day-care surgical hospital and comprehensive medical centre focusing on outpatient service, rehabilitation and hospital in the home services.

Auckland DHB operates New Zealand's largest public hospital provider with the following characteristics:

- A total operating revenue of approximately \$733 million, over half of which is obtained for services provided to people from other DHBs.

-
- Over 7000 staff with a full-time equivalent (FTE) of approximately 6,800 including bureau staff and paid overtime. This workforce comprises clinical, management and support staff in the hospitals and the corporate and support
 - Over two million patient contacts annually
 - A local hospital and outpatient services for approximately 431,510 people in Auckland
 - Tertiary services for about 1.3 million people in the northern and midland regions e.g. neurosurgery, clinical genetics and paediatric oncology
 - Over 50 percent of services are provided to people outside the district (interdistrict flows)
 - Arrangements to provide national tertiary services for New Zealand e.g. major organ transplants such as lungs and livers.
 - The only paediatric intensive care unit in the country that is used by all hospitals.
 - Major programmes underway for clinical effectiveness and for streamlining the use of the new facilities
 - 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 is the largest trainer of doctors in the country with approximately 1,200 doctors, 630 of which are in various stages of training (resident medical officers)
 - Auckland DHB is the largest clinical research facility in New Zealand and engages in work that attracts funding and participation from New Zealand and overseas
 - Provides retail Pharmacies on the Grafton and Greenlane Clinic Centre sites
 - Provides specialist services for New Zealand including:
 - organ transplant (heart, lung and liver)
 - acute massive pulmonary embolism transferred for thrombarterectomy or extra corporeal membrane oxygenation (ECMO)
 - acute major airway obstruction transferred for laser or stent placement
 - massive haemoptysis transferred for surgery or bronchial arterial embolisation
 - hepatic laceration requiring acute hepatic surgery
 - acute respiratory distress syndrome (ARDS) in adults or children requiring extra corporeal membrane oxygenation (ECMO)
 - paediatric Intensive Care Unit transfers
 - major head trauma requiring neurosurgery
 - high risk obstetrics
 - National Forensic Pathology Service (contract with Ministry of Justice)
 - National Newborn Screening Service (contract with National Screening Unit)

- Provides a number of tertiary services (e.g., neurosurgery, clinical genetics and paediatric oncology) for patients in the Northern and Midland regions
- Starship Children’s Health is a specialist paediatric centre that provides health services to children in Auckland city and tertiary and quaternary services to children throughout New Zealand. In addition to providing care, Starship advises other professionals and leads national guidelines.
- Acute services are provided together under one roof so patients can access the skills of multidisciplinary teams of specialists and specialist equipment
- Many conditions are now treated at day-care or outpatient centres so patients spend less time in hospital
- Major programmes are in progress within the Auckland DHB Hospital:
 - co-ordinating all treatment activities to enhance clinical outcomes
 - managing service contracting within the new Auckland DHB environment
 - co-ordinating the purchase of utilities, information services, equipment, supplies, and consumables
 - activities that ensure Treaty of Waitangi obligations are met across all programmes
 - achieving maximum efficiency through local, regional, or national service co-ordination
- Projects to integrate hospital services with services provided by primary health care e.g.:
 - streamlining processes relating to referrals and discharges
 - reducing admissions and readmissions for older people
 - reducing waiting times for mental health patients
 - implementing the booking system that creates certainty for patients needing elective surgery and manages their condition during the waiting time

3. DHB Objectives

Throughout 2005–06 the organisation will see through the hard decisions associated with the deficit to become a disciplined organisation. We are working closely with the Ministry of Health to understand and agree the root causes of our deficit and our plans to manage it. This includes independent benchmarking with other New Zealand tertiary DHB and a focus on the key areas running at a loss. In addition Auckland DHB is working with the other New Zealand tertiary DHBs to address common internal and external issues including national pricing and the application of tertiary adjuster funding.

The strategy for 2005-06 is to clearly separate those components of the deficit related to efficiency and issues that can be owned and addressed by Auckland DHB from those related to the sector issues (such as the cost of providing specialist tertiary services teaching and being a hospital of 'last resort').

The focus for the future continues to rest on the needs of our local Auckland City population and our funding must follow this direction. We will ensure the needs of the Auckland population are met and will attend to some of our services area where we are not performing well (e.g., intervention rates for elective services are less than the national average in areas).

Primary health care will continue to be a key are for future development. We now have six PHOs with approximately 90 percent of our local population enrolled. This includes Maori and Pacific led PHOs and we will continue to develop these PHOs.

In the next year we want continued PHO development with full participation of primary providers including, GPs, nurses, pharmacists, laboratories, lead maternity carers, etc. It is important that we are successful in having a sector wide focus on population health.

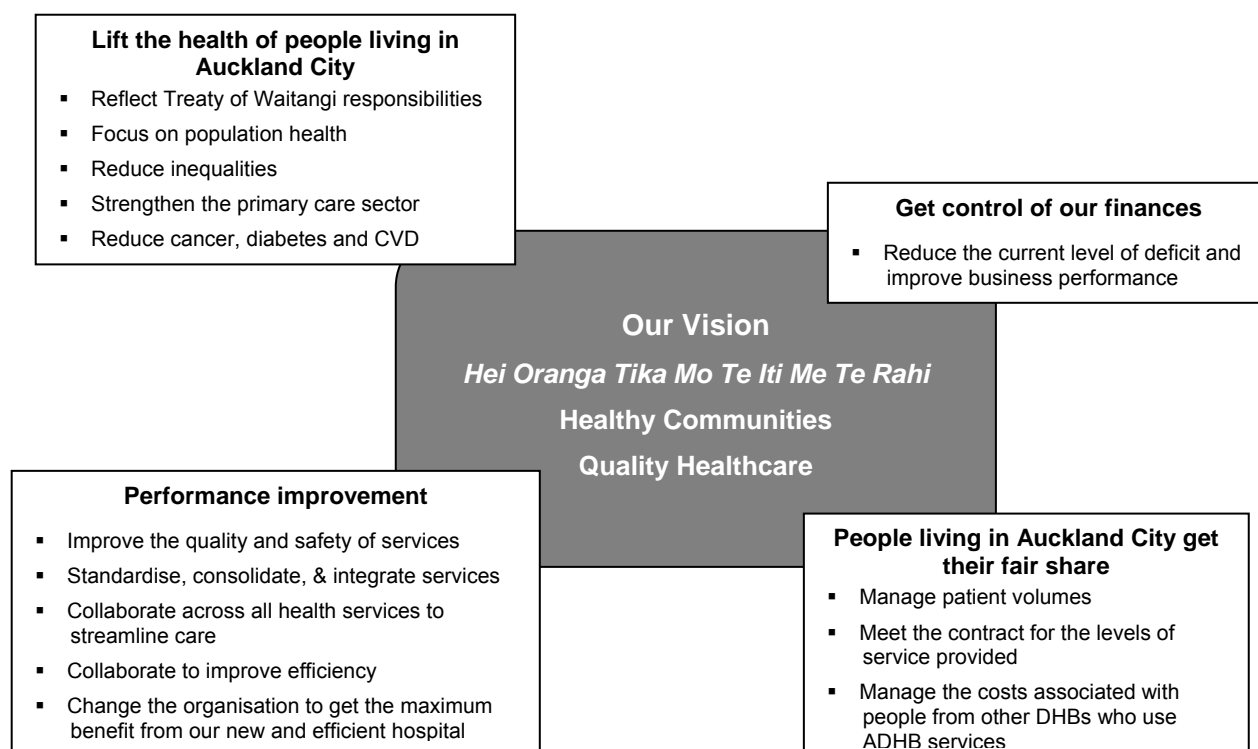
A strong arm of primary healthcare development will be on new models for integrating primary, secondary care for people with multiple and complex needs, particularly children, young people and, older people. Chronic disease management is also a priority especially for diseases such as diabetes and cardiovascular disease.

Strengthen operational management of PHOs including the development and implementation of PHO performance measures. Some projects and initiatives are sufficiently down the track to provide good feedback on successes and areas for improvement.

3.1 Four key goals

Auckland DHB objectives set out in this Statement of Intent are consistent with our District Strategic Plan and District Annual Plan for 2005-06, Government priorities and the Minister of Health's expectations. Auckland DHB has defined four goals to provide the strategic focus for these plans; all of which are concentrated around the population of Auckland city.

Auckland DHB Priority Goals



3.2 Get control of our finances

The financial year 2005-06 will continue to focus on reducing the manageable deficit. There has been a change to the planning and budgeting approach to address financial pressures. We will not accept the continued expansion of our cost base without the revenue to offset this. This approach which started in 2004-05 was one of the longest and most intense budget processes in Auckland DHB's recent history and was based on a bottom up exercise. We now have a realistic and achievable position for the 2005-06 financial year. An overall deficit target has been set for 2005-06 (and each of the subsequent planning years) and we will not vary from this.

Each service unit within our provider arm has been assigned revenue based on Auckland DHB funder and inter-district flow purchasing signals and given a target contribution to achieve. Services will be responsible for costs they can directly managed (e.g. direct treatment costs and salaries). All budgets are accompanied by specific plans that show how these will be achieved. The organisation will not accept variations from target budgets or any re-forecasting of budgets during the 2005–06 year.

General areas of responsibility

Provider arm	Funder arm	Support services
<ul style="list-style-type: none"> • Revenue will be set and budgeting will be to a specific operating surplus target (excluding infrastructure and non-clinical costs that service managers do not have control over). • Effort will be committed to developing approaches so that budget targets can be met and then operationally maintained. • Benefits of the current benchmarking process will be demonstrated within budgets. • Benefits of any performance improvement projects will be included. • Areas where there are significant losses will be addressed with corporate finance. 	<ul style="list-style-type: none"> • Budget to a breakeven position. • Address funding issues related to Disability Support Services. • Develop strategies for the management of demand driven services such as community laboratory and pharmaceuticals. 	<ul style="list-style-type: none"> • All services will budget to their current budget or, if less, the current actual expenditure. • Productivity gains are expected where current actual expenditure is greater than budget. • Benchmarking will be used to justify current expenditure. • Any benefits from improvement projects will be incorporated in the budgets.

Corporate finance is reviewing our overall financial performance to understanding where the significant losses lie compared to other tertiary DHBs. This work along with the benchmarking and other projects underway will help us meet budget targets. We need to better understand our problem areas, internal and external, and to address the root causes. We began this work in 2004–05 and will continue to build on this base.

Table of cost pressures and solutions

Problem	Solution
<p>Capital costs associated with the building programme have grown by \$50 million from the early to the mid part of the decade, and will continue for several years</p> <p>Costs include software which has also grown rapidly.</p>	<p>Understand the problem areas and address the root causes</p> <p>Build accurate, reliable budgets</p> <p>Set a top down budget and hold managers accountable for achieving the budget target</p>
<p>Project aimed at efficiencies</p> <p>Two significant projects relating to the Operating Rooms at Auckland City Hospital and Outpatient Administration Services at Greenlane Clinical Centre failed to deliver savings and have caused cost increases.</p>	<p>Resolve problems in the areas of Sterile Supplies, Outpatient Administration Services and Operating Rooms</p> <p>Achieve benefits from the reviews of: Senior Medical Officers and the research office</p> <p>Complete the community integration project</p> <p>Benchmark to show where Auckland City Hospital can improve efficiency i.e. comparing Auckland DHB with similar DHBs</p>
<p>Labour costs</p> <p>Wage growth is outstripping revenue growth (average of 5% wage growth in the sector compared to 2% revenue increase per annum).</p> <p>This has significant implications for productivity</p> <p>Employee numbers need to be actively managed</p>	<p>All new appointments reviewed by the senior executive group</p> <p>Staff numbers reviewed in the light of national benchmarks</p> <p>Projects underway to review major medical staff employee groups</p> <p>National project underway to review the negotiation and remuneration process for junior doctors</p>
<p>Management of new technologies</p> <p>Auckland DHB is under pressure to provide new drugs and treatments as they become available</p> <p>This creates increased direct treatment costs especially as Auckland DHB provides complex services to other DHBs</p>	<p>Direct treatment costs managed by a special project to review and implement improved control mechanisms including stock and</p>

Problem	Solution
<p>Growth in drug costs have a particular impact through the introduction of new treatments</p> <p>There is wide variation throughout the country on how decisions about new treatments are made and often different access between DHBs</p>	<p>supply management</p> <p>Auckland DHB will continue to advocate for a consistent and simplified process to determine which treatments are funded and who should receive them</p>
<p>Price and population based funding</p> <p>The pricing structure for Interdistrict Flows results in services being paid for twice. If Auckland DHB doesn't recover the full price of the service from other DHBs, the deficit is carried by Auckland DHB</p> <p>This issue is particularly relevant to Auckland DHB because of the high number of patients referred from other centres in NZ</p> <p>Auckland DHB has also had to manage the continued growth in the local population without demographic adjustment funding</p> <p>The National Benchmarking and Pricing Programme has been delayed in implementing findings</p>	<p>Work is currently being undertaken by the Ministry of Health and the national benchmarking and pricing project (DHBNZ)</p> <p>Auckland DHB will purchase service within the population based framework while accepting that this may result in service reduction in some areas</p>
<p>Funding for disability support services</p> <p>Homecare services are provided for patients who remain in their domicile. Because residential care beds are primarily clustered in the Auckland catchment, people over 65 years who require residential care are likely to move into the Auckland DHB area</p> <p>As a result, Auckland DHB continues to be responsible for managing contracts and covering the costs of services</p> <p>The funding model assumes that Auckland DHB is over servicing its older population and consequently there is no demographic funding to cover those people moving into our area</p>	<p>This issue is being discussed with the Ministry of Health</p> <p>Auckland DHB may need to look at reducing capacity to ensure that the overall Auckland DHB population is not disadvantaged</p>
<p>Community pharmacy over servicing</p> <p>Funding for community pharmacy is allocated on a mix of population based funding and National Health Index information</p> <p>During the day people from other DHBs move into Auckland City for primary healthcare and this increases the costs for Auckland DHB (in the use of laboratory and pharmacy services)</p>	<p>Work with community pharmacies and prescribers to increase the use of National Health Index (NHI) numbers</p>

Problem	Solution
<p>The apparent over servicing by community pharmacy is caused by poor National Health Index information for pharmaceuticals (about 30 percent of scripts have this information)</p>	
<p>Interdistrict flow patterns</p> <p>Services related to inter-district flows feature prominently at Auckland DHB since over 50 percent of the work at Auckland City Hospital is from other DHB areas</p> <p>This increases the deficit and draws local resources away to support other DHBs</p> <p>The referring DHB has little incentive to solve the problems created for Auckland DHB</p> <p>Some DHBs are retaining secondary volumes which will reduce Auckland DHB's ability to use the margin in these services to off-set the cost of high end tertiary services</p> <p>Auckland DHB is expected to provide twenty four hour, seven day a week services. These regional acute services such as urology and ORL run at a loss</p> <p>Interdistrict flow business rules favour the referring DHB. The 24/7 acute services are not recognised in the average pricing</p> <p>This reduces volumes at Auckland DHB, decreasing efficiency and increasing the overall cost to the sector</p>	<p>Manage contracts for Auckland City Hospital as two distinct businesses</p> <p>The first associated with the work for the Auckland DHB population</p> <p>The second associated with interdistrict flows and external work</p> <p>This second part is managed by delivering the volumes require by external customers and only undertaking what is paid for</p> <p>Performance reporting will be adjusted to reflect this split</p> <p>The areas around pricing that are outside of the Auckland DHB control will be managed via discussions with the Ministry of Health</p>
<p>Impact of National Services/ Hospital of last resort</p> <p>Auckland DHB provides some services nationally and these are funded to a level that covers the cost</p> <p>Other high cost treatments relate to Auckland DHB's role as a teaching and training hospital, and for these services the national Inter District Flow price doesn't cover the cost</p> <p>These include hepatic surgery, Paediatric Cardiac, Paediatric Renal Services, Paediatric Bone Marrow transplant / MUDS, Paediatric Scoliosis Surgery and National epilepsy programme</p> <p>Patients are transferred when other hospitals have exhausted treatment options or when after-hours capacity is exceeded. Patients are most likely to be admitted to Auckland DHB at the most complex stage of their illness</p> <p>The referring DHB receives a payment for the same treatment episode. The codes used for the type of service do not</p>	<p>Auckland DHB and the Ministry of Health are investigating the impact of these services on Auckland DHB and ways to fund appropriately</p> <p>Work is underway to determine the cost impact of high cost services on Auckland DHB</p> <p>Auckland DHB has a high level of clinician governance with new structures in place to ensure clinicians are directly responsible for service delivery and cost effective care. This helps to manage the high costs associated with some patient care</p> <p>The Clinical Practice Committee will</p>

Problem	Solution
<p>accurately reflect the cost of treatment provided i.e. patients with similar codes are treated at other hospitals with far less clinical complexity yet receive the same payment</p> <p>Providing these services at a loss increases the deficit and draws local funding away to benefit people living in other DHBs</p>	<p>play a major role in the management of high cost treatments</p>

3.3 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 for combined acute services. The Greenlane Clinical Centre now operates as an advanced day-care surgical hospital and comprehensive medical centre focusing on outpatient service, rehabilitation and hospital in the home services.

The majority of efficiency issues for Auckland DHB sit in the provider arm, predominantly within Auckland City Hospital. Auckland DHB will achieve efficiencies and costs where we can and will hold managers and clinicians accountable for these.

Auckland DHB will therefore manage contracts for Auckland City Hospital as if there are two distinct businesses; firstly, that associated with the work for the Auckland DHB population. This work will be managed via population-based funding and a focus on population health outcomes.

Secondly, the inter district flow and external work component of the business will be managed from a price/volume view with a focus on structuring the organisation to deliver the volumes require by external customers and only undertaking work that is paid for. Organisational performance reporting will be adjusted to reflect this split.

Dedicated performance improvement projects for the 2005-06 year include:

- Outpatient Administration and Scheduling
- Research Project Recovery of Overhead Costs
- Operating Theatre Productivity Utilisation
- Surgical Services Top Loss Makers
- Impact of regional services on Women's Health
- Senior medical staff and registered medical officers
- Community integration project
- Sterile supplies

3.4 People in Auckland city 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 volume of patients it sees and especially 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. Inter-district flow volumes at 100 percent of contract and costs within budget. Improvements in this area will require 100 percent 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 recover costs from other DHBs as necessary.

Much of this work can be addressed by working regionally. The three regional DHBs work closely together given the issues in common and the mobility of the greater Auckland population. This also ensures that developments in one area of health do not create problems for others. The three Auckland DHB Chairs and Chief Executives have agreed a set of key tasks to further improve regional co-ordination and efficiency.

- administration management costs – align with national benchmark
- common employment and payroll productivity policies
- expanded healthAlliance with shared back-office services
- regional laboratory services efficiencies
- prioritisation of services and service configurations
- future service provision locations
- review of NDSA role and structure
- joint purchasing initiatives.

Specific areas of service delivery that have been earmarked for regional work include:

- cardiology
- women's health
- general surgery
- endocrinology (adult)
- dermatology
- Regional Pain Service (TARPS)
- all junior doctors across all sectors

The group will also be undertaking a review of sexual health to ensure improved responsiveness to other DHB populations who use the service

3.5 Lift the health of people living in Auckland city

While focusing on the workout plan to address the deficit we will also progress initiatives that are aimed at health gain. The work programme is committed to pursuing the best health outcomes for the central Auckland population within the available funding.

Auckland DHB identified diabetes as a special focus area in the District Strategic Plan and subsequent to that there have been initiatives relating to diabetes. The Planning and Funding team are working in collaboration with providers in the sector to develop and implement an action 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.

Summary of priority areas for 2005-06

- Review the District Strategic Plan and set a clear direction and priorities to 2010 that are endorsed by the people of Auckland city
- Progress He Korowai Oranga and the Auckland DHB Maori Health Plan
- Reduce health disparity for Pacific peoples in priority areas of diabetes, cardiovascular disease and parish nursing services
- Reduce inequalities and health disparities for other groups where there is high need and deprivation
- Implement the disability strategy
- Strengthen the primary care sector and continue to implement the NZ Primary Health Care Strategy.
- Increase level of PHO enrolments
- Equity of access to quality mental health services through integrated services
- Implement the NZ Health of Older People Strategy and resolve problems associated with the movement of people into the area for rest home care
- Develop a child health strategy for Auckland DHB
- Diabetes Management. Meet the "Get Checked" contract targets
- Establishment of the National Forensic Pathology Service with the Department of Justice to reconfigure the way in which forensic Pathology support will be provided to Coroners
- Roll out of the new Pharmacy IT system to support the implementation of the Pharmacy Strategic Plan

- Reduce the incidence and impact of Cardiac Disease and achieve equity of services and health gain cardiac services (cardiology, cardiothoracic and catheter laboratories) for region
- 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
- Target elective services initiatives to improve service delivery to patients
- Elective services and radiotherapy waiting times managed within guidelines
- Diabetes management including the “Get Checked” contract targets other targets set for case management and eye screening
- Focus on areas for clinical quality improvement work using Clinical Indicators
- Undertake the work associated with the National Immunisation Register and MeNZB vaccination strategy
- Improve PHO immunisation rates for Maori and Pacific children
- Work with national bodies, educational facilities, research bodies and other sectors, agencies and organisations

4. Performance Targets

The following performance targets and measures reflect objectives from the Auckland DHB 2005-06 District Annual Plan and the Indicators of DHB Performance developed by the Ministry of Health. The Auditor General will audit the accuracy and reasonableness of Auckland DHB achievements against these measures as recorded in the Statement of Service Performance in the Annual Report.

4.1 Output class 1: DHB Governance and Funding Administration

This output covers the Board's governance functions including high level oversight and administration of funding functions.

Area of activity	Targets 2005-06 (and indicative for 2006-07 and 2007-08)	Link to strategic priorities
Manage costs within agreed budgets to meet all financial targets	2005-06 <ul style="list-style-type: none"> • Report volumes within contracted levels (volumes split into ADHB residents and others) • Staff numbers kept within budgeted FTE levels • Achieve targets set for the management and administration review, by June 2006 • Service reviews completed by June 2006 2006-07 and 2007-08 <ul style="list-style-type: none"> • National Prioritisation Framework applied in decision making and funding allocations by November 2006 • Improved cost recovery from ACC and others 	Get control of our Finances
Specific measures of financial performance	<ul style="list-style-type: none"> • Return on Net Funds Employed – (45.36%) <i>Operating Margin/Net Funds Employed x 100</i> • Operating Deficit to Revenue (-7.14%) <i>Operating Deficit /Total Operating Revenue x 100</i> 	Get control of our Finances

	<ul style="list-style-type: none"> Interest Cover (≥ 2.00) <i>Calculation as per bank covenant requirements</i> Debt to Debt plus Equity Ratio (65.00%) <i>Total Borrowings/Total Borrowings plus Equity x 100</i> <p>Targets to be maintained for all years</p>	
<p>Workforce management plan implemented:</p> <ul style="list-style-type: none"> Employment Relations strategy Learning and Development Plan Workforce action plan New HR information systems <p>Occupational Health and Safety policies and procedures integrated into everyday business and benchmarked</p>	<p>2005-06</p> <ul style="list-style-type: none"> Progress the workforce action plan and Maori health workforce plan Initiatives underway to achieve a competent and qualified Pacific health and disability sector by June 2006 <p>2006-07 and 2007-08</p> <ul style="list-style-type: none"> Continued improved progress in Maori and Pacific workforce development 	<p>Improve performance</p> <p>INV-01 Information management initiatives/capability</p> <p>INV-02 Implementation of the Workforce Action Plan</p> <p>HKO-02 Development of Māori health workforce and Māori health providers</p>
<p>Complete a review of the District Strategic Plan</p> <p>Health Needs Assessment work updated and reflects in the strategic plan</p> <p>Full and formal public consultation reflected in the final copy.</p>	<p>2005-06</p> <ul style="list-style-type: none"> Health Needs Assessment report completed on local health needs and health inequalities by June 2006 District Strategic Plan review and consultation completed February 2006 Strategic priorities reflected in planning and funding decisions July 2006 and ongoing <p>Targets to be maintained for all years</p>	<p>Lift the health of Aucklanders</p> <p>HKO-01 Local Iwi/Māori engaged and participate in DHB decision-making and strategies and plans for Māori health gain</p> <p>PAC-02 Engagement and participation of Pacific peoples in DHB decision-making and strategies and plans which include goals for Pacific Health</p> <p>RIH-01 Progress towards raising awareness of inequalities and refocusing planning and</p>

		funding activities to address inequalities in health
Recognise and respect the principles of the Treaty of Waitangi Engage local Maori	<p>2005-06</p> <ul style="list-style-type: none"> Continued work with Treaty partners and the Maori Health Advisory Committee to improve health gain Increased Maori participation in all consultation work Governance relationships strengthened with Te Runanga o Ngati Whatua to ensure planning priorities are reflected in planning and funding work <p>2006-07 and 2007-08</p> <p>Improvement on previous year's targets</p>	<p>Lift the health of Aucklanders</p> <p>HKO-01 Local Iwi/Māori are engaged and participate in DHB decision-making strategies and plans for Māori health gain</p>
<p>Regional collaboration.</p> <p>Manage access to services within the Auckland Region</p> <p>Achieve efficiency gains through regional collaborative initiatives.</p> <p>Regional Service Planning</p>	<p>2005-06</p> <ul style="list-style-type: none"> Implement the regional work plan to achieve efficiency savings, by June 2006 Implement the Auckland Regional Information Services Strategic Plan Use the 5 year forecasting model to inform regional service planning and capacity planning, June 2006 and ongoing Implement the recommendations of the renal project, June 2006 <p>2006-07 and 2007-08</p> <ul style="list-style-type: none"> Improved management of inappropriate access to out-of-DHB hospitals, ongoing Develop a regional cancer control strategy implementation plan by December 2006 Achieve regional efficiency gains through the Laboratory Supply Side Project, ongoing work 	<p>Get our Finances in Order</p> <p>Improve performance</p>

4.2 Output class 2: Funding and Planning

This output covers service level planning and funding of services.

Area of activity	Target	Priority area
<p>Progress He Korowai Oranga, ADHB Maori Health Plan</p>	<p>2005-06</p> <ul style="list-style-type: none"> • Implement the National Workforce Development Plan, Regional Maori Mental Health Action Plan, Tikanga Best Practice Policy • Maori health status defined within the Health Needs Assessment • Identify the Maori specific spend annually and increase by 8% • Develop Maori PHOs and improve mainstream PHO performance for Maori • Complete projects: Do Not Attend, Discharge Planning, Whare Oranga by June 2006 <p>2006-07</p> <ul style="list-style-type: none"> • Continued work with Treaty partners and the Maori Health Advisory Committee to improve health gain • Achieve Ministry expectations under He Korowai Oranga • Monitor Maori health status, ongoing • Ethnicity data collected by December 2006 • Disability plan written by December 2006 <p>2007-08</p> <p>Progress on all targets</p>	<p>Lift the health of Aucklanders</p> <p>SER-02 Participation by Maori in decision-making in Primary Health</p> <p>RIH-01 Progress towards raising awareness of inequalities and refocusing planning and funding activities to address inequalities in health</p> <p>RIS-02 DHBs will set targets to increase funding for Māori health and disability initiatives</p> <p>HKO-02 Development of Māori health workforce and Māori health providers</p>
<p>Reduce health disparity for Pacific peoples. Priority areas of diabetes, cardiovascular disease and parish nursing services</p>	<p>2005-06</p> <ul style="list-style-type: none"> • Implement the primary health care strategy and monitor the effectiveness of Pacific PHOs • Model of service delivery for Pacific peoples developed by June 2006 • Redesign the Parish nursing service based on the evaluation recommendations by June 	<p>RIH-01 Progress towards raising awareness of inequalities and refocusing planning and funding activities to address inequalities in health</p> <p>PAC-01 Progress towards the implementation of priority areas identified in</p>

	<p>2006</p> <ul style="list-style-type: none"> Participate in the development of the Chronic Care Model Implement the priority areas in the Pacific Health and Disability Action Plan Increase the participation of Pacific people in decision making, developing strategies and plans for Pacific Health <p>2006-07 and 2007-08</p> <p>Continued progress on these targets</p>	<p>the Pacific Health and Disability Action Plan</p> <p>PAC-02 Engagement and participation of Pacific peoples in DHB decision-making and strategies and plans which include goals for Pacific Health gain</p>
Reduce Inequalities and Health Disparities	<p>2005-06</p> <ul style="list-style-type: none"> Implementation plan that outlines activities across the organisation to reduce inequalities by June 2006 <p>2006-07 and 2007-08</p> <ul style="list-style-type: none"> Plan developed to implement the NZ disability strategy by March 2007 Ensure the District Strategic Plan 2005 to 2010 translates into actions for priority populations 	<p>SER-02 Participation by Maori in decision-making in Primary Health</p> <p>RIH-01 Progress towards raising awareness of inequalities and refocusing planning and funding activities to address inequalities in health</p>
Strengthen the primary care sector NZ Primary Health Care Strategy	<p>2005-06</p> <ul style="list-style-type: none"> Care Plus, Reduced Co-payments for Pharmaceuticals, services to improve access and Health Promotion funding all implemented by June 2006 <p>2006-07 and 2007-08</p> <ul style="list-style-type: none"> Integrated primary, secondary care for multiple and complex problems especially children and youth and older people introduced Continued expansion of primary health care to include allied health and health promotion activities 	<p>SER-01 Accessible and appropriate services in PHOs</p> <p>SER-02 Participation by Maori in decision-making in Primary Health</p>
A comprehensive and collaborative model of care within the region	<p>2005-06</p> <ul style="list-style-type: none"> Complete projects areas in the regional workplan by June 2006 Inter-district planning and service development (service shifts and facility 	<p>POP-07 Planning and implementing Family Violence Intervention programmes</p> <p>RIH-01 Progress towards</p>

	<p>planning), ongoing 2006-07 and 2007-08</p> <ul style="list-style-type: none"> Family Violence Intervention Guidelines implemented and expanded each year 	<p>raising awareness of inequalities and refocusing planning and funding activities to address inequalities in health</p>
<p>Equity of access to quality Mental Health services through integrated services</p>	<p>2005-06</p> <ul style="list-style-type: none"> Implement Acute Services Review findings and a quality monitoring framework Review data management systems Stakeholder networks participate in planning and service development, and ongoing <p>2006-07 and 2007-08</p> <ul style="list-style-type: none"> Blueprint funding allocated over all years 	<p>SER-05 Improving the responsiveness of mental health services</p> <p>POP-08 Improving the health status of people with severe mental illness</p>
<p>NZ Health of Older People Strategy</p>	<p>2005-06</p> <ul style="list-style-type: none"> Issues associated with population based funding formula resolved by June 2006 Regional integrated care plan developed Residential Care for Home Based Support Services developed <p>2006-07 and 2007-08</p> <ul style="list-style-type: none"> Regional medium and long term needs assessment and service coordination developed Ongoing increased engagement of Maori in planning activities 	<p>Lift the health of Aucklanders</p> <p>Auckland's population receive its fair share</p>
<p>Child health</p>	<p>2005-06</p> <ul style="list-style-type: none"> Auckland DHB Child health strategy developed by June 2006 Complete the work associated with the National Immunisation Register, June 2006 NIR functional and supporting MeNZ B programme Meningococcal Vaccination (MeNZ B) strategy implemented in the Eastern Corridor and ADHB by June 2006 <p>2006-07 and 2007-08</p> <ul style="list-style-type: none"> Implement the Child Health Improvement Plan 	<p>Lift the health of Aucklanders</p> <p>RIS-03 Progress towards the implementation of the Meningococcal B Immunisation Project</p> <p>POP-12 Progress towards the national target of 95% of two year olds fully immunised</p>

	<ul style="list-style-type: none"> • Joint sector work undertaken that focuses on children and young people • PHO immunisation rates for Maori and Pacific population improves by 25% by 2008 • Provide information on ADHB Birth cohort and maintain NIR. The lesser of 2005/06 immunisation rate + 4% or 90% 	
Oral health	<ul style="list-style-type: none"> • Percentage of ADHB children caries free at 5 years by ethnicity 2004 <ul style="list-style-type: none"> – Asian: 69.2 – European 84.2 – Maori: 57.8 – Pacific: 47.5 – Other: 70.0 • Mean DMFT at 12 years by ethnicity 2004 <ul style="list-style-type: none"> – Asian 0.97 – European 0.85 – Maori 1.62 – Pacific: 1.46 – Other 0.96 <p>Continued progress on these outcomes</p>	<p>Lift the health of Aucklanders</p> <p>Improvements in oral health status for Maori and Pacific children</p>
<p>Manage continuums of care</p> <p>Diabetes Management.</p> <p>Meet the “Get Checked” contract targets</p>	<p>2005-06</p> <ul style="list-style-type: none"> • Programme with PHOs to meet case detection, case management and eye screening targets developed • Access for Maori and Pacific improved • Diabetes Strategic Plan 2004–08 developed • Providers have plans including KPIs for monitoring activities <p>For all years</p> <ul style="list-style-type: none"> • Free Annual Diabetes Reviews (Get Checks) performed. (Target is 60%) • Target for good diabetes control (case management):: Maori and Pacific (70%); All Others (80%) • Target for eye screening within the last 2 years (80%) • Healthy Eating Healthy Action Plan 	<p>Lift the health of Aucklanders</p> <p>POP-01 Diabetes</p>

	Implemented	
<p>Reduce the Incidence and Impact of Cardiac Disease</p> <p>Equity of services and health gain cardiac services (cardiology, cardiothoracic and catheter laboratories) for region</p>	<p>2005-06</p> <ul style="list-style-type: none"> • Heart Failure Project introduced with cardiac services • Manage growth in acute, elective services and vascular volumes within budget and guidelines <p>2006-07 and 2007-08</p> <ul style="list-style-type: none"> • Review cardiac services (cardiology, cardiothoracic and catheter laboratories) for the region • Implement cardiovascular risk assessment guidelines • Research into basic mechanisms, novel therapies and clinical trials • Assess activities from Healthy Eating Health Action 	<p>POP-02 Cardiovascular disease</p> <p>POP-03 Stroke</p>
<p>Reduce the incidence and impact of Cancer through prevention programmes</p>	<p>Over all years</p> <ul style="list-style-type: none"> • Screening programmes with improved access figures for Maori and Pacific • Improvement in waiting times for radiotherapy and chemotherapy • Radiotherapy and chemotherapy treatment waiting times within Ministry of Health Guidelines • Implement palliative care services • Identify research opportunities for clinical cancer treatment trials • Develop cancer treatment data collection 	<p>Lift the health of Aucklanders</p> <p>POP-15 Implementing the Cancer Control Strategy</p>

Regional Collaboration

Government expects the three Auckland DHBs to work closely together to deliver the best possible services for all the people in Auckland. This is important because:

- there is considerable movement of the population across and between the individual DHBs so service planning and provision need to be consistent and co-ordinated across the region
- there are opportunities for synergies and efficiencies by working together at all levels: service planning, capital investment, service delivery, and administration.

Indicator	Targets
<p>1. Regional Service Planning</p> <p>Progress regional planning initiatives:</p> <ul style="list-style-type: none"> • Use of the 5 year forecasting model developed during 2004/05 to inform regional medical, surgical and maternity service planning and regional inpatient and outpatient capacity planning • Implement the recommendations of the renal project • Develop a regional cancer control strategy implementation plan <p>2. Regional Efficiency Gains</p> <p>Jointly implement the agreed regional work plan to achieve efficiency savings with the other two Auckland DHBs.</p> <p><i>Laboratory Supply Side Project</i></p> <p>Review the current laboratory service provision within the region and establish the potential benefits in reorganising the laboratory supply side services.</p>	<p>30 June 06 and ongoing</p> <p>30 June 06 and ongoing</p>

4.3 Output class 3: Provider Arm Activities

Area of activity	Target	Link to strategic area
<p>Improve quality and safety of services</p>	<p>2005-06</p> <ul style="list-style-type: none"> • Patient satisfaction meets or exceeds national DHB average • Proportion of Satisfied Customer Survey Respondents (93%) • Proportion of Very Good Customer Survey Respondents (52%) • Percentage of Complaints Resolved/Closed (60%) • Hospital Acquired Blood Stream Infections (per thousand inpatient admissions) (6.50) <p>To be maintained through to 2007-08</p>	<p>Performance improvement</p> <p>QUA-01 Quality systems</p> <p>SER-03 Continuous quality improvement – Elective services</p> <p>HKO-03 Improving mainstream effectiveness</p>
<p>Organisational Health and Learning</p>	<p>2005-06</p> <ul style="list-style-type: none"> • Improve staff retention. Staff Turnover (voluntary) (16%) 	<p>Performance Improvement</p> <p>Hospital benchmark</p>

	<ul style="list-style-type: none"> • Manage staff health. Sick Leave Rate (2.4%) • Manage injury rates. Workplace Injuries. Lost Time Injury Frequency Rate (7.0) • Institute the Pacific Cultural Competency framework <p>To be maintained through to 2007-08</p>	information																														
<p>Low birth weight babies - Rate per 1000 births in public hospital with low birth rate</p>	<p>2005-06</p> <p>Target discharge rate per 1,000. Babies weighing less than 2,500 grams.</p> <ul style="list-style-type: none"> • Maori (65) • Pacific (57) • Other (58) <p>Maintain targets for 2006-07 and 2007-08</p>	<p>POP-09 Low birth weight babies - Rate per 1000 births</p> <p>Hospital benchmark information</p>																														
<p>Ambulatory Sensitive Admissions - children and older people discharge rate per 1000 population</p>	<p>2005-06</p> <p>Establish interdisciplinary assessment programme for 65+ with strong links to primary care</p> <p>Performance measure/standard definition: Numerator: Total number of hospital discharges (as identified by relevant ICD10 codes)</p> <table border="1"> <thead> <tr> <th colspan="5">Ambulatory sensitive hospital admissions Rate per 1000 for October 2004–September 2005*</th> </tr> <tr> <th>Age</th> <th>Total</th> <th>Maori</th> <th>Pacific</th> <th>Other</th> </tr> </thead> <tbody> <tr> <td>< 5</td> <td>47.0</td> <td>54.3</td> <td>89.9</td> <td>33.7</td> </tr> <tr> <td>5–14</td> <td>14.7</td> <td>19.6</td> <td>24.8</td> <td>10.8</td> </tr> <tr> <td>45–24</td> <td>11.9</td> <td>17.7</td> <td>19.5</td> <td>10.0</td> </tr> <tr> <td>65–74</td> <td>63.3</td> <td>84.6</td> <td>141.2</td> <td>54.4</td> </tr> </tbody> </table> <p>Denominator: Current census populations using medium projection.</p> <p>By ethnicity and by age (<5; 5-14; 15-24; 65-74)</p> <p>2006- 07 and 08: Achieve Ministry expectations under POP 13</p>	Ambulatory sensitive hospital admissions Rate per 1000 for October 2004–September 2005*					Age	Total	Maori	Pacific	Other	< 5	47.0	54.3	89.9	33.7	5–14	14.7	19.6	24.8	10.8	45–24	11.9	17.7	19.5	10.0	65–74	63.3	84.6	141.2	54.4	<p>POP-13 Ambulatory Sensitive Admissions - children and older People discharge rate per 1000 population</p> <p>POP-13 expectation: if the DHB region and ethnic rate is significantly greater than the total NZ (all ethnicity) national rate (99% confidence interval) and DHBs provide information on the current and planned initiatives likely to influence future outcomes specifically for the effected population group(s)</p>
Ambulatory sensitive hospital admissions Rate per 1000 for October 2004–September 2005*																																
Age	Total	Maori	Pacific	Other																												
< 5	47.0	54.3	89.9	33.7																												
5–14	14.7	19.6	24.8	10.8																												
45–24	11.9	17.7	19.5	10.0																												
65–74	63.3	84.6	141.2	54.4																												
<p>Patient volumes up to 10% above contract for</p>	<p>2005-06</p> <ul style="list-style-type: none"> • Inter-district flow volumes at 100% of contract 	<p>Auckland's population receive their fair</p>																														

Auckland's population, and costs within budget	<p>and costs within budget</p> <ul style="list-style-type: none"> • 100% accuracy of classification into ADHB population, DHB Referrers, ACC and overseas patients • Report contract volumes for Auckland's population at up to 110%. Costs within budget. Classification 100% Accurate <p>Maintain targets for 2006-07 and 2007-08</p>	<p>share</p> <p>Reduce the deficit</p>
Elective services managed within guidelines	<p>2005-06</p> <ul style="list-style-type: none"> • 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 • Equity and timeliness of access to assessment, diagnostics, tests, procedures and treatments • Improve Elective Service Performance Indicators and elective patient quality of care management. • Contract volume management improved on previous year <p>Maintain targets for 2006-07 and 2007-08</p>	<p>Lift the health of Aucklanders</p> <p>SER-03 Continuous quality improvement – Elective services</p>
Process and Efficiency	<p>2005-06</p> <ul style="list-style-type: none"> • Occupancy Rate for Resourced Beds (85%) • DRG-Based Average Length of Stay (3 days) • Elective Day of Surgery Admission Rate (80%) <p>Maintain targets for 2006-07 and 2007-08</p>	<p>Hospital benchmark information</p>

Notes

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.

DRG-Based Average Length of Stay: Average length of stay of DRG funded discharges. 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

Hospital Acquired Blood Stream Infections: 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.

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

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.

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. Managing Financial Resources

This financial section is aligned to the material agreed in the 2005-06 District Annual Plan.

5.1 Performance

The budgets below show a gradually improving financial performance over the next three years. The Auckland DHB deficit is projected to reduce as follows:-

2005-06	\$(65) million
2006-07	\$(50) million
2007-08	\$(52) million

Although the 2004-05 actual deficit is \$(58) million, we believe the underlying deficit, after removing the impact of favourable one-off items which are unlikely to recur, to be \$(87) million. The deficit reduction above, if achieved, will represent a considerable achievement.

Arising from analysis carried out over recent months we believe the following to be key factors in attaining a sustainable deficit position:-

- Auckland DHB has been increasing its spending each year by \$11 million more than the corresponding increase in its funding, it is failing to 'live within its means'.
- There are two structural issues within Auckland DHB's deficit which we believe will be virtually impossible to eliminate without external assistance –
 - 1). There is a pay gap differential which has developed between Auckland DHB and other DHBs. The total pay gap between Auckland and an 'efficient' provider is, we believe, \$41 million. In addressing the pay gap cost impact the ADHB will focus on aligning with employee costs within the Auckland region where pay disparity contributes significantly to Auckland DHB's higher cost structure.
 - 2). The capital costs associated with Auckland DHB's building programme.

We believe these two factors combine to leave Auckland DHB with an irreducible deficit of approximately \$35 million. However we will continue to work on eliminating this.

The deficit reduction shown in these statements is a gradual approach to the irreducible deficit explained above. In order to achieve this reduction a significant programme of savings will be required. This programme is outlined later in the body of this report.

With the increased diversity of Auckland DHB's roles and sources of funding we are concerned that the underlying performance of the DHB's operating division – the Provider – may be masked. Non core business activities such as Research Donations (which are often associated with capital) and the results of the DHB's retail pharmacies within the Provider will be separately reported in performance reports.

Statement of Financial Performance

The statement of financial performance is detailed in Table 1. Key features include:

Operating margin

In assessing performance of variable input capacity, a key performance indicator is "Operating Margin". The operating margin is valuable in that it reflects management's performance in respect of controllable costs. In addition, the operating margin indicates the contribution that is available to meet organisational fixed costs such as depreciation and finance charges.

	04/05 Budget \$000	04/05 Actual \$000	04/05 Normalised \$000	05/06 Budget \$000
ADHB Total Revenue	\$1,159,000	\$1,201,000	\$1,184,000	\$1,269,000
Operating Margin - Surplus (Deficit)	\$1,971	\$16,229	(\$8,415)	\$31,494
Operating margin as a percentage of revenue	0.1%	1.3%	(0.7)%	2.5%

The table indicates that before adjusting for "one off" impacts applied to the 2004-2005 result, the strategic initiatives being put in place in 2005-2006 will improve the operating performance by \$11.5 million. Normalising the 2004-2005 financial year, the improvement in operating performance is more dramatic at \$39.9 million.

The unfavourable variance of \$10.4 million reflected in the normalised result for 2004-2005 and the budget for 2004-2005 is substantially a function of higher than budgeted treatment costs and the unfunded portion of employee collective agreement settlements.

Overall performance year on year

The primary drivers for the budgeted deficit for 2005-2006 of \$65 million being higher than the actual deficit for 2004 -2005 of \$58 million by \$7 million are:

Improved operating performance of \$11 million offset by increased fixed costs of \$19 million.

Table 2 compares the movement between 2004-2005 actual performance and the current year budgeted performance.

Tables three and four reconcile the movement between the 2004-2005 actual result and the budgeted result for 2005-2006 removing items that are considered "one offs" relating to the particular accounting period.

Movement in equity

The 2004-2005 financial year has seen a substantial change to the equity position of the DHB. The revaluation of assets has contributed \$143 million to the total increase of \$152 million.

Equity injection for the Building Programme for the year is reflected at \$13 million with deficit support offsetting the deficit applied to owner's equity for the year. (Table 5 provides a summary of the movements forecasted for the next three years). Apart from the final equity required to complete the building programme of \$5 million only equity required to support the ongoing deficit is anticipated.

5.2 Key Assumptions (tables 9 – 19)**Revenue changes year on year:**

	2006	2007	2008
Ministry of Health	6.9%	1.6%	2.6%
Other Revenue	(9.4)%	(2.9)%	1.8%
Total revenue	4.7%	1.3%	2.6%

Operating Cost changes year on year:

Employee Costs	7.6%	4.7%	5%
Treatment Costs	-0.5%	3%	3.3%
Other operating costs	3.8%	4.1%	2.6%
Total Operating Costs after including phased net savings	4.5%	0.6%	2.2%

The percentage increase in operating costs is lower than the increase percentage in revenue. In the 2006 year this favourable operating performance is more than offset by cost increases in the non-operating cost categories of depreciation and finance charges. The net effect is a deterioration in the underlying performance of the Auckland DHB of \$7 million when comparing 2005 actual performance to the 2006 budget.

In the outer years the improved operating performance has a net positive impact on the underlying performance after providing for the movement in non operating costs.

5.3 Savings Targets (tables 20 – 21)

The performance improvement strategies are divided into two main areas:

Living within means

Target savings \$11 million p.a.

Historically the Auckland DHB has not managed to contain costs to the level of funding provided. Analysis has identified that the ongoing unfunded cost creep is in the region of \$11 million per annum.

Addressing the root causes of the deficit

Target savings \$69 million p.a.

Four main areas have been identified as contributing unfavourably to the cost structure of the Auckland DHB. The savings gross targets per annum expected within each area to be achieved in full after three years is:

Pay Gap	\$26 m
Efficiency	\$16 m
Infrastructure	\$ 9 m*
Service Configuration	\$18 m

In the 2006 financial year the net savings budget is \$28 million in total across the four root causes.

* The original target for this area (\$15 m) has been eroded by the impact of applying the Population Based Funding Formula (PBFF) to the revenue stream from the Ministry of Health designed to offset cost increases (Capital Charge and Depreciation) arising from the asset revaluation performed at June 2005.

5.4 Capital Budget (tables 22 – 24)

The Capital Plan must meet the following organisational criteria:

- Living within Means
- Retirement of Long Term Debt
- Self-funding

To achieve these objectives the Capital Plan is based on the principles of:

- Long Term Depreciation releases Cash flows to retire Long Term Debt
- Short Term or Routine Depreciation releases Cash flows to fund short and medium term Capital Expenditure

The budgeted Capital Plan substantially achieves the key objectives above. The Debt Retirement Programme is scheduled to commence in the 2007 Financial Year and is aimed at fully repaying long term debt over 30 years.

	2006 Budget \$,000	2007 Budget \$,000	2008 Budget \$,000
Total Capital Spending	48,179	29,094	30,000
Routine (operational)	20,216	23,394	30,000
Building Programme and non-routine	27,963	5,700	-

5.5 Treasury (table 25)

Borrowing Covenants

Auckland DHB is seeking amendments to the deed of negative pledge which provides security to its financiers. Auckland DHB is encouraging financiers to recognise the close relationship of Auckland DHB with the crown as support for their liberalisation of the restrictive financial covenants which currently apply. It has been assumed in the preparation of these forecasts that the covenants will be liberalised with effect from 1 January 2006.

This will have the effect of delaying and reducing the requirement for equity injections from the crown and consequently reduce capital charges. It will, as a consequence, allow Auckland DHB to fully utilise its established financial facilities at a lower funding cost than the alternative capital charges as shown in 2006-07.

Auckland DHB's maximum borrowing programme will be achieved in 2006-07 with the substantial completion of the building programme. Maximum long term facilities are \$315 million, being \$120 million bonds issued and \$195 million facilities with the Crown Financing Agency, which will then be reduced by \$10.5 million per annum commencing in 2006-07 to amortise the debt over a 30 year term.

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Table 1: Statement of financial performance for the year ended 30 June 2006

	Ref	2004-05 Actual \$000	2004-05 Base Result \$000	2005-06 Budget \$000	2006-07 Budget \$000	2007-08 Budget \$000
Revenue	Table 9					
Ministry of Health	Table 14					
Base – provider		649,812	647,187	686,176	699,486	720,410
Base – governance		2,824	2,824	2,824	2,909	2,996

Base – funder		414,837	401,461	442,558	458,526	472,282
Funding for increased depreciation & capital charge from asset revaluation		-	-	15,058	8,198	8,198
Other contracts		42,813	42,813	40,384	36,754	34,463
Other revenue		1,110,286	1,094,285	1,187,000	1,205,873	1,238,349
Inter-provider revenue		2,065	2,065	2,295	2,295	2,295
Other patient care revenue		25,139	25,139	21,465	21,888	22,348
External revenue		63,714	62,042	58,580	55,733	56,719
		90,918	89,246	82,340	79,916	81,362
Total revenue		1,201,204	1,183,531	1,269,340	1,285,789	1,319,711
Operating costs						
Employee costs	Table 10,15	512,002	512,002	550,726	576,647	606,088
Treatment costs	Table 11,16	181,221	181,221	180,227	185,593	191,778
Funder payments	Table 17	424,862	431,832	440,005	460,586	474,404
Property and equipment maintenance	Table 18	48,911	48,911	52,537	52,952	54,168
Administration	Table 19	17,979	17,979	17,628	17,585	18,345
Additional net savings to be achieved not imbedded in budgets	Table 20	-	-	(3,277)	(50,000)	(68,000)
Total operating costs		1,184,975	1,191,945	1,237,846	1,243,363	1,276,783
Operating surplus/(deficit)	Table 2	16,229	(8,414)	31,494	42,426	42,928
Depreciation, interest and capital charge						
Depreciation	Table 22	43,079	43,079	49,446	49,325	53,011
Interest		17,447	17,947	20,814	21,988	22,744
Capital charge	Table 22	17,909	17,909	25,870	20,949	19,500
		78,435	78,935	96,130	92,262	95,255

Underlying total deficit for the year		(62,206)	(87,349)	(64,636)	(49,836)	(52,327)
Other Costs						
Asbestos Removal		9,895	-	-	-	-
Mental Health Ring Fence		(2,491)	-	7,399	-	-
		7,404	-	7,399	-	-
Other Contributions						
Asbestos Removal		11,500	-	-	-	-
Surplus on Sale of Assets		-	-	6,492	-	-
Total Deficit for the year	Table 3,4,5	(58,110)	(87,349)	(65,543)	(49,836)	(52,327)

Table 2: Comparison of 04/05 actual performance with 2005-06 budgeted performance

Budget 04-05 \$m	Description	Actual 04-05 \$m	Budget 05-06 \$m	Change \$m
1,159	Revenue	1,201	1,269	68
1,157	Operating costs	1,185	1,238	53
2	Operating margin	16	31	15
(85)	Fixed costs - Depreciation and finance costs	(74)	(96)	(22)
(83)	Net deficit	(58)	(65)	(7)

Table 3: Reconciliation of actual performance to underlying performance 2004-2005

	\$000	\$000
Actual : Deficit for the 2005 year		(58,110)
Adjust for abnormal items:		
Revenue		
Funder – Primary Health Revenue	(11,376)	(25,462)
Other Surpluses	(2,625)	
Mental Health revenue clawed back to personal health	(2,000)	
Mental Health surplus for 0405 year	(2,491)	
Pharmac Rebates, 0304 Receipts & Policy Change	(6,970)	
Charitable Trust –Donations & Interest receipts		(2,172)
Asbestos Removal		(11,500)

Costs		
Asbestos Removal		9,895
Underlying deficit for the 2005 year		(87,349)

Table 4: Reconciliation of underlying performance 2004-05 to budget 2005-06

	\$ million
Underlying deficit for the 2005 year	(87,349)
Increase in revenue	85,809
Sale of Land	6,492
Cost changes	
Employee costs	(38,724)
Treatment costs	994
Funder payments	(15,572)
Finance costs	(17,195)
Unallocated savings	3,277
Other costs	(3,275)
Budgeted deficit for the 2005/2006 year	(65,543)
Abnormal revenue items provided for in the 2006 budget	10,729
Funder – Primary Health Revenue	6,000
Pharmac Rebates	3,886
Charitable Trust – Donations and interest receipts	1,750
Mental Health	(7,399)
Sale of Land	6,492
Adjusted Underlying deficit for the 2005/2006 year	(76,272)

Table 5: Statement of movement in equity

	2004–05 Actual \$000	2005–06 Budget \$000	2006–07 Budget \$000	2007–08 Budget \$000
Equity at beginning of the period	177,132	329,220	301,095	256,259
Net deficit for the year	(58,110)	(65,543)	(49,836)	(52,327)
Asset Revaluation	143,187	-	-	-
Equity injections				
Deficit support	54,000	32,000	5,000	40,000
Building programme	13,011	5,418	-	-
	67,011	37,418	5,000	40,000
Equity at end of year	329,220	301,095	256,259	243,932

Table 6: Statement of financial position as at 30 June 2006

	2004-05 Actual \$000	2005-06 Budget \$000	2006-07 Budget \$000	2007-08 Budget \$000
Current assets				
Cash and bank balances	5,718	4,286	4,757	4,470
Receivables and prepayments	102,095	104,397	107,582	107,582
Inventories	9,870	9,000	9,000	9,000
	117,683	117,683	121,339	121,052
Non-current assets				
Cash, bank balances and investment bonds	9,554	11,306	11,877	12,517
Property, plant and equipment	711,043	709,510	689,680	667,070
Investment in associates	276	276	276	276
	720,873	721,092	701,833	679,863
Total assets	838,556	838,775	823,172	800,915
Current liabilities				
Payables and accruals	188,559	192,139	192,470	193,040
Borrowings	35,598	35,598	55,000	55,000
Funds held in trust	789	789	789	789
	224,946	228,526	248,259	248,829
Non-current liabilities				
Payables and accruals	14,154	14,154	14,154	14,154
Borrowings	270,236	295,000	304,500	294,000
	284,390	309,154	318,654	308,154
Total liabilities	509,336	537,680	566,913	556,983
Equity				
Public equity	590,857	628,275	633,275	673,275
Revaluation reserve	143,187	143,187	143,187	143,187
Accumulated deficit	(413,564)	(479,107)	(528,943)	(581,270)
Donations and bequests	8,740	8,740	8,740	8,740
Total equity	329,220	301,095	256,259	243,932
Total liabilities and equity	838,556	838,775	823,172	800,915

Table 7: Total borrowings

Total Borrowing Position	2004-05 Actual \$000	2005-06 Budget \$000	2006-07 Budget \$000	2007-08 Budget \$000
Cash and bank balances (after removal of Trust balances)				
Current	(5,718)	(4,286)	(4,757)	(4,470)
Borrowings				
Current	35,598	35,598	55,000	55,000
Non Current	270,236	295,000	304,500	294,000
	305,834	330,598	359,500	349,000
Net Borrowing Position	300,116	326,312	354,743	344,530

The increase in borrowing is discussed in section 8.4 Treasury

Table 8: Statement of cash flows for the year ended 30 June 2006

	2004-05 Actual \$000	2005-06 Budget \$000	2006-07 Budget \$000	2007-08 Budget \$000
Cash flow from operating activities				
<i>Cash was provided from</i>				
Provision of health services	1,202,819	1,265,751	1,282,004	1,319,111
Interest received	1,692	1,286	600	600
	1,204,511	1,267,037	1,282,604	1,319,711
<i>Cash was applied to</i>				
Employee costs	505,290	547,450	526,647	538,088
Other operating costs	694,324	719,095	737,732	758,023
Interest paid	19,430	20,814	21,988	22,744
	1,219,044	1,287,359	1,286,367	1,318,855
<i>Net cash inflow/(outflow) from operating activities</i>	(14,533)	(20,322)	(3,763)	856
Cash flow from investing activities				
<i>Cash was provided from</i>				
Proceeds from sale of fixed assets	258	6,639	-	-
	258	6,639	-	-
<i>Cash was applied to</i>				
Purchase of fixed assets	66,031	48,179	29,097	30,003
	66,031	48,179	29,097	30,003
<i>Net cash inflow/(outflow) from investing activities</i>	(65,773)	(41,540)	(29,097)	(30,003)
Cash flow from financing activities				
<i>Cash was provided from</i>				
Proceeds from capital contributed	67,011	37,418	5,000	40,000
Proceeds from loans raised	(10,053)	24,764	28,902	(10,500)
	56,958	62,182	33,902	29,500
<i>Net cash inflow/(outflow) from financing activities</i>	56,958	62,182	33,902	29,500
Movement in cash and bank balances				
	38,620	15,272	15,592	16,634
Add opening balance				
Net cash inflow/(outflow)	(23,348)	320	1,042	353
Closing bank balance	15,272	15,592	16,634	16,987
Being				
Cash and bank balances	5,718	4,286	4,757	4,470
Cash, bank balances and investment bonds	9,554	11,306	11,877	12,517
	15,272	15,592	16,634	16,987

The following high level assumptions have been used in the preparation of the three outer years.

Table 9: Changes to revenue

	FY2006	FY2007	FY2008
Revenue			
Ministry of Health – Base Contracts			
Pricing ADHB	Per Funding advice ex MoH 3.3%	3.0%	3.0%
Pricing IDF	Per Funding advice ex MoH 3.3%	3.0%	3.0%
Volume ADHB	0.0%	0.0%	0.0%
Volume IDF	0.0%	0.0%	0.0%
Ministry of Health - Other Contracts			
Public Health	2.3%	2.1%	2.1%
Disability Support Services – see MoH revenue commentary below	-7.1%	2.1%	2.1%
Maternity Claims S.88 – see MoH revenue commentary below	-21.1%	2.1%	2.1%
Cost reimbursement - Funding for Asset Revaluation – after allowing for partial revaluation & population based funding adjustments	\$15,058	\$8,198	\$8,198
Cost reimbursement - Holidays Act – including Provider & NGO sectors	\$4,006	\$4,006	\$4,006
Cost reimbursement - Nursing Award	\$9,101	\$16,013	\$16,013
Other Revenue			
Other Patient Care Revenue	2.4%	2.1%	2.1%
External Revenue	2.4%	2.1%	2.1%

Table 10: Changes to employee costs

Occup. Group	Industrial Group	Negotiation Status	DAP Cost of Living	DAP exten	DAP Total	Actual
FY 2005-06						
Medical	SMO	Settled to 30.6.06	5.9%	0.0%	5.9%	5.9%
	RMO	Settled to 31.12.06	4.0%	0.0%	4.0%	4.0%
Nursing	NZNO	Settled to 30.6.06	5.0%	1.6%	6.6%	5.7%
Technical	Radiation Therapists	Settled to 30.6.06	1.8%	0.0%	1.8%	1.8%
	Dental Assistants	To be negotiated from 1.7.05	3.0%	0.0%	3.0%	
	Support Services	To be negotiated from 1.7.05	3.0%	0.0%	3.0%	
	Cardiac & Resp Techs	Settled to 31.3.07	3.0%	0.0%	3.0%	2.6%
	Diagnostic X-Ray	To be negotiated	3.0%	0.0%	3.0%	
	Laboratory	To be negotiated from 1.4.06	0.75%	0.0%	0.0%	
	Home Aids	To be negotiated from 1.7.05	3.0%	0.0%	3.0%	
	Sonographers	To be negotiated from 1.7.05	3.0%	0.0%	3.0%	

Occup. Group	Industrial Group	Negotiation Status	DAP Cost of Living	DAP exten	DAP Total	Actual
Hotel Services Admin.	Service Workers Retail Assistants PACT IEC	To be negotiated from 1.7.05 To be negotiated from 1.7.05 Negotiating To be negotiated	3.0% 3.0% 3.0% 3.0%	0.0% 0.0% 0.0% 0.0%	3.0% 3.0% 3.0% 3.0%	
FY 2006-07						
<i>Medical</i>	<i>SMO</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
	<i>RMO</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
<i>Nursing</i>	<i>NZNO</i>	<i>Settled to 30.6.07</i>	<i>3.0%</i>	<i>4.4%</i>	<i>7.4%</i>	<i>7.3%</i>
<i>Technical</i>	<i>Radiation Therapists</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>0.0%</i>	<i>3.0%</i>	
	<i>Dental Assistants</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>0.0%</i>	<i>3.0%</i>	
	<i>Support Services</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>0.0%</i>	<i>3.0%</i>	
	<i>Cardiac & Resp Techs</i>	<i>Settled to 31.3.07</i>	<i>3.0%</i>	<i>0.0%</i>	<i>3.0%</i>	<i>1.9%</i>
	<i>Diagnostic X-Ray</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>0.0%</i>	<i>3.0%</i>	
	<i>Laboratory</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>0.0%</i>	<i>3.0%</i>	
	<i>Home Aids</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>0.0%</i>	<i>3.0%</i>	
	<i>Sonographers</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>0.0%</i>	<i>3.0%</i>	
<i>Hotel Services Admin.</i>	<i>Service Workers</i> <i>Retail Assistants</i> <i>PACT</i> <i>IEC</i>	<i>To be negotiated</i> <i>To be negotiated</i> <i>To be negotiated</i> <i>To be negotiated</i>	<i>3.0%</i> <i>3.0%</i> <i>3.0%</i> <i>3.0%</i>	<i>0.0%</i> <i>0.0%</i> <i>0.0%</i> <i>0.0%</i>	<i>3.0%</i> <i>3.0%</i> <i>3.0%</i> <i>3.0%</i>	
FY 2007-08						
<i>Medical</i>	<i>SMO</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
	<i>RMO</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
<i>Nursing</i>	<i>NZNO</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>0.0%</i>	<i>4.0%</i>	
<i>Technical</i>	<i>Radiation Therapists</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
	<i>Dental Assistants</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
	<i>Support Services</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
	<i>Cardiac & Resp Techs</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
	<i>Diagnostic X-Ray</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
	<i>Laboratory</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
	<i>Home Aids</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
	<i>Sonographers</i>	<i>To be negotiated</i>	<i>3.0%</i>	<i>1.0%</i>	<i>4.0%</i>	
<i>Hotel Services Admin.</i>	<i>Service Workers</i> <i>Retail Assistants</i> <i>PACT</i> <i>IEC</i>	<i>To be negotiated</i> <i>To be negotiated</i> <i>To be negotiated</i> <i>To be negotiated</i>	<i>3.0%</i> <i>3.0%</i> <i>3.0%</i> <i>3.0%</i>	<i>0.0%</i> <i>0.0%</i> <i>0.0%</i> <i>0.0%</i>	<i>3.0%</i> <i>3.0%</i> <i>3.0%</i> <i>3.0%</i>	

The increments above do not include 'salary creep' driven by movements up the salary steps within Collective Agreements. This has been allowed for in the following increment in each year respectively in addition to the rate increments outlined in the table above.

Medical	2.6%
Nursing	1.1%
Technical	1.7%
Hotel Services	0.5%
Administration	1.4%

'Salary Creep' is a name often given to the recognition of experience within collective contracts. It normally takes the form of stepped increases that occur by virtue of experience within a job. The % estimates above for the impact of creep are based on an assessment of the value of stepped increases available, the proportions of staff on the top of the scale and not due for an increase and the impact of staff turnover.

Table 11: Changes to treatment costs

Direct Treatment Costs	FY2006	FY2007	FY2008
Drugs	6.0%	6.0%	6.0%
Other	2.4%	2.1%	2.1%
Funder Payments	FY2006	FY2007	FY2008
Payments to Providers	Recognition of growth & other initiatives on Line by line basis	3.0%	3.0%

Table 12 Changes to Other costs

Other Costs	FY2006	FY2007	FY2008
Property & Equipment Maintenance	2.4%	2.1%	2.1%
	& consideration of specific initiatives		
Administration	2.4%	2.1%	2.1%
	& consideration of specific initiatives		

Table 13 Capital Costs

Capital Costs (\$000)	FY2006	FY2007	FY2008
Depreciation	\$49,446	\$49,325	\$53,011
Interest	\$20,814	\$21,988	\$22,744
Capital Charge	\$25,870	\$20,949	\$19,500

Depreciation has been calculated on a "bottom-up" basis after taking into account projected capital spend and the impact of the revaluation of ADHB assets. Depreciation rates have been reviewed with a view to better recognising useful asset lives. The effect of the changes has been to reduce the cost of depreciation some \$10.4m per annum.

Auckland DHB is seeking amendments to the deed of negative pledge which provides security to its financiers. Auckland DHB is encouraging financiers to recognise the close relationship of Auckland DHB with the Crown as support for their liberalisation of the restrictive financial covenants which currently apply. It has been assumed in the preparation of these forecasts that the covenants will be liberalised with effect from 1 January 2006.

A rate of 8% has been used to calculate the capital charge on crown equity.

Table 14: Ministry of Health revenue

Base contracts have been reconciled to revenue advice provided by the Ministry of Health. A comparison between the 0405 Budget and 0506 Budget, as outlined above, shows a difference between the actual growth in revenue and the ministry's reported growth rate for new funding of 3.3%. The table below shows the major components making up the increase in funding for the 2005-2006 year.

	2005-06 Budget \$,000	% of 2005 Base Funding
Base Funding for 2005*	962,664	
New Funding		
Future Funding Track	20,267	2.11%
Growth	9,016	
Blueprint	2,737	
	32,020	3.33%
Adjustments to existing funding		
Net Movement in IDFs	13,990	
Primary Health Strategy	5,355	
Holiday Pays Act 2003	4,641	
Health of Older People Risk Pool 2005-06	1,133	
Aged Residential Care Price Increase	2,043	
NZNO Nurses Settlement	3,732	
Income Testing & Asset testing for Aged Residential Care	9,102	
Transitional Pool	(6,585)	
Other Changes	836	
	34,247	3.56%
Total Changes in Funding	66,267	6.88%
Base Funding for 2006	1,028,931	

*These financials are as at Nov 2004 when the funding envelope was receipted. (there is a minor difference between these numbers and the information on table 1. The difference is not material).

Other Contacts revenue in the 2005-06 budget has been impacted by reduced revenue for the treatment of cancer patients in Australia, a reduction in Disability Support revenue reflecting a decision by Ministry of Health to tender work to other DHBs.

Other Contacts revenue in the 06-07 budget has also reduced. This is a function of the timing of preparation of outer year forecasts and will require further review given the levels of income now forecast for the 2005-06 year.

Other Revenue

Budgeted Other patient care revenue is lower as a result of an anticipated reduction in non-resident income at Starship as a result of lower Tahitian contract patient volumes and a reduction in ACC volumes.

Budgeted 2005-06 external revenue is lower as a result of the completion of the Meningococcal B campaign and the reanalysis of all base funding to being recorded under the Ministry of Health revenue lines.

Table 15: Employee costs & FTE

The table below sets out an analysis of the costs summarised in the statement of financial performance.

Employee Costs	2004-05 Actual \$000	2005-06 Budget \$000	2006-07 Budget \$000	2007-08 Budget \$000
Medical	145,814	160,823	172,274	183,643
Nursing	166,332	178,616	193,577	201,511
Technical	80,275	91,704	96,865	102,387
Hotel services	9,436	8,810	8,941	9,253
Administration & Stores	81,430	81,946	85,428	89,163
Vacancy assumptions	-	(6,816)	(6,959)	(7,105)
Targeted savings	-	(356)	(3,212)	(1,083)
	483,287	514,727	546,914	577,773
% Increase over prior year		6.5%	6.2%	5.6%
Staff related expenses	28,715	27,177	27,733	28,315
% Increase over prior year		(5.4)%	2.0%	2.1%
Redundancy	-	8,822	2,000	-
	512,002	550,726	576,647	606,088
% Increase over prior year		7.6%	4.7%	5%

FTE analysis for 2006 (including temporary staff, overtime and medical fees for service)	As at June 2005 Actual	As at June 2006 Budget
Medical	940	965
Nursing	2,575	2,602
Technical	1,198	1,278
Hotel services	222	218
Administration & Stores	1,451	1,329
Vacancy assumptions	-	(116)
Total ACH,GHS & Governance	6,386	6,276
Mental health	625	701
Public health	159	160
Total Provider & Governance	7,170	7,137

Employee costs account for approximately 68 percent of Auckland DHB operating costs exclusive of funder payments and unidentified savings goals.

Auckland DHB has taken account of the known and expected outcomes of collective agreement negotiations as outlined in the assumptions in section 5.2. This is the primary driver of the increases in overall employee cost identified in the table above. The increase in staff related expenses in the 2005-06 year relates to an unrealistic 2004-05 budget as large section of the cost is driven by agreements imbedded in collective agreements such as continuing medical education.

Human Resources advocates have endeavoured to stay within a CPI target of 3.0% for the 2005-06 year. They wish to highlight the impact of the 5.0 percent campaign currently being run by the Trade Union Movement and the flow on effects of the Nursing agreement which will impact on outstanding agreements such as PACT which are currently under negotiation.

The staff compliment in the outer years is still to be determined. Initiatives such as "living within means", service reviews and savings projects (addressing the root causes of the underlying deficit) will provide the basis for defining future FTE capacity.

Auckland DHB will face significant challenges in containing employee costs given the settlement of collective agreements above budget and annual salary creep

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

- Management of vacancies
- Achievement of staff efficiencies imbedded in the budget
- A continuing search for efficiencies

Table 16: Treatment costs

As noted in last year's District Annual Plan, treatment costs are significantly impacted by the price, quality and technology cost increases across the health sector. These increases have run between 5% and 10% per annum in recent times.

	\$M	Incr.
2003-04	165	
2004-05 Actual	181	10%
2005-06	180	0.0%
2006-07	186	2.7%
2007-08	192	3.3%

Drug costs comprise approximately 30% of the budgeted costs above, other treatment costs 70%. Auckland DHB's expectation, based on recent trends, has been drug cost inflation of 6%. This trend is reflected in the drugs portion of the budgets above. For other costs the following cost increases have been assumed:

2005-06	2.4%
2006-07	2.1%
2007-09	2.1%

The risk associated with managing treatment costs can be gauged by comparing the level of these increases with the price, quality and technology % increases noted in previous years.

Table 17: Funder payments

	June 2005 Actual \$,000	June 2006 Budget \$,000	June 2007 Budget \$,000	June 2008 Budget \$,000
Pharmacy	91,663	95,887	99,435	102,418
Pharmac Rebates	(12,355)	(13,712)	(11,842)	(12,197)
Laboratory	71,124	74,000	79,525	81,911
PHO	37,259	42,000	43,544	44,850
Mental Health	35,178	34,136	34,812	35,856
Health of Older People	78,374	84,989	88,133	90,777
Other	28,134	31,181	32,069	33,032
IDF Expenditure	95,485	91,524	94,910	97,757
	424,862	440,005	460,586	474,404
% Increase over prior year		3.6%	4.7%	3.0%

Funder payments for the 2005-06 have been impacted by the following major factors:-

- Pharmacy: The Pharmac advised increase for pharmacy expenditure is 5.5%. In addition Auckland DHB has provided for a full year share of the Pharmacy One contract taken over from Waitemata DHB
- Pharmac Rebates: Pharmac rebates for the 0405 year reflect the inclusion of rebates due to Auckland DHB at 30 June 2005. The policy of recording rebates received in cash and due each year will continue in the 0506 year
- Laboratory: Auckland DHB has assumed a 4.0% growth in underlying laboratory business. A procurement programme is currently in progress aimed at delivering system efficiencies that will provide reduced purchasing costs and process efficiencies
- PHOs: As in the 2004-05 budget the cost estimates have been based on the numbers of enrolled patients for the June 2005 quarter. In addition there has been a small allowance made for growth
- Health of Older People: There are three elements driving the increase in this expenditure
 - an 8.0% increase in home support costs
 - a 3.0% increase for residential rest home costs
 - the impact of the rise in the level for asset testing which has resulted in higher numbers of eligible patients

Table 18: Property & equipment maintenance

An analysis of the major items included in this expense is set out below.

	June 2005 Actual	June 2006 Budget	June 2007 Budget	June 2008 Budget
Equipment Maintenance	8,186	9,240	9,953	10,165
Computer Maintenance	13,126	12,836	13,113	13,283
Utilities, Security & Property Management	22,595	25,037	25,610	26,119
Other	3,789	3,635	3,526	3,602
	47,696	50,748	52,202	53,168
% Increase over prior year		6.3%	2.9%	1.8%
Major Property Maintenance	252	400	750	1,000
Building Demolition	963	1,389	-	-
	1,215	1,789	750	1,000
	48,911	52,537	52,952	54,168

It is anticipated that, as the building programme draws to a close, the cost of major building & plant maintenance will begin to rise in order to maintain the standard of facilities for the future. In addition, as the building programme draws to a close, the requirement for building demolition work will disappear.

Table 19: Administration

An analysis of the items in excess of \$1.0 million included in this expense is set out below

	June 2005 Actual	June 2006 Budget	June 2007 Budget	June 2008 Budget
Advertising	1,271	1,642	1,676	1,706
Books, Journals & Publications	1,227	1,327	1,383	1,409
Postage	1,391	1,253	1,271	1,296
Consultancy	3,811	2,800	2,321	2,370
Printing & Stationery	3,343	3,336	3,459	3,596
Tolls	1,068	1,185	1,210	1,235
Other Items < \$1.0m	5,868	6,085	6,265	6,733
	17,979	17,628	17,585	18,345
% Increase over prior year		(1.95)%	(0.05)%	4.3%

Administration costs have been based on prior years trends and known cost increases, but have also taken account of new strategies such as the implementation of an Auckland DHB wide communications strategy and organ donation publicity programmes, the latter being specifically ministry funded.

Table 20: Savings included in budget - \$ million

	2006	2007	2008	Total	Benchmark
Source of Savings:-					
1 Living within Means	11	11	11	33	33
2 Root Causes					
– Pay gap: bring our total costs of employment more into line with the health sector generally	8	8	10	26	40
– Efficiency: make sure that our costs for a given level of patient care are more in line with the sector generally	6	7	3	16	16
– Infrastructure: ensure costs from ownership of assets are proportionate with other DHBs	14	1	1	16	23
– Impact of PBFF on savings programme		(7)		(7)	
– Other including Service Configuration: ensure our services are properly 'sized' and adequately compensated for the service provided	8	6	4	18	21
Gross incremental savings in budget	36	15	18	69	100

Reductions in Savings:-				
Gross incremental savings in Budget	36	15	18	69
Redundancy costs	(8)	(2)	(5)	(14)-
Net incremental savings in budget	28	13	13	54

Cumulative Savings:				
Net Cumulative Savings	28	41	54	69

The savings of \$69 million flowing into the 2008 year will substantially address the underlying deficit reflected in the 2005 results. The savings targets are eroded in 2007 and 2008 by the unfunded portion of increases in costs arising from the asset revaluation performed in 2005 (i.e. Capital Charge and Depreciation) amounting to \$7 million per annum.

Table 21: Specific savings identified in the budget

	Root Cause	2006 \$m	2007 \$m	2008 \$m
Savings identified in DAP				
Ongoing Savings				
Nursing – benchmarking	Pay Gap	1.20	2.60	3.80
Medical staff - benchmarking	Pay Gap	-	2.40	3.60
CTA	Pay Gap	0.26	0.26	0.26
OR/SSS – efficiency	Efficiency	-	1.20	3.00
ACH – FTE growth adsorption	Efficiency	2.08	2.08	2.08
HRMS – impact on support services	Efficiency	0.35	0.35	0.35
OAS	Efficiency	0.50	0.50	0.50
Materials management	Efficiency	1.00	1.00	1.00
Ambulatory care savings	Efficiency	0.91	0.91	0.91
GHS stretch savings	Efficiency	0.83	0.83	0.83
HSL Rebates	Efficiency	0.31	0.31	0.31
ACH - 3rd party treatment	Service configuration	0.72	0.72	0.72
Research	Service Configuration	0.50	0.50	0.50
Bonds - no covenants	Infrastructure	2.82	2.82	2.82
Fixed Assets- Depreciation	Infrastructure	10.00	10.00	10.00
		21.48	26.48	30.68

Analysis carried out while compiling the 2005-05 Annual Plan and budget shows that the deficit arises from a number of factors:-

- Staffing costs out of line with the health sector generally
- Capital costs likewise out of line
- Lower efficiency than other healthcare providers
- Failing to constrain increases in spending within funding increases on a year to year basis

It will be clear from this list that some factors are the result of decisions made over many years. The deficit reduction is required to be implemented over a more contracted timescale. Accordingly, the savings identified above are large and challenging, and there is a correspondingly high risk associated with achieving them. Some of these have been partly mitigated against:-

- The potential one-off costs of change e.g. redundancy payments
- Slippage in achieving such large savings
- Lack of acceptance and push back by staff and unions

Table 22: Depreciation and capital charge

Depreciation	FY2005 Actual \$,000	FY2006 Budget \$,000	FY2007 Budget \$,000	FY2008 Budget \$,000
Buildings & Plant	12,375	9,969	9,944	10,747
Clinical Equipment	16,406	18,892	18,882	20,409
Other Equipment	2,394	2,728	2,727	2,946
Information Technology	11,467	14,149	14,119	15,258
Motor Vehicles	34	34	3	-
	42,676	45,772	45,675	49,360
Asset Revaluation	-	3,252	3,252	3,252
	42,676	49,024	48,927	52,612
Asset Purchases under \$1000	403	422	398	399
	43,079	49,446	49,325	53,011

Capital Charge	FY2005 Actual \$,000	FY2006 Budget \$,000	FY2007 Budget \$,000	FY2008 Budget \$,000
Capital Charge before impact of Asset Revaluation	17,909	14,416	9,495	8,046
Increase in Capital Charge as a result of Asset Revaluation	-	11,454	11,454	11,454
	17,909	25,870	20,949	19,500

The tables above are designed to demonstrate the impact of the asset revaluation on the depreciation expense and the capital charge. The Ministry of Health will fully fund the cost

increase effects as a result of the revaluation in the 2006 year and partly offset the cost impacts in the outer years.

Table 23: Capital budget

	FY2006 Budget \$,000	FY2007 Budget \$,000	FY2008 Budget \$,000
Routine Capital			
New Requests	3,381	10,094	10,000
Information Systems	6,200	10,000	20,000
Operations			
Brought Forward from prior years			
Information Systems	4,832		
Operations	5,803	3,300	
Total Routine Capital Spending	20,216	23,394	30,000
Abnormal Capital			
Building Programme Projects	24,963	5,700	-
Building Refurbishments & Relocations	3,000	-	-
Total Abnormal Capital Spending	27,963	5,700	-
Total Capital Spending	48,179	29,094	30,000

It is Auckland DHB's intention to set aside long term depreciation for debt repayment. The table below demonstrates how this is to be achieved by highlighting the surplus of depreciation over routine capital spending.

Table 24: Depreciation used to fund future capital and retire long term debt

	FY2006 Budget \$,000	FY2007 Budget \$,000	FY2008 Budget \$,000
Depreciation expense	49,447	49,325	53,011
Less Depreciation for the following items			
- Asset purchases under \$1000	(423)	(398)	(398)
- Asset Revaluation	(3,252)	-	-
- Long term building & plant	(9,969)		
Asset revaluation		(3,252)	(3,252)
- Long term Debt repayment		(9,944)	(10,747)
Depreciation available for routine capital spending	35,803	35,731	38,614
Routine Capital Spending	20,216	23,394	30,000

Three year Summary:

Total Depreciation 2006-2008	\$151,783,000
Less: Total Funds allocated for Debt Retirement	<u>\$ 20,691,000</u>
Funds available for Capital Expenditure	\$131,092,000
Total Capital Requirements 2006-2008	\$107,273,000

Table 25: Gearing covenant

Equity Ratio	2004-05 Actual \$000	2005-06 Budget \$000	2006-07 Budget \$000	2007-08 Budget \$000
Current portion	35,598	35,598	55,000	55,000
Non-current portion	270,236	295,000	304,500	294,000
Total debt	305,834	330,598	359,500	349,000
Equity	329,220	301,095	256,259	243,932
Total debt plus equity	635,054	631,693	615,759	592,932
Ratio of total debt to debt plus equity	48.16%	52.34%	58.38%	58.86%

This ratio complies with the gearing covenant ratio contained in the deed of negative pledge.

5.6 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 Auckland DHB 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 Auckland DHB, 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 Auckland DHB is a going concern.

Financial Forecasts

The forecast figures are those approved by the Board. The forecast 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 Auckland DHB 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 is the primary beneficiary of the Trust. 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 Auckland DHB 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 received.

(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 property plant and equipment:

- Freehold Land
- Land Improvements
- Leasehold Improvements
- Plant and Equipment
- Work in Progress
- Freehold Buildings
- Leased Plant and Equipment
- Building Fitout and Services

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

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). Valuations have been obtained through an independent valuer.

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 and are recorded in current assets.

(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:

Asset Class

Freehold Buildings	1 to 89 years
Plant and Equipment	2 to 20 years
Building Fitout and Services	1 to 45 years
Leased Plant and Equipment	4 to 8 years
Leasehold Improvements	6 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.

5.7 Process for the sale of surplus property

Stage 1: Identification and Preparation

Land or property no longer required is identified. If it does not have a separate title it may need to be subdivided in accordance with the requirements of the Auckland City Council.

Stage 2: Surplus Declaration

- a) Public Consultation is undertaken, as required by the NZ Public Health and Disability Act. The outcome of the consultation informs the Board decision about whether to proceed or not.
- b) The land is declared surplus by the Auckland DHB Board. A recommendation is made to the Management Finance Committee and Board, after evaluating the submissions received, to either proceed with the sale or not. The recommendation is accompanied by a recent valuation. The Board will then decide to accept or reject. If the Board accepts a recommendation to sell then a motion is passed to declare the land surplus to requirements and to seek Ministerial approval.
- c) Auckland DHB requests the Minister of Health to approve the decision to declare land surplus. Once received, the statutory clearance processes can proceed. The process is irreversible from this point.

Stage 3: Statutory Clearances

- a) Section 40 of the Public Works Act requires properties which were acquired compulsorily under the Act to be offered back to the former owners or their descendants if they are no longer required for the public work. An investigation into the property's history will be carried out by one of the consultants accredited by LINZ to do this work and the CEO LINZ will make the decision on whether it must be offered back. If an offer-back is made it will be at market valuation.
- b) If an offer-back is not required, or it is declined by the former owner, the process enters the Maori Protection Mechanism. This is done by the Office of Treaty Settlements, which invites claims for Landbanking and Sites of Significance. Office of Treaty Settlements then assesses whether to landbank the property for possible use in future Treaty settlements. If the decision is to landbank then Office of Treaty Settlements settles with Auckland DHB, again at market value.
- c) If the property is not landbanked the process passes to Te Puni Kokiri (Dept of Maori Affairs) to assess whether there are valid claims for sites of significance. The outcome of this is uncertain but, if there is some cultural significance at the site, it can often be addressed by a suitable acknowledgement e.g. a plaque.

Stage 4: Sale

After completion to this point the property can be marketed in the normal manner and sold.