West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

STRATEGIC PLAN
2002 – 2012

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FOREWORD

AN OPPORTUNITY TO HAVE YOUR SAY IN OUR COMMUNITY'S HEALTH

The West Coast DHB has been charged with the responsibility of preparing a Strategic Plan for the provision of health and disability services on the West Coast. Input from the community is integral to the preparation of this plan. We need your views and your feedback to ensure, that together, we make the best choices, within the constraints we face, for our community.

Our consultation process will involve health providers, local councils, Iwi groups, community groups and individuals with a view to creating the best health services for our region within the funding provided by Government.

By being involved in the DHB's Strategic planning process you can contribute to a community that has an active interest in its own health, both at an individual and collective level.

Our proposed key health priorities, which are listed inside the document, reflect the Government's expectations of DHBs. One significant priority is the implementation of the New Zealand Primary Care Strategy. A significant part of our plan to support this strategy is the creation of one (or possibly more than one) Primary Health Organisation – about which more can be read in this document.

This is an exciting and challenging time in health. We encourage you to be part of the consultation process and look forward to your input.

Rick Bettle
Chairman

John Luhrs
Chief Executive

RECOGNITION OF TREATY

As a Crown agent, the West Coast DHB accepts its responsibilities and obligations to Maori as set out under the New Zealand Public Health and Disability Act 2000.

It is the intention of the West Coast DHB to reduce Maori health inequalities on Tai Poutini. Among its goals is to ensure wherever the West Coast District Health Board delivers its services, these services will be delivered in a culturally appropriate way.

The West Coast DHB intends to improve its effectiveness of services to Maori by seeking Maori participation in the planning and delivery of services. The West Coast DHB will work to address the barriers that exist for Maori therefore ensuring accessible and appropriate services to Maori.

The West Coast DHB aims to improve its services to Maori by ensuring that staff of the West Coast DHB are given an opportunity through training to gain a comprehensive understanding of the Treaty of Waitangi and its implications and guidance for Maori Health gain and best practice.

SIGNATORIES

AGREEMENT DATED THIS DAY OF 2002

(Made under section 38 (3)c of the New Zealand Public Health and Disability Act 2000)

BETWEEN

Hon Annette King
Minister of Health

Rick Bettle
Chairman of West Coast DHB

1.0 INTRODUCTION

On January 1st 2001, 21 District Health Boards (DHBs) were created as part of the Government's restructuring of the health sector. The West Coast DHB is responsible for working cooperatively with health professionals and the community to improve the health and well being of the people of the West Coast, and, in particular, to reduce disparities in health outcomes of Maori and other population groups.

The Maori Unit at Grey Base Hospital provides links between the West Coast DHB and the Maori community. It is responsible for advising the West Coast DHB on its responsibilities to Maori in a manner consistent with the principles of the Treaty of Waitangi.

The West Coast DHB both provides and funds health and disability services. Services are provided by public hospitals and related services (run by the West Coast DHB) or by other independent providers, such as general practitioners, pharmacists, disability support and mental health community and residential services.

The West Coast DHB is also committed to foster the education of health professionals through its services directly and in association with tertiary institutions, such as Tai Poutini Polytechnic.

The name Coast Health Care will continue to exist. It now refers to the hospitals and related services i.e. those health and disability services provided by the DHB. The West Coast DHB operates Coast Health Care.

The Board has three arms:

1. ***Governance*** – the administration of the Board

2. ***Funder*** –funding publicly funded health services on the West Coast.

3. ***Provider*** – providing its own services at Grey Base Hospital (Greymouth), Seaview Hospital (Hokitika), Buller Hospital (Westport), Reefton Hospital, Hokitika Health Centre, plus a number of clinics around the region. This arm provides a range of acute medical and surgical inpatient services, accident and emergency, AT&R services, continuing care for the elderly, mental health inpatient and community services, community based professional and support services, and primary practices.

The financial affairs of the three arms are separate from each other as a matter of Government policy.

The Board will eventually be responsible for the funding of most publicly funded health services on the West Coast. In this regard, the Board has acquired most of the functions undertaken by the former Health Funding Authority.

The West Coast DHB is required under the New Zealand Public Health and Disability Act 2000 to have three standing committees. These are the Community and Public health Advisory Committee (CPHAC), the Disability Support Advisory Committee (DSAC) and the Hospital Advisory Committee (HAC). The West Coast DHB has also established one further committee: the Mental Health Advisory Committee (see Appendix 1).

1.1 PURPOSE OF THE STRATEGIC PLAN

In order to plan health and disability services for the West Coast, the West Coast DHB assessed the health needs of the people of the West Coast using data collected from a variety of sources, including;

- national policy documents
- demographic needs analysis.
- the impact of future demographic change on both service demand and funding information, on the provision of, and accessibility, to existing services.

In addition the West Coast DHB involved the West Coast community in the consultation process or decision-making process by obtaining information through;

- opinion surveys and questionnaires
- community meetings
- meeting with hospital and community practitioners
- meetings with independent service providers
- meetings with West Coast DHB mangers
- meetings with other agencies.

Based on the findings of the needs assessment, this Strategic Plan proposes a high level strategy for the next 5-10 years for how the West Coast DHB will plan and fund health and disability services that best meet the needs of the people of the West Coast.

1.2 PROCESS FOR DETERMINING THE PLAN

Section 38 of the NZPHD Act 2000 sets out requirements for a DHB Strategic Plan; to develop a plan that sets out to achieve its objectives and functions during a five to ten year time period.

The role of the District Strategic Plan is to identify how the West Coast DHB will work towards achieving the New Zealand Health Strategies over a 5-10 year time span by:

- identifying the significant internal and external issues that impact on the West Coast DHB and affect its ability to fulfil its mandate and purpose
- identifying strategic priorities that demonstrate the contribution that the West Coast DHB will make towards the Government's goals and priorities
- Outlining planning that sets out:
  - the major strategies it intends to adopt to achieve its strategic priorities and how these will be managed; and
  - how it will maintain, build or access the capabilities required to perform its functions as owner, funder and provider.

** Refer to Appendix for summary of Health Needs Assessment

1.3 WEST COAST DISTRICT HEALTH BOARD VISION STATEMENT

"To fund a continuum of quality health services aimed at providing improved health outcomes and maximising the independence of people with disabilities"

WHAKATAUKI

"He aha te mea nui o te ao … he Tangata, he Tangata, he tangata"
What is the greatest treasure of the world?… it is people, it is people, it is people

"Ko tau rorou, ko taku rourou, ka ora ai te iwi"
With your contribution and my contribution we will be better able to serve the people

Principles

Improved Health for the people of the West Coast through better:

Access

Provide the people of the West Coast with equitable access to a comprehensive range of primary and secondary health services in the most appropriate location.

Integration

Establishment of closer working relationships between all health care professionals to provide more comprehensive, better coordinated client centred health care services and to ensure seamless continuity of care for patients.

Quality

The degree to which services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Values

All activities of the West Coast DHB will reflect the values of:

- Manaakitanga – caring for others
- Whakapapa –identity
- Integrity
- Respect
- Accountability
- Valuing people
- Fairness
- Whanaungatanga- family and relationships

1.4 PRIORITY SETTING FRAMEWORK

The West Coast DHB proposes to adopt a prioritisation process, which links strategic planning with annual planning. The Community and Public Health Advisory Committee will work in the next year in consultation with the community to develop a priority setting framework.

The challenge is to build a priority-setting framework which:

- is relevant to (and fits seamlessly into) local strategic and operational planning cycles
- reflects, as much as possible within the national directives, specific local priorities.

The aim of the West Coast DHB is to develop a means of facilitating decision making, which:

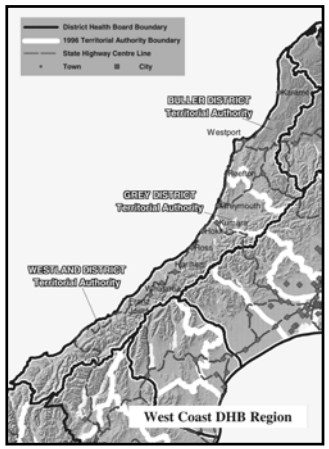
- is explicit and transparent (can be 'seen and understood')
- facilitates a consistent approach to difficult decisions about the allocation of resources at the DHB level
- facilitates public input to and debate over the strategic directions and priorities
- enables the DHB to be accountable for its decisions through an agreed decision making process
- manages service development within the available funding.

2.0 THE WEST COAST

2.1 ENVIRONMENT

The West Coast covers the area between Karamea in the north and Haast in the south and extends east to Springs Junction. The length of this landmass is approximately equal to the distance between Auckland and Wellington, with a land area of 2.3 million hectares, much of which is rugged, and through which are scattered small, isolated pockets of population.

The West Coast is the most sparsely populated DHB in the country with a population density of 1.4 people per square kilometre spanning 3 territorial local authorities (TLAs).



The West Coast is a popular tourist destination with an average of approximately 4500 visitors every day.

Hospitalisation rates of overseas visitors in this region is similar to the national average, and the use of primary care or hospital outpatient/emergency services by tourists is significant.

Rainfall is around twice the national average. The resultant dampness may have implications for people with such illnesses as respiratory diseases, or arthritis.

Demographics

To help set priorities for health funding and strategic planning, we first need to assess the demographic makeup of our communities and the health needs of our population of 30,303 (information based on 2001 NZ census).

DEMOGRAPHIC SUMMARY:

- population projected to decrease by 2.5% in the next 10 years
- 0.8% of the population occupying 8.5% of the total New Zealand land area
- lowest population density in New Zealand
- lowest proportion of Maori (less than 10%) than in New Zealand (15%)
- maori population expected to grow to 14.4% in the next 10 years
- maori population aged over 55 years is expected to grow 64.3% in the next 10 years
- The total population aged over 65 years is expected to grow 20.9% in the next 10 years
- Low fertility and birth rates, relative to New Zealand
- birth rate for Maori significantly lower than for Maori in NZ, though higher than non-Maori
- a very small Pacific Island population
- more males than females, notably in the 40-74 years age group
- higher overall mortality rate than New Zealand overall
- higher mortality rate for men than for men in New Zealand overall.

Socio-Economic And Health Status

A wide range of health indices and risk factors have been found to be patterned by socio-economic factors such as deprivation, income, education, labour force status, housing and occupational class.

The socio-economic status is low on the West coast compared to the rest of the country – the Buller community, in particular, ranks low in New Zealand socio-economic status, with a high proportion of elderly, unemployed and

welfare recipients. The level of deprivation is high.

- median personal income for the West Coast is $14,591, which is 79% of the national average – income levels for individuals[1]
- the proportion of population aged 15 years or over is significantly lower than the rest of New Zealand
- the proportion of people on a benefit is significantly higher than the rest of New Zealand (42% for 1996 compared to the national figure of 38%)
- high percentage of people without qualifications (45%) compared to the rest of New Zealand (35%)
- higher smoking rates compared with other regions – West Coast teenagers have the second highest rate of smoking in New Zealand
- higher than average levels of drug, alcohol and substance abuse
- highest rate of pertussis (whooping cough) in New Zealand
- immunisation rates appear too low to provide adequate protection for the whole community
- highest rate of motor vehicle crashes in New Zealand
- relative risk of cancer for both males and females high.
- employment predominantly high risk industries e.g. mining, fishing, forestry.

[1] Refer Appendix – Environmental Issues

Primary health care utilisation

The paucity of primary health care data for West Coast, as for New Zealand as a whole, is a clear gap in the needs assessment. Understanding the ways and reasons that people use primary health care services is vital for robust analysis. Increasing the capacity for gathering and sharing primary health care data is an important issue for West Coast.

Prescriptions

The use of prescribed drugs in each DHB can be used as a proxy for utilisation of primary care. From prescribed drug usage, inferences can be made about the extent to which need is being met, and/or may prompt questions about diseases and their management in the region.

The total annual per capita expenditure on prescriptions on the West Coast is similar to the national average ($138.52 versus $139.30). The average annual number of prescriptions per capita is higher than New Zealand (11.0 versus 10.1) The types of prescriptions for which numbers, and cost per capita, were above average were most notably cardiovascular, followed by respiratory/allergy, blood and blood-forming organs, and nervous system prescriptions. The higher than average levels of deprivation, and consequently, the higher morbidity, would be expected to result in a higher prescribing rate. This may indicate that lower income levels may inhibit attendance at a doctor and / or subsequent uptake of a prescription.

Diagnostic laboratory tests

Utilisation figures for laboratory tests ordered by referring GPs in the region provide a further component of the health status picture. The average per capita costs of diagnostic laboratory tests on the West Coast were among the lowest in New Zealand for most categories, most notably for cytology and histology tests. It is difficult to draw conclusions from this, but again this may point to an under-utilisation of primary care services.

Secondary health care utilisation

There were 23,531 admissions to public hospitals of people living in the West Coast region in the four years between 1996 and 2000, an annual average crude rate of 179.9 per 1000 (compared with the New Zealand rate of 150.6). The age-standardised all cause hospitalisation rates for West Coast and New Zealand are 165.0 and 143.1 respectively (SRR = 1.15, 95% CI = 1.14 to 1.17). During that period, nearly all major diagnostic categories showed similar or higher hospitalisation rates compared with New Zealand overall – only admission rates for pregnancy/birth and newborns were lower.

An analysis of case-weighted acute admissions for the period July 1996 to June 1999 revealed that in New Zealand during

this period the acute growth is largely an urban phenomenon, whereas many regional providers have experienced falling acute volumes. This is evident on the West Coast where the rate of acute admissions into a hospital in the region fell by 9.0% between 1996 and 2000. However, the number of acute admissions anywhere in New Zealand, from the population normally resident on the West Coast, increased by 9.2% between 1996 and 2000. The number of missions flown from Greymouth Hospital, taking patients to hospitals in other regions, rose from 45 in 1997, to 117 in 2000. The population of the region fell by 6.5% during 1996 and 2001.

Admissions to hospital on the West Coast of patients who normally reside outside the DHB region made up 6.6% of all admissions between 1996 and 2000, compared with the New Zealand average of 17.9%. During this time there was an annual average of 1214 admissions of West Coast residents to hospitals outside the DHB region, compared with an annual average of 329 admissions of people resident outside West Coast to hospital on the West Coast.

Waiting lists and times

Reducing waiting times is a priority service area for the *New Zealand Health Strategy*. The objectives are to have most people (90%) assessed by a specialist within two months of referral, all people assessed by a specialist within six months of referral, and all people assessed by a specialist as meeting the criteria for publicly funded treatment receiving treatment within six months of the assessment. However, due to the number and frequency of clinics by visiting specialists to the West Coast, the DHB will be constrained in meeting those targets.

The West Coast DHB fully supports these targets and is committed to using its best endeavours to achieving these for all services we provide, both through appropriate purchasing and securing resident and visiting specialist staff, in order to meet demand.

Utilisation of other services

This is an area to explore in future needs assessments.

Health Services - Non District Health Board Providers

The West Coast has the following health services and providers:

- General Practitioners
- Optometrists
- Dentists
- Pharmacists
- Podiatry
- Physiotherapy
- Chiropractors
- Private Rest Homes and Geriatric Hospitals
- PACT community residential services
- Crown Public Health (including health promotion and health protection services)
- Disability Information Service
- Lifelinks Needs Assessment and Service Co ordination Service
- Access Homehealth
- Rata Te Awhina
- Rata Maori Women's Welfare League (including Te Waka Hauora mobile Health Clinic)
- Royal New Zealand Plunket Society
- St Johns Ambulance/Air Ambulance services
- Special Education services
- Healthline
- Coast Care Trust
- A number other providers including alternate health care providers

2.2 SERVICE ISSUES & INFRASTRUCTURE

Summary of Access and Capacity Issues

The West Coast DHB is the major provider of health services on the West Coast and the largest employer. The Health services are provided at Grey Base Hospital – Greymouth, Seaview Hospital – Hokitika, Buller Hospital – Westport, Reefton Hospital, Hokitika Health Centre, plus a number of clinics around the region.

Clinical Viability

Clinical Viability is a key issue for the West Coast DHB, with in particular, the senior medical specialist numbers low and at a minimum required to deliver the service. On call rosters and cover can be onerous, and in a number of disciplines specialists are on call for one day out of every two and one weekend out of every two. The DHB will continue to work with other DHB's for the provision of clinical services, as appropriate.

Recruitment

The West Coast DHB also has significant recruitment problems with clinical and other professional staff, which contributes towards significant costs in recruiting and retaining those skilled staff. The West Coast DHB faces this dilemma in order to meet the purchasing intentions of the Ministry of Health and in particular the requirements to deliver a 24-hour trauma service. Recruitment difficulties also impact greatly on other health service providers and areas such as patient records and satisfaction.

The Paediatric Review carried out by the West Coast DHB in January 2001 highlighted some of the problems faced in this isolated region, such as lack of adequate access to a paediatric medical outpatient service on the West Coast, poor stability and lack of continuity in general practices services for much of the West Coast population, no resident Paediatrician to provide leadership in child health.

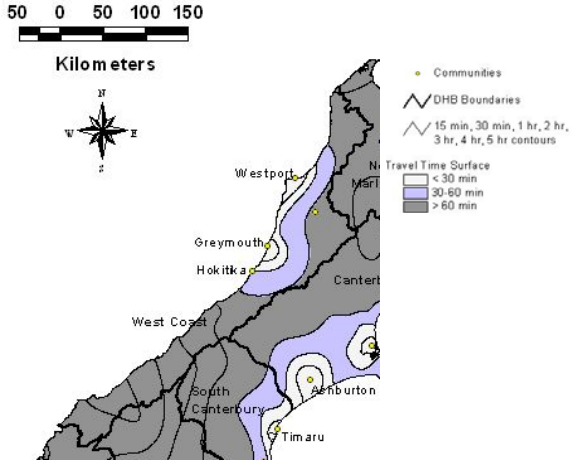
Primary Health

The West Coast DHB has played a leading role in sustaining primary health services on the West Coast by purchasing GP practices in both Westport and Greymouth. A number of General Practitioners have been recruited with the financial backing of the previous Health Funding Authority.

A steering committee has recently been formed in the community with regard to the development of a Primary Health Organisation on the West Coast. Discussion has centered on the retention of health professionals in the region and the development of structure of primary health care in line with the Government's Primary Health Care Strategy.

Access

Travel time to closest hospital



Travel time in motor vehicle to nearest hospital (sub-acute or higher). Note that this map provides population level travel estimates across the country; it is not intended that this should be used to predict an individual's travel time.

For those living in rural areas, travel times to hospital are a major access barrier. Difficulties are compounded for people without access to a car or suitable public transport.

Due to lack of public transport and low average income, subsidised transport from outlying areas should be investigated.

Health Services Stocktake

Maori health providers

Service responsiveness to Maori includes the promotion of access by Maori health consumers to Maori tohunga for use of rongoa or other specialist/traditional Maori health interventions. Collaborative relationships between local Maori health providers and mainstream providers are ways to improve service access and responsiveness to Maori tangata whaiora/consumers.

The service provider stock take identified seven Maori health service providers on the West Coast:

- Kawatiri Maori Women's Welfare League in Westport provides health promotion and information
- Rata Branch, Maori Women's Welfare League, in Hokitika, provides Te Waka Hauora mobile health clinic, and health research
- Rata Te Awhina Trust in Hokitika provides Maori health and social services including screenings, blood pressure and blood sugar checks, smoking cessation, cervical smears, asthma education, Whanau Ora, Tamariki Ora, Well Child checks, Mother & Pepi, a disease state management nurse, health promotion, parenting education, budgeting, whanau support, counselling, advocacy, stopping violence programmes, self esteem for young people, a truancy officer, and Whanau Toko I Te Ora
- Te Korowai Aroha O Mawhera Whanau Support in Greymouth provides cross-sectoral services, including education, home-based support, parenting skills, youth services, and makes referrals to other agencies
- Waka Taua Charitable Trust in Greymouth lists amongst its objectives a desire to promote healthier lifestyles for Maori on the West Coast.

General medical practitioners and nurses

West Coast has one of the lowest ratio of GPs in New Zealand. Provider survey respondents considered that there are not enough GPs on the West Coast, and that this results in a lack of continuity for patients, and long waiting lists for non urgent appointments. Like GPs in other rural regions, GPs on the West Coast work longer than full-time-equivalent hours (they average 1.18 FTE).

The number in the nursing workforce on the West Coast is higher than the national average (due to diseconomies of scale and minimum staffing needs), it has one of the highest ratios of registered nurses per 10,000 population in New Zealand. However, it has one of the lowest ratios of nurses with midwifery qualifications. Although Maori make up around 10% of the West Coast population, only around 5% of nurses in the region are Maori.

Dental services

There are five active dentists listed on the West Coast, with one in Buller, three in Greymouth, and one in Westland. These low numbers result in the lowest ratio in New Zealand of active dentists per 100 000 population 14 years and over. Provider survey respondents expressed concern regarding the shortage of dentists and dental therapists on the West Coast, and the long waiting times for emergency dental treatment.

Mental health services

On the West Coast, the mental health services include:

- adult mental health services, consisting of community mental health and inpatient acute service
- alcohol and drug services, including a methadone service
- child and adolescent mental health service
- elderly care, composed of inpatient long term psychiatric, intellectually disabled, and assessment and treatment of dementia services
- triage, assessment crisis and treatment service (which includes a 24-hour

psychiatric emergency service) plus short-term case management and ongoing support of severely mentally ill in the community
- crisis and planned respite services.

Service integration

The HNA identified consumer feedback that showed a need for greater liaison and communication between primary and secondary services.

West Coast DHB Workforce Profile

The following table provides an occupational breakdown of FTE.

Discipline	**No FTE's as at February 2002**
Clinical Support	197.2
Management / Admin	91.5
Medical	42.3
Nursing	223.3
Physical Resources	33.3

2.3 QUALITY AND SAFETY ISSUES FACING THE WEST COAST DHB

The following issues will impact on the future safe provision of services by the DHB and will require ongoing attention:

- recruitment/retention of health practitioners - in particular but not exclusively:-
  - GPs
  - Nurses
  - Allied health
  - Dentists
  - Medical and Surgical Specialists including Anaesthetists
- funding constraints in an environment experiencing significant cost increases
- capacity as a small DHB to fulfil the expectations of the population and of the Ministry of Health in an increasingly complex health environment
- improving the collaboration and information sharing between health professionals
- the need to focus on patients and consumers with active involvement of consumers and communities at all levels
- strong clinical leadership
- acknowledgement of different values and perspectives among consumers/ patients and health professionals
- continual striving for Clinical competency based on evidence based best practice
- achieving cultural competency
- Lack of integrated data collection and systems capacity between providers.

2.4 GOVERNMENT IMPERATIVES

Timely and Equitable Access

Both the Government and Board want people to have timely and equitable access to health services.

The Government currently has a comprehensive set of rules around access to services within which Boards must operate. It includes the:

- Service Coverage Schedule – defines the services that must be provided
- Elective Services project – sets criteria for access to and operation of elective services (e.g. non urgent surgery)
- Ministry of Health - sets the scope and volume of hospital services to be provided.

Fixed Level of Funding

While it is appropriate for the Board to inform the Minister and public of any additional funding needs it may have, ultimately the Board will be given a fixed level of funding within which it must operate.

Mental Health Blueprint and Regional Planning

The Board together with the other five South Island DHBs has two groups involved in regional planning: the Shared Services Agency (SISSAL) and the South Island Mental Health Network (SIMHN). The SIMHN has produced a regional strategic plan to inform individual Board strategic plans.

Population Health Focus

A population health focus emphasises the needs of the whole community or segments within it, rather than the needs of individuals. This approach should maximise the benefit to the maximum number of people.

Requirements for Long Term Investment in Public Health Services

Long term gains in the health of the population will depend more on healthy environments and lifestyles than on provision of hospital services. The Board's obligation to have a population health focus reflects the importance of lifestyle issues such as smoking, exercise, nutrition and alcohol consumption, as well as broader environmental issues such as clean air and water.

However, the gains from this approach in terms of reduced demand on health care services could take many years to realise, and there is therefore a tension between the population ("preventive") approach, and the secondary care ("treatment") approach.

The Board recognises the importance to the community of good access to health care services, particularly elective hospital services, and the significant impact on the individuals who need them. The Board's intention to maintain current hospital services is outlined elsewhere in this plan.

At the same time, the Board is committed to a population health approach, and sees population health initiatives in both community and primary care settings as key areas for future investment.

2.5 THE PLANNING ENVIRONMENT

The Government has changed the structure of the health system to ensure that health and disability services are directed at those areas that promise the highest benefits for our population, focusing in particular on reducing inequalities in health.

These changes are being guided by overarching strategies, in particular the New Zealand Health Strategy, New Zealand Disability Strategy, Primary Health Care Strategy and the He Korowai Oranga Maori Health Strategy. These strategies provide the basis for the development of this Strategic Plan. In addition, other Ministry of Health documents have been utilised in developing the proposed strategic priorities.

New Zealand Public Health and Disability Act 2000* (The Act) forms the legislative platform for the West Coast DHB and puts the recent changes into effect. The Act requires a reduction in health disparities between population groups. It also specifies that the organisation of health care should involve the greater integration between primary and secondary care. ** This has also been considered when developing this Strategic Plan.

3.0 DHB KEY OBJECTIVES

INTRODUCTION

The following key objectives represent the areas that the West Coast DHB considers have most potential to make the most health gain for the West Coast population. They are part of the Government's health priorities. In addition, local health needs assessment has shown these are of most concern to the local population.

All government health priorities are included in the plan. The priorities emphasise the importance of prevention and early intervention in taking a population health focus. [Refer Appendix 2 – Public Health]. However we have chosen to place most focus on these objectives.
The *New Zealand Health Strategy* outlines the Government's overall health focus and direction. The strategy outlines more specific goals and objectives to guide action on improving the health of the population, and reducing inequalities in health status between population groups. There are 61 objectives, 13 of which have been highlighted for DHBs to focus on for immediate action.

A number of the priority objectives relate to risk behaviours, which are those behaviours that either protect individuals or put them at risk of illness, injury, or death. They are considered to be preventable in the sense that behaviours are modifiable, though for some groups programmes to change lifestyle and behaviour have not been effective.

Risk behaviours are usually, more prevalent among groups with lower socio-economic status. It is important to address the socio-economic determinants of health, upon which risk behaviours are strongly patterned, in order to reduce obesity, smoking, alcohol and other drug use.

The West Coast DHB has further prioritised four of the priority objectives as being particularly relevant to health needs on the West Coast. This is not to diminish the importance of the remaining objectives which are also the subject of comprehensive work plans.

KEY OBJECTIVES

1. **The West Coast DHB will endeavour to improve, promote and protect the health of the West Coast community via a cohesive and collaborative approach to health service delivery.**

   Local consultation in conjunction with the West Coast Health Needs Assessment identified the following priority health need areas, in no particular order, in which it believes can significantly improve the health of people of the West Coast.

   - Diabetes – reduce the impact and incidence of diabetes
   - Cardiovascular disease – reduce the impact and incidence of cardio-vascular disease
   - Child/Tamariki health – implementing the principles of the Child Health Strategy
   - Oral Health – early identification or prevention of dental disease.
   - Cancer / Palliative Care – reduce the incidence and impact of cancer
   - Improve respiratory health and reduce the incidence of smoking.

2. **The West Coast DHB will endeavour to reduce health disparities by improving health outcomes for Maori through:**

   Partnership
   Working together with iwi, hapu, whānau and Maori communities to develop strategies for Maori health gain and appropriate health and disability services.

   Participation
   Involving Maori at all levels of the sector in planning, development and delivery of health and disability services.

   Protection
   Committed to the goal that Maori enjoy the same level of health as non-Maori and safeguarding Maori cultural concepts, values and practices.

3. **The West Coast DHB is aiming, through the formation of a Primary Health Organisation (PHO), to achieve improved health outcomes by delivering comprehensive community - focused primary care.**

   The West Coast DHB is committed to working with the primary community to develop a PHO on the West Coast that will support primary service development through development of an integrated primary care health delivery system for the West Coast.

4. **The West Coast DHB will promote effective care or support for those in need of disability support services through:**
   - greater health and independence for older people with more people able to remain in their homes for longer
   - a focus on reducing barriers for disabled people accessing or providing services.

INTRODUCTION

The following information explains in more detail how the West Coast DHB intends to achieve these key objectives.

OBJECTIVE ONE

THE WEST COAST DISTRICT HEALTH BOARD WILL IMPROVE, PROMOTE AND PROTECT THE HEALTH OF PEOPLE IN THE WEST COAST COMMUNITY.

The West Coast DHB has identified six priority health gain areas where it believes it can make a difference to the health of West Coast people.

These are:

3.1.1 Diabetes
3.1.2 Cardiovascular disease
3.1.3 Child/Tamariki Health
3.1.4 Oral Health
3.1.5 Cancer
3.1.6 Respiratory Health

REDUCE THE INCIDENCE AND IMPACT OF DIABETES

West Coast Health Needs Assessment
Small numbers on the West Coast lead to difficulties in arriving at conclusions. The hospitalisation rates for diabetes might be lower for both Maori and non-Maori, than the respective national rates. However, as in New Zealand overall, the rate of incidence of diabetes for Maori on the West Coast appears to be as much as three times higher than that for non-Maori.

Diabetes is a major cause of morbidity and early mortality, and causes problems for both those affected and their families. The most common of the two types of diabetes is non-insulin-dependent diabetes mellitus (type II), which is a disease of insulin deficiency and resistance and diagnosed most frequently in middle and older age groups. This form of diabetes accounts for nearly nine out of every ten cases of diabetes. Diabetes is rapidly increasing in New Zealand and the incidence is expected to **double** in the next 20 years. Maori and Pacific peoples are three to four times more likely to develop diabetes than other ethnic groups.

Cardiovascular disease is the leading cause of death in people with diabetes.

Key Issues:

- the incidence of type 1 diabetes (insulin dependent) has increased nationally almost five-fold amongst children/ tamariki and adolescents in the last 30 years
- type 2 diabetes (adult onset) rates are increasing. There are strong links between obesity and this type of diabetes
- diabetes can lead to blindness, heart disease and kidney failure
- The Ministry of Health predicts that over the next 20 years type 2 diabetes will increase by 90% for Maori and 39% for the remainder of the population
- the prevalence of type 2 diabetes is increasing both in New Zealand and around the world
- the impact of diabetes in terms of illness and mortality is significant. This impact will grow as the prevalence of type 2 diabetes increases along with the levels of obesity and physical inactivity in the community
- the prevalence of diabetes across the population of New Zealand is currently estimated at around 4%. Within the New Zealand population the prevalence of diabetes in Maori is around three times higher than among other New Zealanders
- diet and exercise can improve insulin action from between 16% and 23%
- cost is a barrier to obtaining regular health care for people on low incomes
- increased service and funding is needed for certain treatments when enhanced screening programmes identify more people with complications from diabetes.

In The Next Ten Years:

- achieve diagnosis for 80% of those with diabetes with a consequent reduction in the regional complication rate
- more effective interventions using evidence based guidelines
- improved uptake of interventions through improved access to services and more culturally appropriate services
- effective liaison and interface between primary, secondary and public health sectors.

In The Next Five Years:

Reduction of prevalence of diabetes (particularly amongst Maori)

- increased understanding of diabetes and self management for Maori, in particular:
- promote health promotion and disease prevention for diabetes risk factors
- Increased Maori workforce capacity.

Provision of appropriate screening programmes and treatments

- work to ensure that diabetes services are culturally appropriate through training of mainstream staff and establishing relevant services for particular groups
- review the provision of diabetes services, in line with the development of a PHO, and implement an action plan to ensure they best meet the needs of people living on the West Coast.
- work to improve retinal screening (to identify risk of blindness) in high-risk groups
- promote free annual diabetes checks e.g. prevention, screening programmes and free treatments.
- work with Maori and communities to support prevention, early intervention and ongoing uptake of services
- work with GPs to identify type 2 diabetes earlier to ensure early treatment
- promote healthy lifestyles which will lead to a decrease in the risk factors (unhealthy eating, being overweight, lack of physical exercise) which contribute to type 2 diabetes)
- work with providers who promote health messages related to physical activity, nutrition, obesity and smoking cessation
- improved data collection
- work to provide care through local diabetes (specialised) teams that have the information and knowledge to continuously improve the quality of care available to people suffering from diabetes
- improve the collection of information about people with diabetes, especially Maori, to help with future service planning
- build on the work of the local Diabetes Team to establish targets for DHB performance indicators and improve retinal screening uptake.

In The Next Year:

- ensure residents of the West Coast with diagnosed diabetes have ready access to free annual checks, to first specialist assessment and follow up attendances and to multi disciplinary education and management services.
- complete a workforce development plan to ensure skilled knowledgeable staff are available to meet the requirements of the diabetes service.
- support the work of the local Diabetes Team in advising the DHB on diabetes services on the West Coast and in agreeing targets to achieve the MOH clinical indicators.
- work to improve liaison and interface between primary, secondary and public health providers.

3.1.2 CARDIOVASCULAR DISEASE

West Coast Health Needs Assessment
The hospitalisation rate for cardiovascular disease for non-Maori on the West Coast is higher than the national rate for non-Maori. The hospitalisation rate for stroke is considerably higher than the rate for New Zealand as a whole.

Key Issues:

- Although cardiovascular disease in New Zealand is declining it is still one of the leading causes of death, mainly due to ischaemic heart disease and stroke. 41% of all deaths in New Zealand in 1997 were caused by cardiovascular disease. Nationally, males have over double the rate of hospitalisation than females. Modifiable risk factors for cardiovascular diseases include high serum cholesterol, smoking, obesity, lack of physical exercise, diabetes, stress, diet, and high blood pressure.
- Maori have higher rates of heart disease, and the highest rates of mortality from all categories of heart disease, than non-Maori, yet recent research has shown that intervention rates (such as coronary bypass operation rates) are significantly lower for Maori than non-Maori. Coronary heart disease is the leading single cause of death for Maori.
- Mortality rates for coronary heart disease are higher among those in lower social –economic groups.
- Stroke is the third highest cause of death at 9% of all deaths in 1997. The average age of stroke is 56 years for Maori and 73 years for non Maori. Stroke causes a high ongoing cost to the health system and to community services.
- Cardiovascular risk is managed through both secondary and primary prevention.

In The Next Ten Years:

o Reduced hospitalisation rates for all cardiovascular disorders through:
  - effective liaison between the primary and secondary sectors
  - early identification of risk with effective treatment
  - effective rehabilitation services.
  - multidisciplinary focus
  - reduction of Maori cardiovascular disease rates to that of non Maori.

In The Next Five Years:

- through the PHO, ensure primary providers are implementing cardio-vascular risk management programmes and projects aimed at reducing risk for at risk groups
- provide culturally appropriate services for Maori which are accessed at an earlier stage of disease
- establish effective liaison and interfaces between secondary and primary services
- work completed with the Ministry of Health on a joint national service review to establish a level of standardisation of acute care for people with acute coronary syndrome
- work under way to reduce early death from heart failure through early consistent treatment
- encourage community CPR training and investigate the appropriate placement of

automatic external defibrillators with all emergency services.

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In The Next Year:

- ensure all providers have available guidelines for the management of cardiovascular disease, including the video on managing heart failure for Maori
- commence cardiovascular needs analysis
- identify barriers to Maori accessing cardiovascular services
- investigate the establishment of a cardiovascular rehabilitation programme through the employment of a cardiovascular nurse
- improve awareness of, and level of education on prevention and treatments
- support health promotion and education programmes through the PHO/Crown Public Health.

3.1.3 CHILD/TAMARIKI HEALTH

West Coast Health Needs Assessment
Infant mortality has often been used as a broad indicator of child/tamariki health. On the West Coast, the infant mortality rate is around average and the child/tamariki mortality rate appears to be low. The sudden infant death syndrome (SIDS) rate appears to have declined, as it has nationally. Numbers are very low, but the birth rate of low birth weight Maori babies may be trending upward, contrary to national rates for all ethnicities. Breastfeeding rates for babies seen by Plunket appear to be lower than the national rates, for both Maori and non-Maori.

To protect a community, an adequate immunisation rate is 90%. Immunisation rates on the West Coast are well below this level, and the lack of accurate immunisation data is a significant data gap. Numbers of avoidable hospitalisations for immunisation-preventable conditions are too small to make interpretations.

In New Zealand injuries are the leading cause of death and disability in the age group 1 to 14 years, and are the second leading cause of hospitalisation of children/tamariki. It is estimated that nearly one-third of child/tamariki injury deaths are readily preventable. Hospitalisation rates for unintentional injuries on the West Coast are similar to the New Zealand averages for both under 5 years and 5 to 14 years. The hospitalisation rate from poisonings of children/tamariki is very high. The proportion of Maori children/tamariki referred for failed hearing tests at school entry is noticeably higher than for Maori children/ tamariki nationally.

About 11% of New Zealand children aged 0-14 years have a physical, intellectual, sensory, psychiatric or psychological disability, or a long term disease or illness.

Chronic conditions such as asthma, ADHD, cystic fibrosis, and renal failure are now more common (or identified more often) in the community than previously identified.

The principles of the Child/Tamariki Health Strategy are:

- children/tamariki should have their needs treated as paramount
- child/tamariki health and disability support services should be focused on the child/tamariki and their family and whanau
- child/tamariki health and disability support services should be available as close to home as possible, within the bounds of quality and safety
- child/tamariki health and disability support services staff should work together with each other and with staff from other sectors to benefit the child/tamariki
- child/tamariki health and disability support services should be provided to achieve equity
- child/tamariki health and disability support services should be based on international best practice, research and education
- child/tamariki health and disability support services should be regularly monitored and evaluated
- child/tamariki health and disability support services should be culturally safe, culturally acceptable and value diversity.

Most families/whanau can meet the health and disability support needs of their children.

There are however large disparities in health status in New Zealand with tamariki Maori and children from low income families experiencing comparatively poorer health outcomes than the overall population.

Good child/tamariki health is vital for later adult health, as the risk factors for many adult diseases and the opportunities for preventing these diseases arise in child/tamariki-hood. Poor child/tamariki health and development also have an adverse impact on broader social outcomes, including sexual and reproductive health, mental health, violence, crime and unemployment.

Access to appropriate and accessible paediatric services is an important part of providing health and disability support services to the tamariki/children of the West Coast.

Well child services are an important part of child health – a range of services to children under 5 years are funded.

The Strengthening Families Initiative works to address problems of fragmentation and poor co-ordination of services for families. An intersectoral activity it co-ordinates health, education, welfare and other sectors working with at risk children.

Key Issues:

- the health of New Zealand children /tamariki is not as good or improving as fast as the health of children /tamariki in other developed countries
- New Zealand still experiences epidemics of measles and whooping cough at greater rates than many other developed countries. There are, and will be, more Maori, Pacific Peoples and refugee children/ tamariki in the future
- immunisation coverage is poor with a lack of accurate immunisation data
- there is increased awareness of violence against children/ tamariki and its harmful effects
- hospitalisation rates for poisons and non intentional injuries is high
- lack of resident Paediatrician on the West Coast
- improving immunisation rates will involve taking innovative approaches such as opportunistic immunisation, use of mobile clinics and home-based services
- impact of low birth weight babies on future health status
- high proportion of Maori children/tamariki failing hearing tests at school entry.

In The Next Ten Years:

- seamless and integrated child/tamariki health service where information is shared
- provision of available, acceptable and appropriate screening programmes
- better child/tamariki health statistics especially among Maori
- increased Maori workforce capacity.

In The Next Five Years:

- work with schools and Early Childhood Centres to achieve 95% of children/tamariki being fully immunised at age 2 by 2005
- work with other organisations to identify and implement measures to lower the incidence of child/tamariki abuse, in particular put in place robust information collecting systems
- promote healthy lifestyles for children /tamariki including healthy eating and physical activity programmes
- increased Maori workforce capacity.
- increased sharing of information
- promote breast feeding as a key component in ensuring short and long term health of children
- prioritise child hearing and vision screening and necessary treatment so needs of blind, vision impaired and deaf blind children can be identified earlier.

In The Next Year:

- implement the new Ministry of Health “Well Child/tamariki” actions due out in 2002
- work to ensure child/tamariki health services are culturally appropriate
- continue to encourage child/tamariki health providers and other agencies to work together to provide services that are centred on supporting children/ tamariki and their families
- promote the immunisation programme and ensure child/tamariki immunisation is accessible to all children/tamariki
- continue to promote healthy lifestyles for children /tamariki including healthy eating and physical activity programmes
- facilitate opportunities for the continued development of Maori health services and workforce
- work with health care providers to promote abstinence from alcohol during pregnancy
- Strengthen smoking cessation programme for pregnant woman.

Oral health

West Coast Health Needs Assessment
The dental health of children/tamariki in the West Coast DHB region is amongst the poorest in New Zealand. The proportions of children/tamariki who are caries free at ages 5 and 12 years (37.6 and 36.2% respectively) are markedly lower than the national proportions for those age groups (53.6 and 43.0%). Consistent with this, the MFT scores (the number of teeth missing or filled due to caries) are also higher in both age groups (2.8 and 2.0 versus 1.8 and 1.6). Although the difference is reduced in the latter, the MFT score for 5-year-olds is one of the worst in the country. There are no fluoridated water supplies in the region.

Diseases of the teeth and gums are among the most common of all health problems and are experienced by most New Zealanders at some stage of their life. Most dental disease is preventable and early onset dental disease can be an indicator of poor overall health status. The introduction of various public health measures such as fluoridated water, fluoride toothpastes, regular dental care, health promotion and education and improved clinical practice such as fluoride application and fissure sealants have improved markedly the incidence of dental disease in New Zealand.

While the majority of the population has experienced improved oral health, there are significant minorities in the community with chronic oral health problems related to socio-economic status, poorer education, isolation and ethnicity. Oral health trends relate closely to general health status in such instances.

There are significant inequalities in dental health status between different population groups. In particular, Maori and Pacific Island children/tamariki have worse oral health than other children/tamariki. Maori children/tamariki are less likely to be caries free than non-Maori, and are more likely to have high caries experience than non-Maori children/tamariki. 75% of Maori children have fillings by age 12.

The school dental clinic is generally the first contact primary school children/tamariki have with oral health services. The service is publicly funded and provided by trained dental nurses. Free dental services are also available for secondary school age children/tamariki up to 18 years of age.

Public dental services have been under pressure over the last 10 years. Reorganisation of the services has led to fragmentation, and work pressures have meant some child/tamariki and adolescent dental services have not maintained the levels of access and the provision of preventive services that were available in the past.

Government strategies in oral health

The Government is placing particular emphasis on the school dental service as the cornerstone of oral health services to children/tamariki and adolescents and in raising oral health status and reducing inequalities within this group. The Government is also interested in extending access to fluoridated water supplies, as this is the most effective method of avoiding tooth decay on a community basis.

In accordance with the National Health Strategy, the Government has therefore developed an Oral Health Implementation Plan. The key deliverables of the Plan are to:

- re-establish a nationwide dental health system for children/tamariki and adolescents
- allow dental therapists to perform a greater range of services

- upgrade the training of, and introduce registration for, dental therapists
- investigate greater access to assisted dental care for low-income adults
- review the Dental Benefit Scheme
- review the Dental Act 1998.

Initiatives currently under way by the Ministry of Health include:

- the establishment of a Technical Advisory Group to define appropriate clinical standards and the mix and level of services to be provided by District Health Boards
- the establishment of a Technical Advisory Group to provide advice on the registration, discipline, employment arrangements and range of services provided by dental therapists
- contracting an independent review of the Dental Benefits Scheme. This review is now completed. The review advised on the difficulties associated with the present scheme and on ways of improving it. There has been some criticism of the review in terms of risk factors and of issues around funding which were not addressed.

The vast improvement in children/tamariki's oral health over the last 30 years is due to the improvement in social conditions and the introduction of preventive measures such as fluoridation, fluoride toothpastes, clinical application of fluoride and fissure sealants as well as health promotion, health education and regular dental care.

Key Issues:

- West Coast children/tamariki have among the poorest dental health in New Zealand
- lack of fluoridation – children/tamariki in non-fluoride areas have more fillings than children/tamariki in fluoride areas
- poor access to dental services on the West Coast due to low numbers of practitioners and cost (some assistance available through emergency benefits).

In The Next Ten Years:

- community consideration of fluoridating drinking water
- increased use by older people of dental services.

In The Next Five Years:

- increased use by adolescents of free dental services
- reduced numbers of missing and filled teeth in children/tamariki and adults.

In The Next Year:

- work with Crown Public Health/health educators and local government to educate communities about the benefits to teeth from drinking fluoridated water or having fluoride through tablets
- work with well child health providers to increase the enrolment of children/tamariki and young people, (including adolescents) in dental programmes at an earlier age
- work to determine the oral health needs of older people
- work to identify the groups most at risk of oral health problems
- work with stakeholders to improve access to dental services on the West Coast for all age groups, particularly for children in high deprivation areas
- Investigate free or subsidised dental services available in other regions.

To reduce the incidence and impact of cancer

West Coast Health Needs Assessment

The West Coast's overall all cause mortality rate is significantly higher than the rate for New Zealand. Small numbers prevent confident interpretation. However, there appears to be a consistent pattern that suggests that the mortality rates from cancer may be higher on the West Coast than the national rates for the population overall, for both Maori and non-Maori, and for males. This consistent, if inconclusive, pattern is also seen in the mortality rates from lung cancer and cervical cancer.

Cancer is the leading cause of death in New Zealand in both males and females and is a major cause of hospitalisation.

Maori loss of life from cancer is high in relation to non-Maori. Cancer is the leading cause of death among females and is second only to cardiovascular disease in males. It is a significant public health issue for New Zealand.

Good evidence exists that cancer outcomes can be improved through early detection and diagnosis and by good management at secondary and tertiary levels. Prevention strategies reduce the incidence of cancer.

It is estimated 75% to 80% of cancers are due to environment or life style and potentially preventable.

Lifestyle changes may reduce the impact of cancer. Smoking cessation will contribute to a reduction in lung cancer, also lung disease, cardiovascular disease and diabetes. Early detection and diagnosis improves the survival time in many cancers.

The overall incidence of cancer is higher in Maori than non-Maori. In 1996 Maori had considerably higher registration rates than non-Maori for cancer of the liver, stomach, lung, cervix, pancreas, testis and breast. Maori registration rates were considerably lower than non-Maori for cancer of the prostate and colon, and for melanoma of the skin.

Cancer burden is also unequally distributed according to socio-economic status. Men in manual and unskilled occupations tend to experience higher overall cancer mortality.

Health Strategy The NZ Health Strategy states [p 16]

"To address the cancer priority, a coordinated approach is being developed across prevention activities, early detection [particularly screening], treatment and rehabilitation."

The term "rehabilitation" has been since substituted by palliative care.

Implementation of Cancer Control Strategies

Information on pathways for the management of cancer discusses evidence based approaches to:

- reducing inequalities in population groups (e.g. Maori, lower socio-economic groups)
- supporting specific interventions to prevent cancer (reducing smoking, obesity, improving nutrition, increasing physical activity, hepatitis screening/vaccination, encouraging safer sexual behaviour, reducing overexposure of skin to sunlight)
- improving access to screening programmes (breast cancer, cervical screening, familial cancers, skin)
- early detection and diagnosis (access to primary, diagnostic and surgical services)

- treatment/symptom control (access to full range of services, oncology speciality services, access to drugs and resources, co-ordination of service provision)
- palliation (access to local palliative care in the home, hospice or hospital) assessment, care, clinical care and specialist service co-ordination
- rehabilitation and support (transport, accommodation, counselling, family support).

In The Next Ten Years:

- 100% uptake by target populations in national cervical and breast screening programmes
- reduced rates of some cancers in groups currently at risk
- reduced rate of death from breast and cervical cancer.

In The Next Five Years:

- ongoing health promotion about healthy lifestyles
- encourage enrolment into Primary Health Organisation to increase chances of early cancer detection.

In The Next Year:

- support health promotion programmes in relation to improved nutrition, reduction of smoking, limiting alcohol intake, increasing exercise and sun protection campaigns
- support screening programmes.

PALLIATIVE CARE

The NZ Palliative Care Strategy Objectives include:

> *"Palliative care is the active total care of patients whose disease no longer responds to curative treatment, and for whom the goal must be the best quality of life for them and their family and carers" - WHO 1990.*

- ensure access to essential palliative care services
- each DHB to have at least one local palliative care service
- develop specialist palliative care services
- implement hospital palliative care teams.
- develop quality requirements for palliative care services
- inform the public about palliative care services
- develop the palliative care workforce and training
- ensure that recommendations from the Paediatric review are implemented
- address issues of income support.

Essential components of a palliative care service include:

- Specialised home based medical and nursing services
- Access to inpatient facility
- Day care
- Counselling
- Support Services
- Liaison and co-ordination
- Information/education programmes.

Key Issues:

- Palliative care services on the West Coast require improvement.

In The Next Ten Years:

- The whole of the West Coast region will have access to a palliative care service that caters for all ages from paediatrics to aged care.

In The Next Five Years:

- the service will be provided in a culturally appropriate way to ensure that non Maori and Maori are willing to access it
- investigation into the need for appropriate facilities to cater for outpatient and inpatient needs to ensure best practice is established and ongoing physical, social, cultural, psychological and spiritual needs are met
- improved support for staff through supervision, education and information programmes
- appointment of specialist Palliative Care Nurse resulting in improved care and co-ordination
- improved co-ordination of support services.

In The Next Year:

- provision of education and training for palliative care medical and nursing staff
- improved access to hospital through 'open admission' policy for palliative care patients
- improved access to short term inpatient care for symptom management, respite and terminal end stage care.

3.2 OBJECTIVE TWO
TO REDUCE HEALTH DISPARITIES BY IMPROVING HEALTH OUTCOMES FOR MAORI

Ko te pae tawhito, kia whakatata
Ko te pae tata, whakamaua kia tina

Seek the distant horizons, cherish that which you obtain

Maori Health

The West Coast DHB recognises that there are considerable disparities between the health of Maori and non-Maori and that decreasing inequalities between the health of Maori and other New Zealanders is a priority in current health policy. There is a clear expectation for the services of the West Coast DHB to identify how inequalities in health between Maori and others will be identified and addressed.

As a Crown agent, the West Coast DHB accepts its responsibilities and obligations to Maori as set out under the New Zealand Public Health and Disability Act 2000.

As part of this, the West Coast DHB acknowledges and respects the principles of the Treaty of Waitangi – Partnership, Participation and Protection.

Partnership

Working together with iwi, hapu, whānau and Maori communities to develop strategies for Maori health gain and appropriate health and disability services.

Participation

Involving Maori at all levels of the sector in planning, development and delivery of health and disability services.

Protection

Committed to the goal that Maori enjoy the same level of health as non-Maori and safeguarding Maori cultural concepts, values and practices.

Strategic Direction

The following are keys guiding the strategic direction for Maori health in the West Coast DHB.

Alignment With Current Health Policy

Reducing Inequalities

- It is a priority for the West Coast DHB to reduce health inequalities between Maori and others on Tai Poutini (West Coast). In order to reduce health inequalities, firstly, a clear understanding of the nature and extent of inequalities is required.
- Currently, our knowledge of Maori health status on Tai Poutini is limited as there is no specific current needs analysis of Maori health.
- As a high priority, the West Coast DHB must undertake an accurate needs analysis with measurements of health status. It will be important to ensure accurate data collection, adequate analysis of health status by ethnicity and monitoring of inequalities in health status and service outcomes.
- Develop and meet targets arising from the assessment of Maori health needs.

Key Issues:

- to collect accurate ethnicity data for all services by all providers
- to identify areas of health inequality in health status of Maori
- to develop specific strategies focussed on decreasing inequalities and achieving health gain.

In The Next Ten Years:

- Reduction of disparities in health status between Maori and non Maori on Tai Poutini.

In The Next Five Years:

IMPLEMENT ALL THE RECOMMENDATIONS OF THE NEEDS ASSESSMENT WITHIN RESOURCE CONSTRAINTS.

This Year:

- set in place the following to improve ethnicity data collection by:
  - training of all staff on the importance of ethnicity collection
  - investigate the feasibility of the introduction of external monitoring of the quality of ethnicity data
  - begin talks with all other health providers, to co-ordinate health strategies and activities
- undertake a needs analysis for Maori on Tai Poutini in consultation with Papatipu Runanga, Poutama Ora and other Maori communities.
- educate staff/community on the value to the West Coast of implementing special actions to address Maori health status and the resultant need to possibly reallocate scarce resources to do so.

He Korowai Oranga

The West Coast DHB recognises and supports the principles of He Korowai Oranga, the Maori Health Strategy. This document supports Maori aspirations including the aspiration to deliver health services.

He Korowai Oranga is premised on the knowledge that whanau, iwi and hapu can make significant contributions to the advancement of Maori health. He Korowai Oranga emphasises whanau health and well being an overall aim. whanau health will be achieved through building the strengths of whanau to achieve whanau ora (health and well being) reducing inequalities in Maori health status in priority areas. Whanau are recognised as the foundation of Maori society. As a principal source of strength, support, security, and identity, whanau plays a central role in the well being of Maori individually and collectively.

He Korowai Oranga further acknowledges Maori models of health including whanau, spiritual, and mental well being and the importance of Te Reo and Tikanga and Whakapapa to Maori.

The West Coast DHB strategy for Maori health thus must align with the final strategy of He Korowai Oranga and the West Coast DHB has a commitment to this when undertaking strategic development and planning.

Key Issues:

- to identify, through consultation and ongoing participation with Maori, what the current health aspirations of Maori are
- to use He Korowai Oranga and the forthcoming action plan, as the guides for ongoing planning and direction of Maori health development on Tai Poutini.

Maori Health Priorities

The West Coast DHB has a focus in the short to medium term for achieving health gain in the eight Maori Health gain priorities established by the Health Funding Authority (now a focus of the Ministry of Health and DHBs).

These eight priorities are included in the population health objectives on which DHBs and the Ministry of Health are to make progress.

These are:

- Immunisation
- Hearing
- Smoking Cessation
- Diabetes
- Asthma
- Oral Health
- Mental Health
- Injury Prevention.

Relationships With Maori

Partnership With Iwi And Maori Communities

The West Coast DHB is committed to working in partnership with Iwi and Maori communities to ensure their decision-making effectively leads to whanau health improvement and to support the achievement of Maori health aspirations.

As a Crown agent, the West Coast DHB accepts its responsibilities and obligations to Maori as set out under the New Zealand Public Health and Disability Act 2000. The West Coast DHB will work within the spirit of the Treaty with the Mana Whenua health group, Poutama Ora and Ngai Tahu. It is the intention of the West Coast DHB to enter into a Memorandum of Understanding with Ngai Tahu and Papatipu Runanga on Tai Poutini.

Maori Participation

As part of its needs analysis and priority setting the West Coast DHB will seek to work with Maori to further identify any other specific health needs of the Maori population on Tai Poutini, and to develop a pathway towards addressing those needs.

The West Coast DHB will enhance the effectiveness of its services to Maori. The strategy will include ensuring Maori input at all levels in the planning and delivery of services. The West Coast DHB will work to identity and then rectify gaps in Maori

participation throughout the services to the degree appropriate.

In The Next Five Years:

- Review and renew all Memoranda of Understanding.

In The Next Year:

- establish a memorandum of understanding with local Maori through Papatipu Runaka, Poutama Ora, Te Runanga O Ngai Tahu
- continue to participate in the Regional Intersectoral Fora (RIF) to ensure Maori interests are promoted and protected in activities of crown agencies
- work with Poutama Ora and Hauora Mata – to work together to develop and implement a plan for Maori Health promotion.

Providing Effective Services

The West Coast DHB intends to improve the effectiveness of services to Maori. One strategy will be to ensure Maori participation in the planning, delivery and evaluation of culturally appropriate services.

Reducing Barriers

It is acknowledged that there may be barriers to accessing services for Maori. The West Coast DHB will ensure there are processes in place to identify existing barriers to health services for Maori and ensuring accessible, appropriate and effective services to Maori.

Key Issues:

- barriers to access are identified in all West Coast DHB services and action developed to remove barriers
- prioritisation and re-definition of services to better address Maori health disparities
- introduction of Tikanga Maori within the West Coast DHB.

In The Next Ten Years:

- Ensure all Maori have access to timely, appropriate and high quality health care and support to meet their needs.

In The Next Five Years:

- provide whanau facility at Grey Base Hospital
- develop a structure of ongoing in-dependent monitoring of the appropriateness and quality of care to Maori provided by the West Coast DHB or any service contracted to provide health services on Tai Poutini.

In The Next Year:

- identify barriers for Maori in accessing health services by consumer and community surveys.

Support For Maori Providers

The West Coast DHB supports the development of Maori providers and will work to ensure that services to Maori are appropriate.

Key Issues:

- Maori provider development is a continuing focus for the West Coast DHB
- opportunities for Maori provider staff development are made available through in-service education training sessions open to Maori providers
- Maori on Tai Poutini are able to access a range of Kaupapa Maori services
- engaging with iwi and other Maori communities to enable them to influence planning, purchasing and delivery of services to build Maori health.

In The Next Ten Years:

- To provide Maori on Tai Poutini with services adequate to meet their health needs and appropriate to their cultural requirements.

In The Next Five Years:

- Establish a permanent ongoing relationship with all Maori providers on Tai Poutini through Poutama Ora or other appropriate bodies.

In The Next Year:

- To consult with all Maori providers on Tai Poutini, through Poutama Ora or other appropriate bodies, on the best way to establish a permanent ongoing relationship with all providers.

Training for Staff

The West Coast DHB aims to improve its services to Maori by ensuring that staff are given an opportunity through training to gain a comprehensive understanding of the Treaty of Waitangi and its implications and guidance for Maori Health gain and best practice. Providing training for staff that ensures that they are culturally safe in working with Maori.

Key Issues:

- all recruitment processes, job descriptions and performance reviews
- contain a focus on the Treaty of Waitangi and responsiveness to Maori
- all new staff receive orientation on the West Coast DHB commitment to Maori
- all staff are offered the opportunity to participate in education sessions to ensure greater knowledge of, and responsiveness to, Maori.

In The Next Ten Years:

- To have sufficient Maori health professionals that reflect the health needs of their communities.

In The Next Five Years:

- employees are to attend Treaty training as part of their employment with West Coast DHB
- establish scholarship to encourage greater Maori numbers in staff for West Coast DHB.

In The Next Year:

- initiate training around the Treaty of Waitangi, Maori health needs as well as collection of ethnicity data for all new and existing staff
- discuss with Maori providers how they can access in-house training
- begin to promote the employment of Maori staff through recruitment drive with local schools and polytechnic.

Maori Workforce Development

It is important that the West Coast DHB recognises and supports its Maori staff. He Korowai Oranga recognises that trained Maori professionals are needed to strengthen the health and disability sector's capacity to deliver services to Maori that are both appropriate and effective.

Key Issues:

- Maori are encouraged to apply for positions
- Maori career pathway structures are developed within the provider arm
- planning to ensure Maori staff are provided with appropriate level of resourcing for recruitment, advancement and retention within their own organisations
- ensure the availability of appropriately qualified Maori
- develop strategies to improve recruitment and retention of Maori staff at all levels
- research ways to enhance Maori gaining entry into the health and disability workforce
- support Maori staff to develop in areas of Te Reo and Tikanga.

3.3 OBJECTIVE THREE -
THE WEST COAST DISTRICT HEALTH BOARD WILL, THROUGH THE FORMATION OF A PRIMARY HEALTH ORGANISATION (PHO), ACHIEVE IMPROVED HEALTH OUTCOMES BY DELIVERING COMPREHENSIVE COMMUNITY-FOCUSED PRIMARY CARE

PRIMARY HEALTH

National Strategies

The New Zealand Public Health and Disability Act 2000 provides the context for the development of integrated health care services. Section 22(1)(b) defines that an objective of DHBs is to promote the integration of health services, especially primary and secondary health services. Each DHB must pursue its objectives in accordance with its district strategic plan, its annual plan, its statement of intent, and any directions or requirements given to it by the Minister.

The New Zealand Health Strategy provides a framework within which DHBs and other organisations across the health sector are to plan and operate. It identifies the priorities the Government considers most important to ensure that health services are directed at those areas that will ensure the highest benefit to the population. One of these areas is primary health care. Accordingly "...a key priority for DHBs is to ensure comprehensive primary care coverage and quality primary care services in both urban and rural areas" (Pg. 20. New Zealand Health Strategy).

The Primary Health Care Strategy was a key first step in realising the goals and objectives of the New Zealand Health Strategy for the primary sector. The purpose of the Primary Health Care Strategy is to guide DHBs in how to organise and fund the provision of services to meet local needs. The Primary Health Care Strategy emphasises that a strong primary health care system requires community involvement so that local people can have their voice heard in the planning and delivery of services.

The vision and new direction of the Primary Health Care Strategy involves moving to a system where services are organised around needs of a defined group of people. DHBs will therefore be expected to work through PHOs to achieve local health goals.

A PHO is a local structure through which DHBs implement the Primary Health Care Strategy. PHOs are new organisations rather than organisations built up from existing providers. A PHO will be organised around the needs of a defined population and seek to directly enrol the members of this population. It will be contracted to and funded by the DHB and may provide services either directly by employing staff or through a network of affiliated member primary health care providers.

The key characteristics of a PHO as set out in the Primary Health Care Strategy are:

- A PHO will be funded by a DHB for the provision of a set of essential primary

health care services to those people who are enrolled

- At a minimum, PHO services will include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people's health when they are unwell.
- A PHO will be expected to involve its communities in its governing processes. It must also be able to show that it is responsive to communities' priorities and needs.
- All providers and practitioners must be involved in the organisation's decision-making, rather than one group being dominant.
- A PHO will be a not-for-profit body and will be required to be fully and openly accountable for all public funds that it receives. It will be funded according to the populations it serves.
- While primary health care practitioners will be encouraged to join a PHO, membership will be voluntary.

A key feature of the implementation process, crucial to ensuring all issues are considered in developing PHOs, is the involvement and collaboration with the primary health sector and the engagement of local communities.

Government policy framework and Ministry of Health PHO guidelines define the framework, principles, expectations and boundaries of the PHO. Within this it is the responsibility of the West Coast community to define the local concept and determine an effective implementation plan. Because of the uniqueness of the West Coast health care environment it is necessary that the PHO concept definition be shaped by input from West Coast communities.

Implementation

The West Coast DHB is committed to meeting its obligations within the New Zealand Public Health and Disability Act 2000 and achieving the intent of the New Zealand Health Strategy and Primary Health Care Strategy. The West Coast DHB is therefore committed to ensuring a stable, evolutionary and constructive development of and transition to the implementation of a West Coast PHO.

A key implementation principle of the Primary Health Care Strategy is that the implementation process should focus on evolutionary change that is progressively consistent with the Primary Health Care Strategy. In adhering to this principle the West Coast DHB supports, in the first instance, the development of a single PHO that protects sub-district autonomy. The purpose is to protect gains made, and build on successful initiatives to ensure that the future system is established on an understanding of what works best for local communities. Implementation planning will support a transition to the development of a single organisation that recognises the differences within respective sub-districts and communities whilst integrating primary health services to achieve the best overall health for the population of the West Coast health district.

In The Next Ten Years:

- Improved range of appropriately resourced primary health services achieving improved health outcomes for the West Coast population.

In The Next Five Years:

- PHO evolves to include all primary health practitioners on the West Coast, thus achieving close to 100% enrolment of the West Coast population
- progress the implementation of the NZ Health Strategy and supporting strategies in reducing health disparities among population groups

through effective planning and contracting of services

- support ongoing workforce development programmes for the multi disciplinary range of health professionals so the workforce is diverse, skilled, culturally appropriate and adequate in numbers
- support the development of an integrated primary health information infrastructure.
- Support the development of the primary nurse practitioner role
- encourage primary health care providers to incorporate a substantial mental health component into their work to meet the needs of the 17% of the population with mild to moderate mental disorders.

In The Next Year:

- support the establishment of a PHO on the West Coast
- use new funding opportunities (primary health new funding, capitation, management of demand driven expenditure) to improve the effectiveness of primary health services and to work towards reducing inequities of access to these services
- collaborate with Crown Public Health and other agencies to ensure a co-ordinated approach to the development of health programmes and initiatives
- promote collaboration with a view to reducing duplication of clinical and support services across the health sector where this currently exists.

3. 4 OBJECTIVE FOUR – THE WEST COAST DISTRICT HEALTH BOARD WILL PROMOTE EFFECTIVE CARE OR SUPPORT FOR THOSE IN NEED OF DISABILITY SUPPORT SERVICES (DSS)

DISABILITY ISSUES

One in five people in New Zealand report having a long-term impairment.

Many people with impairments face life long barriers to full inclusion and participation in society.

The West Coast DHB has a statutory responsibility to promote the inclusion, independence and participation of disabled people in society. (New Zealand Public Health and Disability Act 2000, 22(1)(d)).

In addition it provides a range of disability support services.

Direction of Disability Support Services

On 9 July 2001 Cabinet agreed that funding and planning for older people's disability support services be separated from that for younger people with disabilities. The two groups are people aged 65 and older and those under that age with disabilities.

The reason for this change is that older people are more likely to need a mix of health and disability support services than those under 65 with disabilities and that integration is needed between these services.

Cabinet has sought from the Ministry of Health an implementation plan to transfer the funding for older people with disabilities to DHBs. While (at the time of writing) no decision has been made on an implementation date, it is likely that the transfer of funding responsibility for older people will be from July 2003.

Relevant Government Policy and future strategic directions

The New Zealand Public Health and Disabilities Act 2000 requires that the Minister determine strategies for health services. These strategies are required to provide a framework for the Government's overall direction in health and progress toward them must be reported on annually. To date a number of strategies have been presented to the House of Representatives. Strategies directly relevant to the West Coast DHB DSS planning include:

- The New Zealand Health Strategy
- The New Zealand Disability Strategy
- Health of Older People Strategy
- Positive Ageing Strategy (APPENDIX 5).

In developing district strategic plans DHBs are required to be guided by the above (and other) strategies. It is important, therefore, that the West Coast DHB consider carefully the intent of the strategies in relation to the DSS development plan. The following provides a description of aspects of each strategy relevant to the West Coast DHB DSS planning.

The Government is planning to implement the Health of the Older People Strategy by

2010 and is developing a national policy framework which will include advice on funding for long term care, review of specialist personal and mental health services for older people and a review of dementia services.

The Strategy also expects that the Disability Sector will have in place services for ageing and carer support.

Government Expectations

In meeting its obligations to progress Government's health and disability strategies the West Coast DHB is expected to plan to:

- enable care in the community, or if this is not possible, to integrate hospital services with community-based care

** Refer to Appendix 5

  - support people living in rural areas to remain in their communities by improving access to services

- ensure funding is managed to achieve affordable access to an integrated range of services based on individual needs.

Health Needs Analysis

The HNA did not provide information on the needs of people with disabilities as it was beyond the scope of the project.

The New Zealand Disability Strategy was under development at the time. West Coast DHB now needs to assess the needs of people with disabilities pursuant to that Strategy. This work needs to be completed by the DHB, in conjunction with existing information holders, to provide a health and disability needs assessment to guide future planning and purchasing of services.

Key Issues:

- people with disabilities may perceive West Coast DHB and other organisations insufficiently responsive to their needs
- West Coast DHB has a responsibility to reduce barriers to access to services for disabled people. Sect 22.1 (d) of the NZ Public Health and Disability Act 2000 requires DHB's to "promote the inclusion and participation in society and independence of people with disabilities".
- full assessment of the health and disability needs of disabled people has not yet been completed.

In The Next Ten Years:

- barriers to accessing services and activities by people with disabilities will be minimised or removed
- people with disabilities will receive well coordinated health and disability services which focus on support for individual needs and aspirations.

In The Next Five Years:

- progressively implement the recommendations contained within various Government strategies - in particular The New Zealand Disability Strategy and The Health of Older People Strategy
- review all activities of the West Coast DHB to ensure a focus on the needs of people with disabilities.

In The Next Year:

- complete assessment of health and disability needs of people with disabilities on the West Coast
- develop specific capacity to accept devolved funding responsibility for

services for older people – contracting, monitoring, information systems, prioritisation

- the West Coast DHB is committed to work with stakeholders to develop a West Coast plan to meet the service requirements of people with disabilities through implementing the Government Strategies.

Health of Older People

Good health and quality of life are particularly strongly linked in older age groups. Older people are major users of health services, both in terms of frequency of use and the costs of supplying services. For both of these reasons, assisting older people to maintain good health is important.

The West Coast has similar proportions of older people to the New Zealand averages. Non-Maori over 65 years make up 13.2% of the non-Maori population, and Maori over 65 years make up 3.5% of the Maori population.

The total West Coast population over 65 years is projected to increase by 20.9% over the next ten years, a rate that is lower than the projection nationally (23.4%). Within this overall increase, the relatively small Maori population over 65 years is projected to increase by 75% (versus 55% nationally). Maori life expectancy is around eight to nine years less than non-Maori. Diseases affecting older people occur at younger ages for Maori, and the premature death of many Maori kaumatua, in particular, has serious implications for Maori as a people.

The diseases that dominate the older age group are diabetes, cardiovascular, stroke, and cancer. National studies have shown respiratory infections to be the most common superfluous cause of admission to hospital for older people.
Most deaths of older people are caused by gradual-onset, progressive illnesses that are best prevented from an early age. As should be the case in any high-deprivation area, reducing socio-economic inequalities and improving overall socio-economic conditions should have a positive impact on the health, quality of life and longevity of older people. Interventions to reduce risk behaviours such as smoking, poor diet and alcohol misuse (which are strongly patterned by socio-economic factors) may be most beneficial. Attention to Maori health in a holistic sense (improving the control of Maori over factors which influence all dimensions of health) would also be desirable.

The hospitalisation rate from falls for those aged over 65 years is significantly higher than the national rate. Ministry data suggests that the flu immunisation rate in the region is very close to the national rate.

Key Issues:

- the proportion of older people on the West Coast is increasing
- older people have high health needs and consume more services
- the DHB must plan to ensure the future provision of elderly care services meets the projected growth
- an integrated continuum of care means the older person is able to access needed services at the right time in the right place and from the right provider
- improved co-ordination of health and disability support programmes is needed to support older people.

In The Next Ten Years:

- all older people on the West Coast are able to access more integrated primary health services which are focused on

the needs of the elderly and are well integrated with secondary services and other community agencies

- greater health and independence for older people with more able to remain in their homes for longer
- progressive implementation of The Health of Older People Strategy.

In The Next Five Years:

- reduce hospitalisation rates due to falls by developing "prevention of falls in the home" programme
- initiate programmes to ensure older people are able to access screening for vision impairment to help prevent falls
- 100% uptake of the influenza vaccination for elderly persons
- close liaison between service providers to identify and manage at risk elderly in the community
- improved integration between service providers in the community and hospital.
- Improved range of support options for older persons, their caregivers and family/whanau in the community e.g. improve access to day care facilities.
- better coordination between government and non-government agencies to improve health status through attention to the holistic needs of the older person
- an appropriate continuum of services efficiently configured to meet the needs of the elderly close to their local communities
- a well-trained workforce with expertise in older persons' health and well-being
- progressive implementation of the West Coast DHB DSS action plan
- encourage primary providers to include hearing and vision in regular wellness checks.

In The Next Year:

- centralise AT&R referrals to improve service coordination
- encourage primary providers to provide regular wellness checks with the long-term aim of lowering the incidence and impact of cardiovascular disease, diabetes and respiratory conditions
- develop a DHB Disability Action Plan within our own services and with other service providers
- produce a detailed framework for the development of an Elderly Care Strategy that addresses the future provision, location and facilities for care of the elderly.

4. OTHER DHB STRATEGIES

4.1.1 IMPROVE NUTRITION AND REDUCE OBESITY, INCREASE LEVEL OF PHYSICAL ACTIVITY

West Coast Health Needs Assessment
As part of the Hillary Commission Push Play survey carried out every month from May 1997 to April 1998, information was collected for 419 adults and 127 young people living in the Canterbury/West Coast region, and this survey indicated that, for this composite region, slightly higher than average proportions of both young people and adults are active. Of these, young people tended to spend more time active than young people nationally, and adults spent time in activity at a similar rate to the national average. Unfortunately, no conclusions can be drawn from these findings regarding the West Coast population because of the small numbers involved.

Nationally, 15% of males and 19% of females are obese, and 40% of males and 30% of females are overweight (but not obese). Obesity and nutrition have been linked to most major non-communicable diseases including diabetes, most cancers and cardiovascular disease. This is a particularly significant issue for Maori and Pacific peoples. Hypertension, osteoporosis and dental decay are other ailments directly attributable to nutritional status.

Due to a general lower socio-economic status, and the transport costs added to groceries on the West Coast, basic staple foods are less affordable. Also, because of the geography of the region, people in rural areas have limited access to fresh produce and grocery items. The national marketing of poor food choices has been effective, and advertising supporting healthy food choices has been minimal.

Physical activity is important in reducing avoidable mortality and avoidable morbidity, particularly in relation to stroke, high blood pressure, obesity, diabetes and colon cancer.

Key Issues:

- poor diet contributes to the three leading causes of death in New Zealand - heart disease, stroke and cancer

physical activity and good nutrition can help people avoid heart disease, stroke and cancer

- people with Type 2 diabetes are likely to be overweight.

In The Next Ten Years:

- encourage increased physical activity and thereby diminish the prevalence of cancers, diabetes, cardiovascular disease and obesity
- improved nutrition patterns through health promotions in pre-schools, schools, workplaces etc
- reduce obesity levels, especially among Maori, to 7% of the population.

In The Next Five Years:

- increase levels of physical activity, especially for school children/tamariki.
- improved nutrition patterns through health promotions in pre-schools, schools, workplaces etc.
- reduce obesity levels, especially among Maori to 12% of the population.

In The Next Year:

- continue to fund and promote healthy lifestyle programmes that cover better nutrition and promote exercise programmes
- work with our own staff (approx 980 people) to promote healthy lifestyles.

4.1.2 REDUCE THE RATE OF SUICIDES AND SUICIDE ATTEMPTS

West Coast Health Needs Assessment
For the 12 month period ending 1999, although there is variation at DHB level, no overall national trend in suicide rates is apparent. However, the West Coast has suicide rates significantly higher than the nationals rate (along with 3 other DHBs).

Youth rates of suicide for the West Coast for 1999 however match the national average. Local statistics show 21 suicides for the period `1996 – 1998, of which 18 were male, 7 were in the 20-24 years age group, 9 were 25-40 years and 5 over 340 years.

New Zealand leads the Organisation for Economic Co-operation and Development (OECD) in suicide rates.

Nationally, the total number of suicides in 1999 has reduced to 514 in 1999 from 577 in 1998 and 561 in 1997. This is the lowest total number since 1994 (512) and the lowest rate since 1993.

Total suicide deaths and rates have reduced amongst males in recent years, but there has been a slight increase in numbers and rates amongst females.

In 1999 a total of 120 young people aged 15-24 years died by suicide, compared with 140 in 1998, and 142 in 1997. Young people still have higher rates of suicide than other age groups.

Nationally suicide deaths have reduced amongst both Maori and non-Maori. In 1999 the rate of suicide among both Maori and non-Maori was almost identical (12.0 to 12.2 per 100,000). However, Maori continue to have higher rates of youth suicide.
Nationally the hospitalisation rate for suicide attempt and self inflicted injury in 1999/2000 has increased slightly for the total population compared to 1998/1999 and 1997/1998 (but is identical to the 1995/1996 rate). Hospitalisation rates for youth (15-24 years) in 1999/2000 have also increased slightly on 1998 / 1999 but are lower than 1995/1996 rate.

There is some variation in regional suicide rates for the total population, but no apparent trend. There is more variation among youth rates, but still no emergent regional trends.

The New Zealand Health Strategy has identified reducing suicide and suicide attempt across all ages as a priority health objective.

Suicide prevention requires a range of interventions across a number of settings and the co-operation of Government, service providers, communities and families.

Key Issues:

- people with mental illness are at a higher risk of suicide than the rest of the population
- in 1999 514 people in New Zealand died by suicide – accounting for 2% of all deaths.

In The Next Ten Years:

- effective crisis response services in place.
- reduce overall suicide and attempted suicide rates across the region
- effective multi sectoral approach to suicide prevention.

In The Next Five Years:

- support community development initiatives which strengthen family/whanau,

improve social support, parenting skills and reduce violence and discrimination

- support evidence based mental health promotion programmes which encourage the development of good mental health
- work to counter discrimination and stigma associated with mental illness
- work with the PHO to assist primary practitioners to recognise and treat mental illness to prevent youth suicide through early intervention programmes
- effective links encouraged between the agencies working in this area
- remove barriers to accessing services [cost, cultural acceptability, stigma]
- work with schools to encourage the development of protocols for effective responses to suicide and suicide attempts
- foster relationships with local media to encourage safe reporting of suicide and avoidance of sensationalism.

In The Next Year:

- improve the quality and consistency of local data collection for suicide attempts presenting to all agencies
- facilitate the dissemination of best practice information about suicide prevention to key stakeholders and sectors
- facilitate skill training and development among the accident/emergency/ primary/ mental health and community services
- support regional suicide prevention planning initiatives
- encourage use of MOH suicide prevention guidelines by primary health practitioners.

4.1.3 MINIMISE THE HARM CAUSED BY ALCOHOL AND DRUG USE

West Coast Health Needs Assessment

The hospitalisation rate for alcohol-related conditions on the West Coast is the highest for any of the 12 provincial DHBs project and is higher than the rate for New Zealand as a whole. The mortality rate for alcohol-related conditions might also be high. Provider survey respondents identified the need for more alcohol and drug health promotion in the region.

At some time in their lives, nearly one in five New Zealanders will suffer an alcohol-related disorder, whether from a disease such as cirrhosis, or an increased risk of some types of cancer, stroke, and heart disease. Alcohol abuse also significantly contributes to death and injury on the roads, drowning, suicide, assaults and domestic violence. Whilst moderate alcohol use can offer some protective effect against heart disease and stroke later in life, the net effect on mortality is negative because so many deaths occur at younger ages (particularly from accidents and injuries).

Illicit drug use is difficult to quantify. Daily use of cannabis is recognised as having adverse health effects. Only 1% of people in a New Zealand national sample were daily users. Young people aged between 18 and 24 years have the highest frequency of cannabis consumption and are thus most at risk of adverse consequences. Injecting drug use (IDU) produces serious risks to individuals and society. Current estimates suggest that there are around 15 000 regular IDUs in New Zealand. 45% of IDUs are infected with Hepatitis C.

Government Strategies

Various government strategies inform service development:

- National Drug Policy utilises a harm minimisation approach and sets a national framework to improve co-ordination, set priorities, identify service deficits and reduce drug related harm
- National Alcohol Strategy, (a sub set of the National Drug Policy)
- National Mental Health Strategy which confirms alcohol and drug services as part of mental health services
- National Alcohol and Drug Service funding strategy soon to be released which prioritises:
  - Development of Maori responsive alcohol and drug services.
  - Development of specialist child and youth alcohol and drug services.
  - Development of specialist services for those with complex or severe needs [dual diagnosis].
  - Workforce development.

Evidence indicates a comprehensive intersectoral approach to reducing alcohol and drug related harm is most effective. Co-ordination within and between services is essential.

In The Next Ten Years:

- Reduced harm to individuals using alcohol and drugs through:
  - Education
  - Reduced consumption
  - Early identification and intervention
  - Access to specialised treatment
- Increased level of awareness by the community.

In The Next Five Years:

- improve service provision for Maori through mainstream and Kaupapa Maori service development

- improve service provision for children and young people
- reduce alcohol related harm for young people thru early intervention
- improve access to methadone treatment to Benchmark levels and increase numbers accessing GP provided methadone services
- work with the other South Island DHBs to ensure consistency of entry criteria and treatment processes across the region.

In The Next Year:

- increase screening and brief intervention in primary health settings for at risk drug and alcohol users, including pregnant women
- review and improve resourcing for specialist alcohol and drug assessment and intervention services
- review access to residential services
- ensure active consumer participation in service planning, implementation and evaluation
- develop mechanisms to ensure the provision of advice on alcohol and drug service issues to the Board
- support intersectoral collaboration in particular with schools and the police
- improve workforce skills and knowledge
- improve screening and early intervention across secondary health services.

4.1.4 IMPROVE THE MENTAL HEALTH STATUS OF PEOPLE WITH SEVERE MENTAL ILLNESS

The National Mental Health Strategy is based on more and better services for the 3% of the population suffering from serious mental illness.

The World Health Organisation (WHO) research shows mental illness accounts for 15% of the total world burden of disease.

In New Zealand there will have been a 100% increase in funding for mental health services in less than 10 years. This increase has driven many changes:

- more mental health services
- workforce development is now a priority
- the Mental Health Information National Collection [MHINC] project has developed the mental health reporting system and will be fully implemented when NGO's have joined
- new Mental Health standards have led to quality improvements with associated audit programmes
- Like Minds Like Mine is a national programme to destigmatise mental illness and promote recovery
- Intersectoral links aim to improve access to housing, education and employment.

The Mental Health Commission, established by the Government in 1996 has produced a Blueprint for Mental Health Services in New Zealand outlining the range of services required to meet the Government strategy of meeting the needs of the 3% of the population by 2004 suffering from serious mental illness.

This means the West Coast DHB has less autonomy in funding mental health services than it does in other services, with the aim being to protect funding and prevent the erosion of services.

REGIONAL MENTAL HEALTH PLANNING

The MOH has required District Health Boards to collaborate in planning regional mental health service provision.

The South Island Regional Mental Health Network has produced a regional mental health plan aimed at providing a strategic direction for the development of South Island Mental Health services consistent with the Blueprint guidelines to enable DHB to respond effectively to the needs of the 3% of people in their communities affected by severe mental illness.

An analysis of service levels at regional and district levels indicate some mental health services are over delivered and some under delivered.
Fulltime funding growth is likely to be aligned to the Benchmarks. Further growth in the quality and quantity of services within funding parameters will occur by:

- a reconfiguration of existing services
- collaboration with the primary health sector
- collaboration with sectors outside health (Justice, Education and Welfare)
- improvements in the quality of service delivery through e.g. workforce development.

The regional plan describes goals for:

- Maori mental health
- Rural mental health
- Children/tamariki and young people
- Alcohol and drug
- Regional specialist services
- Needs assessment and service coordination
- Quality assurance
- Regional public health programmes

Workforce development.

The West Coast Strategic Mental Health Plan is informed by the regional plan.
In addition the West Coast DHB has completed a benchmarking project providing mental health services against the Commission's Blueprint resource guidelines.

It is noted that the Commission's guidelines were never intended to be applied proportionately to populations smaller than 100,000.

A fundamental assumption was made that there will be no additional [nor any less] funding available, and any new initiatives or gaps need to be met through reconfiguration of existing services.

Key Issues:

- West Coast DHB mental health inpatient beds are over provided, especially in long stay beds, when compared to national benchmarks
- lack of mental health services to the 17% of the population with non-serious mental disorders
- need to develop a comprehensive rehabilitation service with a range of accommodation and care options
- there is overprovision in community mental health services and some under provision in Child and Youth community teams, alcohol and drug community and residential services
- access to regionally provided mental health services is an issue.

In The Next Ten Years:

- appropriately configured recovery based specialist mental health services meeting consumer needs and Benchmark guidelines
- easy access for consumers and family individually and collectively into participation in service functions (provision, monitoring and planning)
- better trained and more highly skilled work force.

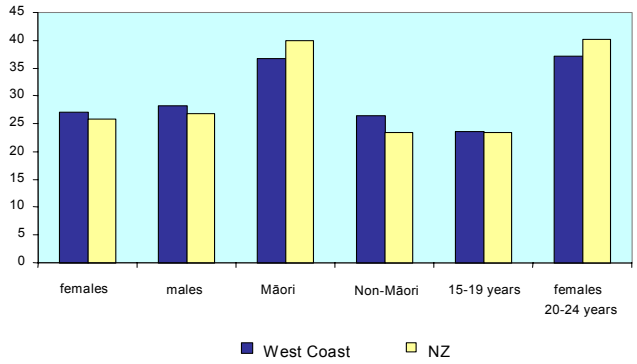
In The Next Five Years:

- improved range of rehabilitation services
- increased resources available to child/tamariki and adolescent service
- increased resources available to alcohol and drug services through service reconfiguration
- better targeting of high needs group of mental health patients to improve their quality of life and utilisation of services
- multi agency approach in the areas of accommodation, employment and education developed to improve recovery.

In The Next Year:

- review services:
  - Community residential services
  - Alcohol and drug services
  - Child/tamariki and youth service
- improve access to regional services
- Improve relationships with NGOs
- develop West Coast Mental Health workforce development plan
- monitor contracts with non DHB providers to ensure quality services
- improve the interface between primary and specialist mental health services
- support the development of an effective and accessible primary mental health service.

4.1.5 IMPROVE RESPIRATORY HEALTH AND REDUCE THE INCIDENCE OF SMOKING



Smoking prevalence (%), West Coast versus New Zealand, 1996
Source: Ministry of Health, from 1996 Census data

Smoking is considered to be an intermediate factor between deprivation and morbidity. Smoking is one of the most significant preventable causes of ill health, and remains a considerable burden to the health status of Maori in particular. There are 4700 deaths annually in New Zealand attributable to smoking. Smoking kills one in two smokers, and smokers who die prematurely from smoking-related causes on average die 14 years earlier than non-smokers. Smoking is also an important prenatal and child/tamariki health risk factor.

Smoking by pregnant women and by parents and other adults around young children contributes significantly to morbidity and mortality in children.

On the West Coast, the overall smoking prevalence is slightly higher than the New Zealand average. Higher than average prevalence is seen for non-Maori, both male and female, whereas the smoking prevalence of Maori is lower than for Maori in New Zealand as a whole. The prevalence in the Buller TA is in the top 20% of prevalence rates for TAs in New Zealand, with very high rates among non-Maori, and the highest rate nationally for adolescents.

Key Issues:

- respiratory infections are among several causes of admission to hospital for all age groups, which are higher than the national rates
- asthma and emphysema type conditions could be better managed with more appropriate prescribing and better support and follow up
- high turnover and low ratio of GPs can lead to avoidance of the service and conflicting advice and treatment, leading to poorer health, and more important, higher admission rates
- there are no support groups or agencies to refer to
- apart from Quitline and Haurora Matauraka (not accessible to everyone) there is no other free smoking cessation service available West Coast wide

- the West Coast has the highest national smoking rate for adolescents (in particular Buller), and there are no smoking cessation services within high schools
- about 21% of adults smoke regularly
- smoking rates are higher for Maori (39%) than non Maori, especially young women
- smoking contributes to a number of preventable illnesses and is the major cause of preventable death on the West Coast.

In the Next Ten Years:

- reduce smoking rates to less than 5% of the population
- improved access to respiratory and smoking cessation services from Karamea to Haast.

In the Next Five Years:

- establishment of Pulmonary Rehabilitation Programme for individuals with Chronic Obstructive Pulmonary Disease
- educate hospital staff to encourage patients to assess their patient's smoking
- provide ongoing education to teachers in schools and preschools to safely and effectively manage childhood asthma
- streamline ongoing education to ensure all health professionals are giving the same information
- respiratory clinics are held regularly in all areas.
- reduction in numbers of people smoking on the West Coast
- all indoor public areas smoke-free.

In the Next Year

- continue to support health promotion and services to help people quit smoking
- encourage the monitoring of the effectiveness of tobacco control programmes.

4.1.6 REDUCE VIOLENCE IN INTERPERSONAL RELATIONSHIPS, FAMILIES, SCHOOLS AND COMMUNITIES

West Coast Health Needs Assessment

There is little data available regarding violence on the West Coast. Over the period 1998 to 2000 the numbers of reported violent crimes in the region have remained relatively constant. During the period 1996 to 2000, there were two children/tamariki hospitalised as a result of intentional injuries.

4% to 10% of New Zealand children experience physical abuse and approximately 18% experience sexual abuse. 21% of New Zealand men said they had physically abused their female partners in the previous year. 8% of school children experience persistent very serious bullying. 3% to 5% of older people are victims of elder abuse.

DHBs have a responsibility to use population based strategies to address interpersonal violence through support for young families, support for school based prevention programmes and ensuring early identification and referral of violence cases.

Key Issues:

- health and disability service providers are in an excellent position to identify and intervene at an early stage to refer family violence issues
- A lack of further enquiry about injuries obviously inflicted by another person may contribute to ongoing serious abuse or even fatalities
- A multi dimensional, multi sectoral approach often using public health strategies is recommended.

In The Next Ten Years:

- reduction of interpersonal violence in the West Coast community through the development of violence prevention programmes
- Intersectoral programmes in place which emphasise public awareness, access to help lines, community development programmes and training and capacity building.

In The Next Five Years:

- home visiting programmes developed where possible in conjunction with existing home visiting services to provide intensive support to young and at risk families – appropriate training provided for staff
- support school based anti violence programmes
- reduce elder abuse through awareness programmes and effective responses, when there is abuse, through working collaboratively with other agencies.

In The Next Year:

- increase responsiveness within the West Coast DHB and primary sector to family violence by working with the MOH project to develop intervention strategies including:
- development of appropriate protocols
- training programmes for health professionals
- possible development of a family violence prevention campaign.

4.2 OWNERSHIP OBJECTIVES

Ownership Objectives – The Long-Term Management Of Assets

Asset Management

The West Coast DHB strategic direction for the provision of quality health services is inclusive of appropriate facilities. This strategic direction establishes longer-term direction, size and nature of the investments required.

The West Coast DHB will continually assess the appropriateness of facilities to ensure alignment with changes in service delivery and best practice.

Grey Base Hospital

Grey Base Hospital is essential to the continuing delivery of secondary personal health services, in-patient aged care services, and acute in-patient mental health services, allied health, diagnostic and some ambulatory care and community services.
The recent completion of the redevelopment of part of Grey Base Hospital has achieved an increase in efficient use of resources and available floor space in upgraded areas.

The structure of Grey Base Hospital is sound. Maintenance of those areas not attended to during the redevelopment project was deferred for some time. A "catch-up" maintenance programme is now in place. The current configuration of the hospital contributes to inefficiencies restricting integration of services.

During the redevelopment project asbestos was found throughout the hospital. Asbestos has been removed or contained in those areas of the hospital, which were part of the redevelopment project. There is a requirement to complete the fire upgrade within those areas of the hospital, which were not part of the redevelopment project. This will require the removal or containment of asbestos during the fire upgrade project within the next two years.

Buller Hospital – Westport

Buller Hospital provides a level two emergency service and inpatient service and geriatric and rest home services. In addition the facility provides outpatient, diagnostic and community health services, inclusive of mental health services. Attached to the Buller Hospital is a General Practice Clinic.

Reefton Hospital

Reefton Hospital provides primary community health services with general practitioner support. The hospital provides medical, continuing care and Rest home beds and provides a level two emergency service.

Seaview Hospital

This property, inclusive of buildings, is being actively marketed for sale. Planning is underway for relocation of the remaining 45 residents.

Hokitika Health Centre

The Hokitika Health Centre provides outpatient and community services, inclusive of physiotherapy, public health, visiting consultants, district nursing, public health nursing, occupational therapy and community mental health.

The building is structurally sound with the maintenance programme continuing.

Clinics

There are seven health clinics spread along the West Coast region from Karamea to Haast. The majority of these clinics are of sound structure with an ongoing maintenance programme. Future location and clinic size requirements are to be addressed with potential capital investment implications as the need arises.

Retention of these clinics is imperative to the provision of health services along the vast geographical West Coast region.

4.3 CAPABILITY

This section sets out the development and maintenance of resources, systems and infrastructure for the West Coast DHB to deliver its objectives and strategic priorities and how the West Coast DHB intends to achieve this.

4.3.1 Workforce Development

Introduction

A workforce plan is a natural follow-on to strategic planning. The strategic plan helps to identify where the West Coast DHB is, where it is going, and how it is going to get there. Similarly, the workforce plan lays out the actions to be taken in order to achieve the West Coast DHB human resource goals and objectives. Workforce planning is the process of ensuring that the right people are in the right place and at the right time to accomplish the mission of the West Coast DHB. It also equips managers with the human resource information they need to manage their departments more effectively.

Strategic Direction

By setting the strategic direction and developing a strategic plan, the West Coast DHB will be positioned for long term success. The strategic plan outlines the organisation's vision, mission, values and objectives. In the workforce plan, strategic partners will be identified and approached to assist the West Coast DHB in achieving its strategic objectives. A review of the organisational Human Resources will be undertaken in order to examine current workforce demographics and competencies. Processes within the West Coast DHB will be analysed, and, where necessary, redesigned. Specific performance indicators will be identified in order to define how the West Coast DHB is progressing.

The Ministry of Health (MOH) will also be relied upon to provide strategic vision and direction. The Ministry's five-year HR strategic plan is focused on building core capability for the future. The ministry also has two key initiatives underway to ensure the health workforce is adequately trained:

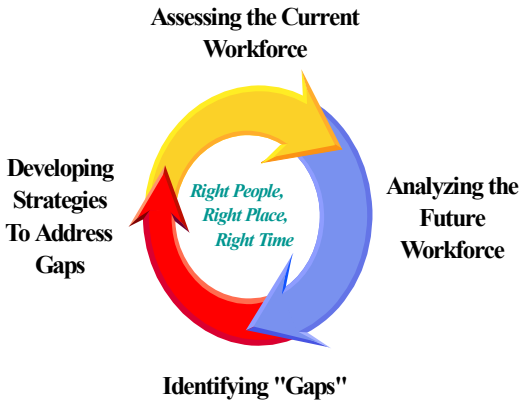
- The Health Workforce Advisory Committee (HWAC) was established in 2001 and has recently completed a stocktake of New Zealand's health workforce
- The Health Professional's Competency Assurance Bill is scheduled to be introduced to Parliament in 2002.

CRITICAL STEPS TO WORKFORCE PLANNING

1. Assess The Current Workforce

The West Coast DHB needs to determine what the current workforce resources are and how they are projected to change over time through turnover, natural attrition, etc. This stocktake will help the organisation have a better understanding of what areas of the workforce need to be strengthened, providing further goals for the workforce plan. Tools to be used to identify supply, demand and discrepancies include the organisation's own collection of personnel information, MOH publications on staffing, population surveys, census data, etc.

The HWAC has advised the MOH that three workforce issues have been identified as areas of concern by health staff:



- **Shortages of staff:** This is a major issue for both providers and users of health care. There is a perception that many newly qualified staff leave to work elsewhere overseas to avoid prepayment of high student debt. Focus areas are shortages of GPs in rural practices, adequate locums for rural GPs, medical specialists eg (general surgeons, specialists anaesthetics, etc), registered nurses and qualified Maori providers.

- **Recruitment:** Recruitment of qualified staff has always been a problem, with specific challenges facing recruitment in rural areas.

- **Retention:** Again the perception is that people are training in NZ and then going overseas.

2. Analyse The Future Workforce Needs

Developing specifications for the types, numbers and location of health workers and support staff we will need to accomplish the West Coast DHB mission, goals and objectives. This information will be developed in conjunction with the corporate strategic plan and budget constraints.

The MOH has indicated that the future may require a different mix of workforce skills to those of the present. Issues include:

- more skilled personnel are required in community-based and primary health care settings
- Maori development and action on reducing health inequalities will mean continuing initiatives to develop the Maori workforce
- changing health needs of an aging population
- advances in technology causing different specialist skills to be required. Developments in information technology and telecommunications are also two of numerous tools that could be utilised to improve service access and workforce support.

3. Identifying Gaps And Strategies To Address Gaps

This entails determining what gaps will exist between our current and projected workforce needs. Strategies for addressing gaps would include recruiting, training / retraining, reconfiguration, performance manage-ment, leadership development, succession planning, technological enhancements, etc. Strategic measures will also be used to assess progress.

Developing An Action Plan

A workforce action plan needs to be developed to ensure that the West Coast DHB has the resources to deliver quality health services to its community in a timely manner. It will also facilitate the management of change and contribute to better people management. The steps in designing an action plan include:

- identifying stakeholders[2]
- developing ways to address skill gaps
- setting specific goals
- developing a communications strategy
- evaluating progress

Implementing the action plan

- **Communicating the Action Plan**

The West Coast DHB has already made significant progress in creating an infrastructure that facilitates open communication throughout the organisation. This will continue to be encouraged and managers will be required to communicate the workforce action plan consistently throughout the organisation.

- **Targeting and Recruiting**

The West Coast DHB will continue to develop recruitment materials that clearly

[2] Stakeholders include the Ministry of Health, other DHBs, the HWAC, other health care providers, professional bodies, non-government organisations, community groups, the education sector and various other organisations such as the Mental Health Workforce Society, the Community Support Services Industry Training Organisation, etc.

communicate to the target audience it is seeking to recruit. Recruitment processes will be focussed on identifying the target market, designing customised recruitment messages and delivering these messages to the target audience.

- **Conduct Recruiting and Training**

This includes further developing methods to evaluate the qualifications of applicants for employment. The evaluation and selection process represents the final stage of recruiting. Once the candidate is selected, further training needs can be identified. For example: Increased training opportunities result in increased exposure of doctors and other health workers to practice in provincial, and especially, rural settings. This strategy is recognised internationally as an important part of a long term strategy aimed at maintaining a skilled and responsive health and medical workforce in provincial and rural areas.

- **Implement Retention Strategies**

An important principle behind maintaining a quality workforce is employee retention. Workforce research has shown which factors most affect retention:

1. organisational commitment to the promotion of workforce diversity
2. commitment to career development and advancement of employees
3. organisational commitment to policies and programmes designed to improve the quality of an employee's work and which in turn is likely to lead to greater personal satisfaction
4. recognising contributions made by employees to the organisation
5. ensuring a fair and equitable system for evaluating employee performance.

- **Conduct Organisational Assessments**

Research shows that the lack of career development opportunities is one of the primary reasons an employee leaves an organisation. The organisational assessment will focus on succession planning. Succession planning will be developed as part of a longer term strategy.

- **Monitoring, Evaluation And Revision**

- **Monitor:** Assess Effectiveness

Performance measures and benchmarks will be set to monitor progress, e.g. links to the in-house performance management system, employee satisfaction assessments, etc.

- **Evaluate:** Adjust Plan as Needed
This includes a review of the planning strategies outlined in the action plan, eg: recruiting, selection, career development, retention, etc.

- **Revise:** Address new workforce and organisational issues
In response to new workforce and organisational issues, as well as the dynamic nature of the organisation, the West Coast DHB will need to make revisions to the workforce plan for future action.

WORKFORCE PLANNING IS PUTTING THE RIGHT PEOPLE IN THE RIGHT PLACE AT THE RIGHT TIME TO ACCOMPLISH THE MISSION OF THE WEST COAST DISTRICT HEALTH BOARD.

4.3.2 Improving Information Systems

The challenge for the West Coast DHB is to develop systems that allow the right information to be accessible by the right people at the right time. There are a number of problems which prevent this from happening now. Data collected about patients is stored in a variety of databases, and not always fed back to the service providers and users. Ethnicity data collection is poor. Databases are not linked. Patient care can be duplicated and/or is fragmented. As a result of this some practitioners (such as those working in hospitals) have access to a wide range of clinical information, and new research information published in international journals, while other health workers (community providers, or rural practitioners) may not.

The West Coast DHB is required to capture information about the health needs and health service delivery across the region. To do this, the DHB must enhance its capability in these areas, and work more closely with all health providers in the region to collect meaningful information, (preferably once).

Within its own hospitals and services, the West Coast DHB is improving systems of collecting patient information electronically, making patient information available at all DHB sites, and using video-conferencing to allow specialists to contact patients and health professionals in remote areas. This is for treatment, education, peer review, supervision and service planning.

4.3.3 Building Capability

The West Coast DHB is challenged in its quest to build up the capability to fund health services. It is the smallest DHB servicing a significant land area with limited resources, not only in health provision but also in planning, funding, contracting, monitoring and payment systems.

The West Coast DHB has joined with the five other South Island DHBs in forming Shared Services Agency (SISSAL) to provide support for many of the above non clinical functions.

With the support of SISSAL, the DHB fulfils its new funding role and is also actively engaged in a number of new and innovative projects to enhance health service provision in the local area into the future.

4.3.4 Partnership with Maori

The Treaty is about partnership between two main groups but it lays the foundation for many cultures by providing the legitimate basis for the presence of all New Zealanders, whatever their ethnic origin. It also clarifies the unique position of Maori people within New Zealand.

4.3.5 Structures and systems to manage safety and improve quality

The DHB has an active approach to Risk Management within the organisation and is focused on the improvement of quality systems which ensure safe care is delivered.

Providers will be expected to develop systems to meet legal and contractual quality and safety requirements, including national standards.

An audit programme to ensure requirements are met will be maintained.

Appropriate workforce development programmes will continue to ensure appropriate skills and best practice activities are maintained or enhanced.

4.4 MONITORING AND REPORTING

This section describes how progress against strategic priorities will be monitored and reported by the West Coast DHB. This will include a high level description of performance management tools and processes, which will be used by the West Coast DHB. This section will also inform about the West Coast DHB outcome indicators, based on health needs assessment, to indicate progress towards strategic priorities set out in Sections 3 and 4.

4.4.1 How Progress against Strategic Priorities will be Monitored and Reported

The West Coast DHBs Strategic Plan is given effect in its Annual Plans.

The Annual Plan contains numerous of time lined objectives and reporting requirements against which the Board publicly (at its meetings and to the MOH) reports as they fall due.

The West Coast DHB is required to produce an Annual Report. It contains a Statement of Service Performance that lists the Board's performance against its statutory functions and objectives, plus all the other objectives and reporting requirements in its Annual Plan. This is audited by Audit New Zealand.

4.4.2 Performance Management Tools and Processes

Any change to existing systems will be evolutionary and will respond to needs as they present at the time.

The Board and management have an extensive management information system, providing regular information including reporting on:

- financials
- staffing
- volumes.

Extensive information is routinely provided to the MOH.

Information is also routinely provided to the Board and public.

The system is supported by the following systems or processes:

- benchmarking
- audit – internal and external
- an overall Maori Advisory Group – which will also be involved in implementation
    - patient status
    - key performance indicators
    - complaints
    - incidents.

Monitoring of providers (other than its own) consists of:

- providers reporting as required in their service agreements
- a provider audit programme.

4.4.3 Outcome Indicators

Most indicators are currently based on inputs or outputs.

The long-term preference is to use measures of outcome (i.e. the results). This can be expanded as health status information improves.

4.5 RISK MANAGEMENT

By its very nature, a DHB faces a multitude of risks. The functions of a DHB are complex and often are associated with risks on a daily basis. This coupled with the often involved legal, regulatory and financial framework that the DHB operates in means that it is exposed to a wide range of risk across all its activities. Management of these risks requires vigilant attention to a structured risk management approach that will ensure improved outcomes through identification and analysis of risks, and systematic informed decision making.

Having a structured and formalised risk management system also enhances and encourages the identification of improved opportunities for continuous improvement of the services and functions of the DHB.

The DHB will move to establishing a more formal process involving the establishing the context of risks faced, identification, analysis, evaluation, treatment and monitoring of risks. This will ensure that the management of risks faced by the DHB will stand up to relevant public sector accountability mechanisms (local, regional, national).

The DHB is establishing a Quality Management System (based around AS/NZS that will incorporate processes to ensure that identified risks are managed appropriately. The provider arm of the DHB will (before 1 October 2004) meet the requirements contained within *NZS 8134:2001 Health and Disability Sector Standards*, and the associated legislative compliance with the *Health and Disability Services (Safety) Act 2001*. The DHB will also work with other providers that it develops a funding relationship with to ensure their compliance with this Standard, to ensure that the DHB is not materially compromised or adversely affected by the move to a funder role. The DHB will monitor and audit providers it funds to ensure attainment of the *NZS 8143:2001* (and others such as *NZS 8142:2000 Infection Control, NZS 8141:2001 Restraint Minimisation and Safe Practice* and *NZS 8143:2001 National Mental Health Standards*). However specific monitoring and audit functions will need to be clarified between the District Health Board and the Ministry.

The DHBs Quality Management System will contain risk management processes that also:

- evaluate and prioritise identified risks based on severity, the effectiveness of controls and the probability of occurrence
- minimise, isolate and where reasonably practicable, eliminate risks
- minimise the adverse impact of emergencies (both internal and external)

- maintain a hazard management system that safeguards consumers, staff and visitors from avoidable incidents, accidents and hazards.

This risk management process also includes, but is not limited to:

- asset management
- change management
- consultation with stakeholders
- contract management
- medico-legal activities
- employment practices
- workforce development
- waste management
- legislative compliance
- performance monitoring
- information/records management
- financial and treasury management.

The key risks faced by the DHB during the next ten years include:

- difficulties in workforce recruitment and retention
- a lack of resources to effectively implement government strategies
- service sustainability
- development and management of a Primary Health Organisation
- provider sustainability without associated funding increases
- service safety.

4.6 FINANCIAL INFORMATION

4.6.1 Financial Statements

A set of financials is not available at this time.

The Board does not believe this will hinder consultation with the public.

In the short term it must be recognised that service development will be constrained by available finances.

At the time of writing the Board is still working on the impact of the funding it will receive from the Ministry over the next 3 years. This funding is for both activities devolved to the DHB as a funder and for services provided by the DHB.

It has also been announced by the Ministry that $410 million will be available for implementation of the Government's Primary Health Care Strategy over the next 3 years. This additional money will be made available to DHBs through Primary Health Organisations to improve access and improve services.

DHBs will not have the option of applying the funding for other purposes. Primary Health Care Strategy funding will be ring fenced.

For this money to be available on the West Coast, a Primary Health Organisation must be established. Planning is well underway to achieve this requirement.

The additional funding will significantly contribute to achieving the Board's Strategic Objectives as identified in this plan.

4.6.2 Financial Strategies

Asset Management

Funding for services will be maximised where:

1. Assets provide a health and/or economic health return on investment.
2. The Board minimises its capital investment and maximises asset life, whilst ensuring that its capacity matches it requirements; and provided that the asset base is not being run down, and assets fit for the purpose.

Ensuring Mental Health Ring-Fencing

1. The Board expects to receive Mental Health funding on the basis that it is ring-fenced.
2. Existing information systems support this tagging.
3. Mental Health is expected to make a fair contribution to common costs (overheads) of the West Coast DHB.

Strategic Plan Assumptions

Years 4-10 will be status quo as the West Coast DHB is servicing a small population base (32,200). In a number of areas there is excess capacity to service the population. In the short to medium term anticipated movements in population growth, ageing, etc should not impact significantly on the West Coast DHB ability to deliver.

This plan assumes by Year 4 the funding of the West Coast DHB will be resolved and as such funding will be sufficient to eliminate deficits. This will require increased funding of $1.5 million pa.

The cost of establishing a PHO has not been included as it has been assumed that this will be offset by revenues from the MOH. Given the uncertainty of future funding tracts for the PHO no allowance has been made for this. It is assumed any new funding will be spent on increased primary care. Given the current overall underfunding of the West Coast DHB it is not anticipated that there will be any capacity to reallocate funds from secondary care.

Preliminary planning is to be underway shortly proceeding on new or reconfigured facilities for Reefton and Buller Hospitals. A separate capital plan will be required to support any outcome from this work and as such is not included in this plan.

Financial Strategies

The West Coast DHB will be working with the MOH to remedy the funding, of the West Coast DHB. It is pleasing to note after numerous reviews there have recently been a movement towards addressing the funding requirements for future years.

In line with Government policy it is anticipated that any new loans or refinancing of existing private debt will be through RHMU. It is expected that RHMU will be the sole and hopefully cheapest, form of debt financing. The West Coast DHB will continue to pursue overdraft facilities with rates that are competitive.

Within the limited financial resources of the West Coast DHB assets will be maintained in working order with priority being given to replacing assets that have health and safety or quality implications.

DHB ID	Reporting Unit / Ring Fence Code	Account Code	Suffix Number	Description	Jun-00 Opening Balance	2000/01 Audited Actual	2001/02 Forecast	2002/03 Budget	2003/04 Budget
Section 1: Financial Information									
Part 4: DHB Consolidated									
Part 4.1: DHB Consolidated - Statement of Financial Performance									
				REVENUE					
				Government and Crown Agency sourced					
				MoH					
17	0	1090	N/A	Clinical Training Agency	-	-	-	-	-
17	0	1002	N/A	MoH – Vote Health	-	(32,110)	(12,596)	(13,005)	(13,086)
17	0	1102	N/A	MoH – Personal Health	-	-	(22,954)	(27,357)	(27,911)
17	0	1202	N/A	MoH – Mental Health	-	-	(6,864)	(7,408)	(7,781)
17	0	1302	N/A	MoH – Public Health	-	-	-	-	-
17	0	1402	N/A	MoH – Disability Support Services	-	-	-	-	-
17	0	1502	N/A	MoH–Maori Health	-	-	-	-	-
				Other Government					
17	0	1602	N/A	Other DHBs	-	-	-	-	-
17	0	1095	N/A	IDCC Funding	-	-	-	-	-
17	0	1674	N/A	Training Fees and Subsidies	-	-	-	-	-
17	0	1684	N/A	Accident Insurance	-	(890)	(973)	(1,086)	(1,091)
17	0	1694	N/A	Other Government	-	(4,804)	(4,468)	(4,425)	(4,514)
17	0	1001	N/A	*Government and Crown Agency sourced Total*	-	(37,804)	(47,855)	(53,281)	(54,383)
				Other Revenue					
17	0	1702	N/A	Patient / Consumer sourced	-	(2,707)	(3,059)	(3,135)	(3,150)
17	0	1802	N/A	Other Income	-	(424)	(485)	(439)	(432)
				Other Revenue Total	-	(3,131)	(3,544)	(3,574)	(3,582)
17	0	1097	N/A	Internal Allocation DHB Governance (should be zero)	-	-	-	-	-
17	0	1902	N/A	Internal Allocation DHB Provider (should be zero)	-	-	-	-	-
17	0	1000	N/A	***REVENUE TOTAL***	-	(40,935)	(51,399)	(56,855)	(57,965)
				EXPENSES					
				Personnel costs					
17	0	2002	N/A	Medical Personnel	-	3,728	5,101	5,410	5,509
17	0	2202	N/A	Nursing Personnel	-	11,280	10,523	11,320	11,379
17	0	2402	N/A	Allied Health Personnel	-	6,287	6,802	7,620	7,577
17	0	2602	N/A	Support Personnel	-	1,101	1,083	1,075	1,117
17	0	2802	N/A	Management/Administration Personnel	-	3,650	4,668	5,013	5,067
17	0	2001	N/A	*Personnel costs Total*	-	26,046	28,177	30,438	30,649
				Outsourced Services					
17	0	3102	N/A	Medical Personnel	-	1,439	1,843	1,907	1,785
17	0	3202	N/A	Nursing Personnel	-	-	40	5	5
17	0	3302	N/A	Allied Health Personnel	-	-	-	-	-
17	0	3402	N/A	Support Personnel	-	-	49	39	40
17	0	3502	N/A	Management/Administration Personnel	-	232	180	162	170
17	0	3602	N/A	Outsourced Clinical Services	-	1,369	1,153	1,201	1,224
17	0	3802	N/A	Outsourced Funder Services	-	-	-	-	-
17	0	3849	N/A	DHB Governance & Administration (Should be zero)	-	-	-	-	-
17	0	3000	N/A	*Outsourced Services Total*	-	3,040	3,265	3,314	3,224
				Clinical Supplies					
17	0	4002	N/A	Treatment Disposables	-	552	619	681	681
17	0	4202	N/A	Diagnostic Supplies & Other Clinical Supplies	-	1,422	1,628	1,697	1,707
17	0	4302	N/A	Instruments & Equipment	-	844	1,002	1,001	1,026
17	0	4402	N/A	Patient Appliances	-	283	241	257	263
17	0	4502	N/A	Implants and Prostheses	-	391	590	687	708
17	0	4602	N/A	Pharmaceuticals	-	65	75	71	73
17	0	4902	N/A	Other Clinical & Client Costs	-	362	485	435	443
17	0	4000	N/A	*Clinical Supplies Total*	-	3,919	4,640	4,829	4,901
				Infrastructure & Non-Clinical Supplies					
17	0	5002	N/A	Hotel Services, Laundry & Cleaning	-	2,686	2,591	2,744	2,726
17	0	5102	N/A	Facilities	-	2,193	2,195	2,396	2,418
17	0	5202	N/A	Transport	-	965	1,017	1,203	1,212
17	0	5302	N/A	IT Systems & Telecommunications	-	1,047	1,146	1,222	1,238
17	0	5402	N/A	Interest & Financing Charges	-	1,854	1,099	1,232	1,232
17	0	5502	N/A	Professional Fees & Expenses	-	547	440	532	545
17	0	5602	N/A	Other Operating Expenses	-	2,430	2,126	1,905	1,911
17	0	5802	N/A	Democracy	-	214	234	350	352
17	0	5902	N/A	Subsidiaries, Joint Ventures & Minority Interests	-	46	-	-	-
17	0	5000	N/A	*Infrastructure & Non-Clinical Supplies Total*	-	11,982	10,848	11,584	11,634

Account Code	Suffix Number	Description	Jun-00 **Opening Balance**	2000/01 **Audited Actual**	2001/02 **Forecast**	2002/03 **Budget**	2003/04 **Budget**	2004/05 **Budget**
		Payments to Providers						
6105	N/A	Personal Health	-	-	-	-	-	-
6111	N/A	Child and Youth	-	-	-	-	-	-
6124	N/A	Other Child and Youth	-	-	-	-	-	-
6128	N/A	Adolescent	-	-	-	-	-	-
6132	N/A	Vision Hearing Screening and Testing	-	-	-	-	-	-
6136	N/A	Laboratory	-	-	243	252	252	252
6140	N/A	Infertility Treatment Services	-	-	-	-	-	-
6144	N/A	Maternity	-	-	11	11	11	11
6148	N/A	Tertiary and Secondary Obstetrics	-	-	-	-	-	-
6152	N/A	Pregnancy and Parenting Education	-	-	-	-	-	-
6156	N/A	Maternity Payment Schedule	-	-	-	-	-	-
6160	N/A	Neo Natal	-	-	-	-	-	-
6164	N/A	Sexual Health	-	-	30	31	31	31
6168	N/A	Adolescent Dental Benefit	-	-	79	82	82	82
6172	N/A	Other Dental Services	-	-	73	75	75	75
6176	N/A	Relief of Pain – Dental	-	-	-	-	-	-
6180	N/A	School Dental	-	-	-	-	-	-
6184	N/A	Secondary/Tertiary Dental	-	-	-	-	-	-
6188	N/A	Provider Development	-	-	-	-	-	-
6192	N/A	Pharmaceuticals	-	-	6,375	6,587	6,587	6,587
6196	N/A	High Cost Pharmaceuticals	-	-	-	-	-	-
6204	N/A	Respiradone	-	-	-	-	-	-

Account Code	Suffix Number	Description	Jun-00	2000/01	2001/02	2002/03	2003/04	2004/05
6206	N/A	Clozapine	-	-	-	-	-	-
6208	N/A	PCO savings	-	-	-	-	-	-
6212	N/A	Management Referred Services (Base)	-	-	-	-	-	-
6216	N/A	Management Referred Services (Performance)	-	-	-	-	-	-
6220	N/A	Additional Services	-	-	-	-	-	-
6224	N/A	Population Based Services	-	-	1	1	1	1
6228	N/A	General Medical Subsidy	-	-	914	944	944	944
6232	N/A	Primary Practice Services – Capitated	-	-	-	-	-	-
6236	N/A	Practice Nurse Subsidy	-	-	8	9	9	9
6240	N/A	Rural Bonus	-	-	84	87	87	87
6244	N/A	Immunisation	-	-	26	27	27	27
6248	N/A	Radiology	-	-	-	-	-	-
6252	N/A	Other Community Based Services	-	-	-	-	-	-
6256	N/A	Palliative Care	-	-	11	11	11	11
6260	N/A	Meals on Wheels	-	-	-	-	-	-
6269	N/A	Other	-	-	-	-	-	-
6271	N/A	Medical Inpatients	-	-	-	-	-	-
6273	N/A	Medical Outpatients	-	-	-	-	-	-
6275	N/A	Surgical Inpatients	-	-	-	-	-	-
6277	N/A	Surgical Outpatients	-	-	-	-	-	-
6279	N/A	Paediatric Inpatients	-	-	-	-	-	-
6281	N/A	Paediatric Outpatients	-	-	-	-	-	-
6284	N/A	Asthma Related Services/Mate Huango	-	-	-	-	-	-
6285	N/A	Diabetes Related Services/Mate Huka	-	-	-	-	-	-
6286	N/A	Emergency Services	-	-	-	-	-	-
6287	N/A	Miscellaneous Services	-	-	-	-	-	-
6288	N/A	Price adjusters and Premium	-	-	-	-	-	-
6299	N/A	Other	-	-	-	-	-	-
6299	N/A	Non-Communicable Diseases	-	-	-	-	-	-
6299	N/A	Tobacco	-	-	-	-	-	-
6299	N/A	Nicotine Replacement Therapy	-	-	-	-	-	-
6299	N/A	Service Co-ordination	-	-	-	-	-	-
6299	N/A	Specialist Support	-	-	-	-	-	-
6299	N/A	Maori Provider Development - Provider Assistance	-	-	-	-	-	-
6299	N/A	Rongoa Maori	-	-	-	-	-	-
6299	N/A	Service Development	-	-	-	-	-	-
		Total Personal Health	**36,707**	**-**	**7,855**	**8,117**	**8,117**	**8,117**

Account Code	Suffix Number	Description	Jun-00 Opening Balance	2000/01 Audited Actual	2001/02 Forecast	2002/03 Budget	2003/04 Budget	2004/05 Budget
		Mental Health						
6311	N/A	Acute Mental Conditions	-	-	-	-	-	-
6315	N/A	Sub-Acute & Long Term Mental Conditions	-	-	359	371	371	371
6321	N/A	Crisis Respite	-	-	-	-	-	-
6325	N/A	Alcohol & Drug - General	-	-	-	-	-	-
6331	N/A	Alcohol & Drug – Child & Youth Specific	-	-	-	-	-	-
6335	N/A	Methadone	-	-	-	-	-	-
6340	N/A	Dual Diagnosis – A&D	-	-	-	-	-	-
6345	N/A	Dual Diagnosis – MH/ID	-	-	-	-	-	-
6350	N/A	Eating Disorder	-	-	-	-	-	-
6355	N/A	Maternal Mental Health	-	-	-	-	-	-
6360	N/A	Child & Youth Mental Services	-	-	-	-	-	-
6365	N/A	Forensic Services	-	-	-	-	-	-
6370	N/A	Kaupapa Maori Services	-	-	-	-	-	-
6375	N/A	Kaupapa Maori Mental Health - Residential	-	-	-	-	-	-
6380	N/A	Kaupapa Maori Mental Health - Inpatient	-	-	-	-	-	-
6385	N/A	By Maori for Maori Mental Health	-	-	-	-	-	-
6390	N/A	Mental Health Team Services	-	-	-	-	-	-
6395	N/A	Prison/Court Liaison	-	-	-	-	-	-
6410	N/A	Mental Health Workforce Development	-	-	-	-	-	-
6415	N/A	Day Activity & Rehab Services	-	-	-	-	-	-
6420	N/A	Mental Health Services for Older People	-	-	-	-	-	-
6425	N/A	Consumer and Carer/Family Support	-	-	-	-	-	-
6430	N/A	Home Based Support	-	-	-	-	-	-
6435	N/A	Carer/Family Support	-	-	-	-	-	-
6440	N/A	Community Residential Beds & Services	-	-	762	787	787	787
6490	N/A	Mental Health – Other	-	-	5	5	5	5
		Total Mental Health	**-**	**-**	**1,126**	**1,163**	**1,163**	**1,163**
		Disability Sypport Services						
		Total Disability Support Services	**-**	**-**	**-**	**-**	**-**	**-**
		Public Health						
		Total Public Health	**-**	**-**	**-**	**-**	**-**	**-**
		Maori Health						
		Total Maori Health	**-**	**-**	**-**	**-**	**-**	**-**
8002	N/A	Internal Allocation (should be zero)	-	-	-	-	-	-
2000	N/A	***EXPENSES TOTAL***	36,707	44,987	55,911	59,445	59,688	60,995
2500		**NET RESULTS**	36,707	4,052	4,512	2,590	1,724	1,393
lidated - Supplemental Information to Statement of Financial Performance								
5105	N/A	Depreciation - Land and Buildings (5105)	-	484	1,062	1,078	1,078	1,078
4355	N/A	Depreciation - Clinical Equipment (4355)	-	-	-	-	-	-
5605	N/A	Depreciation - Other Equipment (5605)	-	866	917	1,021	1,021	1,021
5310	N/A	Depreciation - Information Technology (5310)	-	324	308	376	376	376
5205	N/A	Depreciation - Motor Vehicles (5205)	-	93	102	76	76	76
101	N/A	Depreciation (account codes: 4355, 5105; 5205; 5310; 5605)	-	1,767	2,389	2,551	2,551	2,551
103	N/A	Interest costs	-	1,197	748	800	800	800
105	N/A	Financing component of Operating Leases	-	23	-	-	-	-
107	N/A	Capital Charge	-	611	322	400	400	400
109	N/A	Gain/Loss on Disposal of Assets (account codes: 5110; 5210; 5315;	-	(28)	(92)	-	-	-
199		Total Supplemental	-	3,570	3,367	3,751	3,751	3,751

Account Code	Suffix Number	Description	Jun-00	2000/01	2001/02	2002/03	2003/04	2004/05
dated - Statement of Financial Position								
		Current Assets						
9005	N/A	Petty Cash	38	4	-	-	-	-
9010	N/A	Bank Account	(262)	(1,370)	(827)	(1,257)	(477)	553
9020	N/A	Short Term Investments	2	2	2	-	-	-
9021	N/A	Short Term Investments – Trusts	124	15	7	7	7	7
9025	N/A	Prepayments	183	205	255	255	255	255
9030	N/A	Accounts Receivable – Control Account	3,925	4,435	5,300	5,300	5,300	5,300
9039	N/A	Provision for Doubtful Debts	(44)	(381)	(50)	(50)	(50)	(50)
9040	N/A	Accrued Debtors	712	420	700	700	700	700
9045	N/A	Inventory / Stock	550	557	550	550	550	550
9050	N/A	Provision for Obsolete Stock	-	-	-	-	-	-
9055	N/A	Assets Held for Resale	1,204	1,204	1,204	1,204	1,204	1,204
9001	N/A	*Current Assets Total*	6,432	5,091	7,141	6,709	7,490	8,519
		Non Current Assets						
9205	N/A	Land	9,454	8,656	15,037	15,037	15,037	15,037
9210	N/A	Buildings & Plant (inc Lifts etc)	-	-	-	-	-	-
9215	N/A	Clinical Equipment	-	-	-	-	-	-
9220	N/A	Other Equipment	9,271	10,346	11,146	13,255	15,364	17,473
9225	N/A	Information Technology	3,075	3,479	4,079	4,829	5,579	6,329
9230	N/A	Motor Vehicles	1,341	1,435	1,435	1,435	1,435	1,435
9235	N/A	Trust Properties	-	-	-	-	-	-
9240	N/A	Provision Depreciation – Buildings & Plant	-	(483)	(1,545)	(2,623)	(3,701)	(4,779)
9242	N/A	Provision Depreciation – Clinical Equipment	-	-	-	-	-	-
9244	N/A	Provision Depreciation – Other Equipment	(4,765)	(5,588)	(6,796)	(8,177)	(9,558)	(10,939)
9246	N/A	Provision Depreciation – Information Technology	(2,541)	(2,771)	(3,079)	(3,455)	(3,831)	(4,207)
9248	N/A	Provision Depreciation – Motor Vehicles	(1,157)	(1,067)	(1,169)	(1,245)	(1,321)	(1,397)
9250	N/A	Provision Depreciation – Trust Properties	-	-	-	-	-	-
9260	N/A	WIP	1,114	5,956	-	-	-	-
9405	N/A	Investment in Subsidiaries	-	(1)	-	-	-	-
9415	N/A	Investment in Associates	-	-	-	-	-	-
9425	N/A	Long Term Investments	110	-	-	-	-	-
9426	N/A	Long Term Investments – Trusts	-	-	-	-	-	-
9201	N/A	*Non Current Assets Total*	15,902	19,962	19,108	19,056	19,004	18,952
		Current Liabilities						
9505	N/A	Accounts Payable Control Account	(2,206)	(1,205)	(1,200)	(1,200)	(1,200)	(1,200)
9512	N/A	Risk Sharing Pool	-	-	-	-	-	-
9515	N/A	Accrued Creditors	(1,388)	(1,244)	(1,927)	(1,927)	(1,927)	(1,927)
9525	N/A	Income Received in Advance	(952)	(1,915)	(2,556)	(1,556)	(1,556)	(1,556)
9560	N/A	Capital Charge Payable	-	(551)	(551)	-	-	-
9530	N/A	GST & Tax Provisions (account codes: 9530-9550; 9620; 9625)	(177)	(261)	(211)	(211)	(211)	(211)
9555	N/A	Unclaimed Creditors Monies	-	-	-	-	-	-
9590	N/A	Term Loans – Finance Leases (current portion)	(97)	(126)	(80)	(84)	(115)	-
9593	N/A	Term Loans – Private (current portion)	(678)	(1,845)	(574)	(104)	(104)	(232)
9596	N/A	Term Loans – Crown (current portion)	-	-	(8,866)	-	-	-
9602	N/A	Payroll Accrual & Clearing Accounts (excl tax - account codes: 9620	(631)	(664)	(846)	(846)	(846)	(846)
9702	N/A	Employee Entitlement Provisions	(1,738)	(2,177)	(2,196)	(2,196)	(2,196)	(2,196)
9501	N/A	*Current Liabilities Total*	(7,867)	(9,988)	(19,007)	(8,124)	(8,155)	(8,168)
		WORKING CAPITAL	(1,435)	(4,897)	(11,866)	(1,415)	(666)	351
		NET FUNDS EMPLOYED	14,467	15,065	7,242	17,641	18,339	19,303
		Non-Current Liabilities						
9805	N/A	Long Service Leave – Non-current portion	(137)	(186)	(200)	(200)	(50)	(50)
9810	N/A	Retirement Gratuities – Non-current portion	(775)	(837)	(850)	(850)	(100)	(150)
9820	N/A	Term Loans – Finance Leases (non-current portion)	(194)	(333)	(201)	(115)	-	-
9823	N/A	Term Loans – Private (non-current portion)	(3,348)	(2,674)	(2,300)	(336)	(232)	-
9826	N/A	Term Loans – Crown (non-current portion)	(9,467)	(8,866)	-	(8,000)	(8,000)	(8,000)
9830	N/A	Trust and Special Funds – restricted use	-	(15)	-	-	-	-
9801	N/A	*Non-Current Liabilities Total*	(13,921)	(12,911)	(3,551)	(9,501)	(8,382)	(8,200)
		Crown Equity						
9905	N/A	Crown Equity	(25,909)	(31,569)	(37,569)	(44,569)	(48,069)	(50,569)
9915	N/A	Trust and Special Funds (no restricted use)	(653)	(653)	(653)	(653)	(653)	(653)
9925	N/A	Revaluation Reserve	-	-	-	-	-	-
9930	N/A	Revaluation Reserve – Trust Assets	-	-	-	-	-	-
9935	N/A	Other Reserves	-	-	-	-	-	-

Account Code	Suffix Number	Description	Jun-00	2000/01	2001/02	2002/03	2003/04	2004/05
lated - Statement of Movement in Equity								
701	N/A	Total equity at beginning of the period	-	(546)	(2,154)	(3,691)	(8,140)	(9,957)
702	N/A	Net Results for the period - DHB Governance & Funding Administrat	-	-	-	-	-	-
703	N/A	Net Results for the period - DHB Provider	-	4,052	4,463	2,551	1,684	1,353
704	N/A	Net Results for the period - DHB Funds	-	-	-	-	-	-
710	N/A	Revaluation of Fixed Assets	-	-	-	-	-	-
720	N/A	Equity Injections	-	(5,660)	(6,000)	(7,000)	(3,500)	(2,500)
730	N/A	Other	-	-	-	-	-	-
780	N/A	Movement in Trust and Special Funds	-	-	-	-	-	-
799	N/A	Total Equity at end of the period	-	(2,154)	(3,691)	(8,140)	(9,957)	(11,103)
		Zero Check	Out of Bal	O.k.	O.k.	O.k.	O.k.	O.k.
lated - Statement of Cashflows								
		Operating Activities						
201	N/A	Government and Crown Agency Revenue Received	-	5,694	17,980	18,307	17,450	17,595
211	N/A	Internal Receipts for DHB Provider	-	27,454	27,195	32,157	34,056	35,471
212	N/A	Internal Receipts for DHB Governance & Funding Administration	-	-	964	939	960	980
213	N/A	Receipts from Other DHBs	-	-	-	-	-	-
214	N/A	Receipts from Other Government Sources	-	4,367	4,468	4,425	4,514	4,604
218	N/A	Other Revenue Received	-	-	(930)	(903)	(924)	(944)
219		***Total Receipts***	-	37,515	49,677	54,925	56,055	57,706
220	N/A	Payments for Personnel	-	(25,835)	(27,949)	(30,438)	(31,549)	(31,597)
250	N/A	Payments for Infrastructure & Non-Cliical Supplies	-	(14,196)	(14,634)	(15,930)	(15,963)	(16,272)
251	N/A	Interest Paid	-	(897)	(979)	(800)	(800)	(800)
252	N/A	Capital Charge Paid	-	(191)	(327)	(956)	(405)	(405)
290	N/A	GST (Net) & Tax	-	(333)	(50)	-	-	-
611	N/A	Payment to own DHB Provider	-	(27,454)	-	-	-	-
612	N/A	Payment to own DHB Governance & Funding Administration	-	-	-	-	-	-
620	N/A	Payments to other DHB's	-	-	-	-	-	-
650	N/A	Payments to Providers	-	27,454	(10,926)	(11,888)	(10,917)	(10,945)
300		***Total Payments***	-	(41,452)	(54,865)	(60,012)	(59,634)	(60,019)
305		***Net Cashflow from Operating***	-	(3,937)	(5,188)	(5,087)	(3,579)	(2,313)
		Investing Activities						
310	N/A	Sale of Fixed Assets	-	-	-	-	-	-
320	N/A	Decrease in Investments and Restricted &Trust Funds Assets	-	-	-	-	-	-
		Capital Expenditure						
330	N/A	Land, Buildings & Plant	-	(6,405)	(425)	-	-	-
340	N/A	Clinical Equipment	-	-	-	-	-	-
350	N/A	Other Equipment	-	(477)	(509)	(1,749)	(1,749)	(1,749)
360	N/A	Information Technology	-	-	(1,025)	(750)	(750)	(750)
370	N/A	Motor Vehicles	-	-	-	-	-	-
		Total Capital Expenditure	-	(6,882)	(1,959)	(2,499)	(2,499)	(2,499)
380	N/A	Increase in Investments and Restricted & Trust Funds Assets	-	100	(1)	-	-	-
385		Net Cashflow from Investing	-	(6,782)	(1,960)	(2,499)	(2,499)	(2,499)
		Financing Activities						
410	N/A	Equity Injections	-	5,660	6,000	7,000	3,500	2,500
		New Debt						
420	N/A	Private Sector	-	927	200	-	-	-
430	N/A	RHMU	-	-	-	-	-	-
		Repaid Debt						
440	N/A	Private Sector	-	(1,152)	(2,023)	(2,516)	(188)	(219)
450	N/A	RHMU	-	-	-	(866)	-	-
460	N/A	Other Non-Current Liability Movement	-	-	-	-	-	-
470	N/A	Other Equity Movement	-	-	-	-	-	-
480		Net Cashflow from Financing	-	5,435	4,177	3,618	3,312	2,281
		Total Cash In	-	44,102	55,877	61,925	59,555	60,206
		Total Cash Out	-	(49,386)	(58,848)	(65,893)	(62,321)	(62,737)

FURTHER INFORMATION AND FEEDBACK

This plan and the listed background documents are available on the West Coast DHBs

web site www.westcoastdhb.org.nz or from the Board office through which feedback on the plan is also invited:

PA to the CEO
West Coast District Health Board
PO Box 387
GREYMOUTH

Phone 03 768 0499
Fax 03 768 2791
E-mail CEO@westcoastdhb.org.nz

Background documents on the Boards website:

The Governments:

- NZ Health Strategy
- NZ Disability Strategy
- Primary Care Strategy
- Mental Health Blueprint

The Boards:

- Summary report of Health Needs Analysis
- Full technical report of Health Needs Analysis
- Prioritisation Policy
- Annual Plan 2001/04
- Regional Strategic Plan

Crown Public Health's

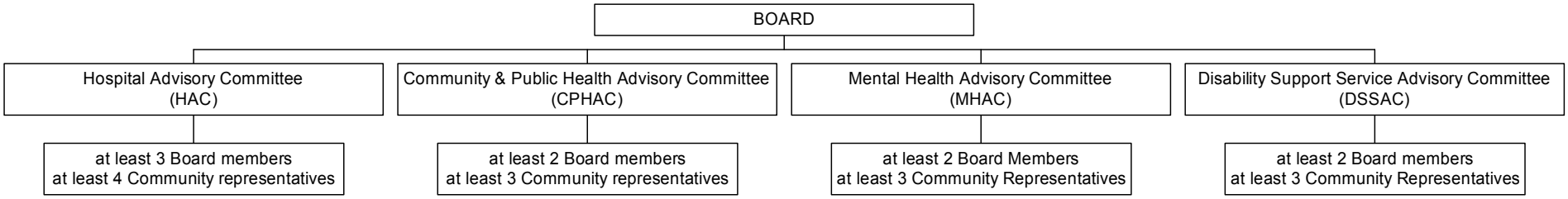
- Report on the public health services it currently provides on the West Coast

GLOSSARY

Consumer	In this context, a person who uses health services. "Client" is also used sometimes and both words are used instead of "patient", which some people regard as either having a narrower meaning or conveying an unsatisfactory meaning in provider/recipient relationship terms
DHB	District Health Board
MOH	Ministry of Health
Needs Analysis	An assessment of the health needs of the population. Undertaken by reviewing health related and other statistics, and through interviews with interested parties. Requirement o fs.23 & s.38 NZPH&D Act 2000.
Personal Health	Services for individuals e.g. medical/surgical treatment in hospital, GP visits
Primary Health Services	First level health services accessible directly by the public e.g. GPs, community health, pharmacists etc
Provider Arm	The health services owned and provided by the West Coast DHB e.g. Grey Base, Buller, Reefton & Seaview Hospitals
Public Health	Focuses on the health of the population not individuals and includes health promotion and protection activities
Ring fenced	Funding ear marked for a particular purpose to which it must be applied
Secondary Health Services	Second level health services that the public need referral to. E.g. hospital based services (except for emergency services, which are primary)
Tertiary Services	More specialized than secondary hospital services. Are concentrated in larger hospitals outside of the West Coast region due to high cost and high specialization of resources and relatively low volumes

APPENDICES

APPENDIX 1 - WEST COAST DHB COMMITTEE STRUCTURE



Functions / Aims of Advisory Committee

Community and Public Health Advisory Committees

(1) The functions of the Community and Public Health Advisory Committee of the Board of a DHB are to give the board advice on:

(a) the needs, and any factors that the committee believes may adversely affect the health status, of the resident population of the DHB; and

(b) priorities for use of the health funding provided.

(2) The aim of a Community and Public Health Advisory Committee's advice must be to ensure that the following maximise the overall health gain for the population the committee serves:

(a) all service interventions the DHB has provided or funded or could provide or fund for that population

(b) all policies the DHB has adopted or could adopt for that population.

o A Community and Public Health Advisory Committee's advice may not be inconsistent with the New Zealand Health Strategy.

Disability Support Services Advisory Committee

(1) The functions of the Disability Support Services Advisory Committee of the Board of a DHB are to give the Board advice on:

(a) the disability support needs of the resident population of the DHB; and

(b) priorities for use of the disability support funding provided.

(2) The aim of a Disability Support Services Advisory Committee's advice must be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the DHB's resident population:

(a) the kinds of disability support services the DHB has provided or funded or could provide or fund for those people

(b) all policies the DHB has adopted or could adopt for those people.

(3) A Disability Support Services Advisory Committee's advice may not be inconsistent with the New Zealand Disability Strategy.

Hospital Advisory Committee

The functions of the Hospital Advisory Committee of the Board of a DHB are to:

(a) monitor the financial and operational performance of the hospitals (and related services) of the DHB; and

(b) assess strategic issues relating to the provision of hospital services by or through the DHB; and

(c) give the Board advice and recommendations on that monitoring and that assessment.

Mental Health Advisory Committee

The aim of the Mental Health Advisory Committee's advice must be to ensure that the following promotes the inclusion and participation in society, and maximises the independence of people with mental illness on the West Coast:

(a) The kinds of mental health services the West Coast DHB has provided, funded, or could provide or fund those people

(b) All policies the West Coast has adopted or could adopt for those people.

APPENDIX 2 - POPULATION (PUBLIC) HEALTH

Public Health

Public health has been defined as 'the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society' (Acheson 1988).

Public Health Services

Public health services are those which are delivered to communities or population groups rather than individuals and which set out to prevent illness or injury, or to promote health and well-being. Health protection and health promotion, along with the science of epidemiology and other research approaches, are the main branches of public health

Determinants of Health

A number of factors and conditions affect our health and well being. These have been called 'the wider determinants of health', and include:

- age, sex and hereditary factors
- individual lifestyle factors
- social and community influences
- living and working conditions
- gender and culture
- general socio-economic and environmental conditions.

Because public health services set out to keep people and communities well, study and analysis of the determinants of health is central to the work. It is now well established that many of the most powerful factors influencing health status act primarily at the level of whole communities and population groups, rather than individuals. Health is significantly influenced by position in society and the physical and social environment. Public health services set out to influence these factors.
Many of these determinants of health lie outside the health sector. Significant gains in health status will only, therefore, be achieved through the co-ordinated action of policy makers and service providers in many sectors. Public health must therefore work with other sectors to influence the wider determinants of health.

The same population health principles can be used by other parts of the health sector.

Health Protection

Health protection strategies focus on factors in the physical, chemical and biological environment that contribute to health outcomes. Health protection sets out to influence these factors through public policy (much health protection activity is mandated or required by law) and information. Health protection is well established in New Zealand and elsewhere, and over the last 100 years has contributed significantly to achieving major health gains. There are many aspects of our environment that we take for granted, such as safe food and water, effective sanitation. Health protection services work towards maintaining this safe environment.

Health Promotion

Health promotion is the process of enabling people to increase control over and to improve their own health. Health is seen as a positive concept and a valued resource for everyday life. Health promotion is therefore not just the responsibility of the health sector, and goes beyond 'healthy lifestyles' to a concept of well being. This approach acknowledges that community development is an effective way to improve health. Health promotion takes account of a wider idea of environment, which includes public policy and social factors. It recognises that personal health services, especially in primary care, can contribute to public health goals

APPENDIX 3 - ENVIRONMENTAL ISSUES

The main environmental issues of concern in the West Coast region are substandard water supplies, sewage disposal, and solid and hazardous waste disposal. The concept of 'kaitiakitanga' and the spiritual relationship Maori people have with the land is an illustration of the strong environmental link with health.

In terms of environmental hazards, food-related illnesses are the most common cause of morbidity in humans. The West Coast has a number of geographically dispersed small-to-medium sized retail and manufacturing food businesses. Transportation of food in a safe manner has been identified as an issue requiring on-going attention.

The standard of drinking water is a concern in the West Coast region. The *Drinking-water standards for New Zealand*, 1995, lists three Priority 1 determinants that are to be tested for at the treatment plant, namely faecal coliforms, giardia and cryptosporidium. These pose the greatest biological risk to human health and are found in high rates on the West Coast, where only 1 of the 55 treatment plants was fully compliant. This plant supplied water to 22% of the population. On the West Coast, 33% of the population was supplied drinking water from treatment plants that were not monitored. Probable consequences of this are the high rates of notified cryptosporidiosis and giardiasis on the Coast.

Significant sewage issues on the West Coast include raw sewage discharges into rivers, sewage treatment plants operating inadequately due to storm water intrusion and increased population demands, large numbers of failing septic tank (on-site) disposal systems, and rural/residential subdivision in areas that were previously considered remote but that are becoming built up. Also, trade waste discharges, including blood products and industrial chemicals, are not managed.
Significant population centres that have problems with municipal sewage discharges include Greymouth, Westport and Reefton. Communities that are not on sewerage systems, and in which on-site disposal has failed, include Blackball, Gladstone, Orowaiti and Inangahua Junction. These communities have poor soakage areas. Sewage discharges to the Buller, Inangahua and Grey Rivers are likely to be resolved in the near future with the installation of engineered sewage treatment plants.

Solid waste management is an increasing issue for the larger population centres, such as Greymouth, Westport and Hokitika.

Chemical spills appear to be occurring with increasing frequency on the West Coast. These have the potential to create a significant health risk. Chemical spills on the West Coast within the last two years include a timber treatment chemical spill at Bluff Creek, a diesel spill in Greymouth, and a spill of 1080 poison between Kumara and Christchurch. All these spills were preventable. The use of 1080 is emerging as a contentious issue on the West Coast. Perceived risk of human poisoning from 1080 is greater than the actual risk. There have been no notifications of accidental 1080 poisoning of humans in New Zealand.

Some communicable diseases are notifiable (meaning that diagnosed cases must be reported). However, numbers are generally considered to be under-estimated because of under-reporting, under-diagnosis and the fact that many people with some of these diseases never access health services, either because of barriers to access or lack of serious symptoms. West Coast experiences higher rates for several enteric preventable communicable diseases than the national average. These diseases include giardiasis, cryptospridiosis, yersiniosis, and salmonellosis, which have been linked to drinking water. There have been seasonal outbreaks of campylobacteriosis and crytposporidiosis during the calving season.

West Coast experienced several outbreaks of pertussis (whooping cough) in 2000 and has the highest rates in the country. Notification rates in adults are high. Immunisation rates generally appear to be too low to provide adequate protection for the whole community.

APPENDIX 4 - SUMMARY OF WEST COAST HEALTH NEEDS ASSESSMENT

The picture of health need for the West Coast DHB has been created using both qualitative and quantitative methods. Full details of methodology, findings and discussion are contained in the technical report and are available from the West Coast DHB.

Demography

West Coast's population of 32,200 is characterised by a lower than average percentage of Maori (10%), a very small but growing Pacific peoples population, an age structure that closely reflects the national age structure, and there are more males than females in the region, most notably in the 40 to 75 age group. The West Coast has a lower than average birth rate and for some time has had a net loss through migration out of the region, although this has reduced in recent years. The total population is projected to fall in all three of its territorial authorities (TAs) over the next ten years. The Maori population is increasing, although at a slower rate than Maori nationally.

Around 41% of the region's population live rurally (compared with 15% in New Zealand overall), and this proportion is projected to increase. The remainder of the population live in three small main centres and a scattering of rural centres. The West Coast is a relatively large and elongated region, spread thinly along the western side of the Southern Alps. It has the lowest population density of any DHB region in New Zealand (approximately 1/10th of the national average).

Note: 1996 Census date used, as full information from 2001 Census not available at time of writing.

Socio Economic Status

Generally, West Coast presents a bleak picture in terms of low socio-economic status, including very high levels of deprivation, and some of the lowest levels of income and educational achievement in New Zealand. Levels of social and occupational class, and the numbers of households with access to cars and telephones are also lower than average. Deprivation is not evenly spread. The Buller TA consistently shows the highest levels of deprivation, which is further exacerbated by its rural isolation, transport and communication difficulties.

Two main groups are identified as having high health needs in the West Coast region, those of relatively low socio-economic status, and Maori. While there is interaction and overlap between these two groups, a focus on one alone would miss a large group with high health needs. For example, most people of low socio-economic status are not Maori, and the health status of Maori is still relatively poor compared to non-Maori, even after adjusting for socio-economic status.

Hospitalisation

Consistent with the above demographic and socio-economic issues is the picture of higher morbidity and mortality rates and lower life expectancy on the West Coast compared with the New Zealand average. The overall rate of avoidable hospitalisation is high. Age-standardised rates for nearly all top avoidable hospitalisation diagnoses are higher, and considering the 13 priority objectives in the *New Zealand Health Strategy*, 2000, (*NZHS*) of

the eight for which there is comparative information, seven are of concern or contain areas of concern. Of particular note are hospitalisations for alcohol-related conditions, poisonings of children, strokes, and low birth weight Maori babies. Of the 26 major diagnostic categories used to classify admission diagnoses, the only categories with lower than average crude rates were pregnancy/birth and newborns, which is likely to be, at least in part, a consequence of the low birth rate in the region.

In addition, where the West Coast region shows statistically significant differences to the New Zealand average, areas of comparative need include hospitalisation rates for the following: injuries, including injuries resulting from motor vehicle crashes; falls in the over 65 age group; pregnancy-related complications in the 15 to 24 age group; and children suffering from poisonings. Other areas of comparative need include the oral health of children; hearing referrals of children; an increase in acute admissions (albeit outside the region); and a low cervical screening rate. Immunisation rates appear low, although data quality is very poor.

Maori

The situation of Maori on the West Coast, with respect to some demographic statistics (such as life expectancy, housing and income) and health statistics (such as avoidable hospitalisation - for example for injuries, smoking prevalence, cardiovascular disease, suicides, and breast screening rate), appears to be generally better than for Maori in New Zealand as a whole. Some of the apparent reduced disparity of Maori with non-Maori, however, is a consequence of the generally lower life expectancy, high levels of deprivation, low incomes, low property prices, and high levels of health needs seen in the total West Coast population. Numerator-denominator bias may also play a part in showing reduced disparity.

Rural Population

Rural populations appear to have high health needs, and are relatively under-serviced with low numbers per capita of general practitioners (GPs), nurses, dentists and pharmacists, and Maori health providers who are stretched to provide services. West Coast has low numbers (per capita) of GPs and dentists. Travel times to hospital are significant for much of the West Coast rural population.

The main environmental issues of concern in the West Coast region are substandard water supplies, sewage disposal, and solid and hazardous waste disposal. The concept of tiakitanga (guardianship) and te Ao Turoa (environment) depicts the strong spiritual relationship Maori people have with the land thus highlighting the environmental connection to health.

Of note is the paucity of information on primary health care, and the difficulties in measuring health disparities between ethnic groups. Also, the small population results in small numbers in various demographic, socio-economic and health status categories, which presents challenges in data collection and interpretation.

Recommendations from the West Coast Health Needs Assessment

Two potential areas of activity are outlined. One involves the West Coast DHB working intersectorally with other agencies; the other describes activities the West Coast DHB can pursue within its own health services, or by linking with other DHBs and the MOH. It is acknowledged that many of these activities may be currently happening in the region.

Intersectoral activities

- Improving Maori health by acknowledging the rights of Maori to equality in health status, and supporting tino rangatiratanga whereby Maori gain control over factors that influence their health. This could involve the DHB advocating and working with other organisations such as Poutini Ngaitahu, Maata waka and Maori development organisations, local authorities, the regional Te Puni Kokiri office and other government agencies, and social services and non-government organisations in the West Coast DHB region.

- Addressing the socio-economic determinants of health, through advocacy and working with other government agencies (e.g., the Ministry of Social Development on benefit entitlements, Housing New Zealand Corporation on further housing initiatives, Child Youth and Family on factors leading to injuries to children, and regional and local authorities on transport issues).

- Reducing smoking, and alcohol and other drug use (e.g., through community action projects) and working with relevant agencies such as District Licensing Authorities, the Alcohol Advisory Council, and the Health Sponsorship Council.

- Advocating for protection of the environment, and safe and sustainable use of resources with regional and local councils, iwi and Maori organisations, and local businesses.

District Health Board Activities

- Addressing Maori health through such activities as developing closer working relations with Maori in the region, involving Maori in decision-making, increasing the numbers and scope of well-resourced Maori health providers, promoting Maori workforce development in both mainstream and by Maori for Maori sectors, encouraging and resourcing the use of traditional Maori medicine, actively promoting the use of te reo Maori in health services in the West Coast region, ensuring West Coast DHB staff understand Maori values and concepts.

- Allocating resources according to need. Funding should follow patterns of disadvantage so that groups with higher need (e.g., Maori, socio-economically disadvantaged) receive more resources.

- Focusing on well-resourced primary health care. There is potential for improving health status and reducing avoidable hospitalisations through better access to improved primary care. Working with the MOH towards affordable primary care services in line with the *Primary health care strategy,* 2001, would improve accessibility to primary care services in the West Coast region. Consideration of using mobile clinics, and/or increasing rurally based services to rural areas would be desirable, as would fostering the interface between primary and secondary health care services.

- Working closely with the local public health service, which has considerable expertise in improving, promoting and protecting health across all the West Coast DHB priority health gain areas.

- Improving the scope, accuracy and consistency of data collection (e.g., ethnicity coding, primary care data and immunisation data).

- Continuing to present the health needs of the people of the West Coast region on a national stage. Although absolute numbers of people with high socio-economic need are larger in New Zealand's urban areas, rural areas such as West Coast need special attention and resourcing because barriers to health and health care are often greater.

Socio-economic Status and Health

People who have higher levels of education, higher incomes and live in less socio-economically deprived neighbourhoods are likely to live longer and enjoy better health than those who have no qualifications, are unemployed or in low-skilled jobs, earn less and live in socio-economically deprived neighbourhoods. A wide range of health indices and risk factors have been found to be patterned by socio-economic factors such as deprivation, income, education, labour force status, housing, and occupational class.

Overall the socio-economic status is low on the West Coast compared to the rest of the country. The Buller community, in particular, ranks low in New Zealand socio-economic status, with a high proportion of elderly, unemployed and welfare recipients. The level of deprivation is high. The median income for the West Coast is $18,521, which is 84% of the national average, and is rated as the 3rd lowest of the 23 local government regions. Maori make up 10% of the population with an additional 1% mix of Pacific Islanders and Asian. The percentage of population over 65 is higher than the national average. A 1999 University of Otago study of Self-reported dental health and the use of dental services on the West Coast reported that the two characteristics associated with poorer self-reported dental health and infrequent use of dental services were lower socio-economic status and self-reported dental anxiety. Life expectancy for people on the Coast was 73.5yrs compared to 75.7yrs nationally. The region also has a lower proportion of general practitioners, dentists and dental surgeons.

Various socio-economic parameters for the West Coast DHB region, 1996

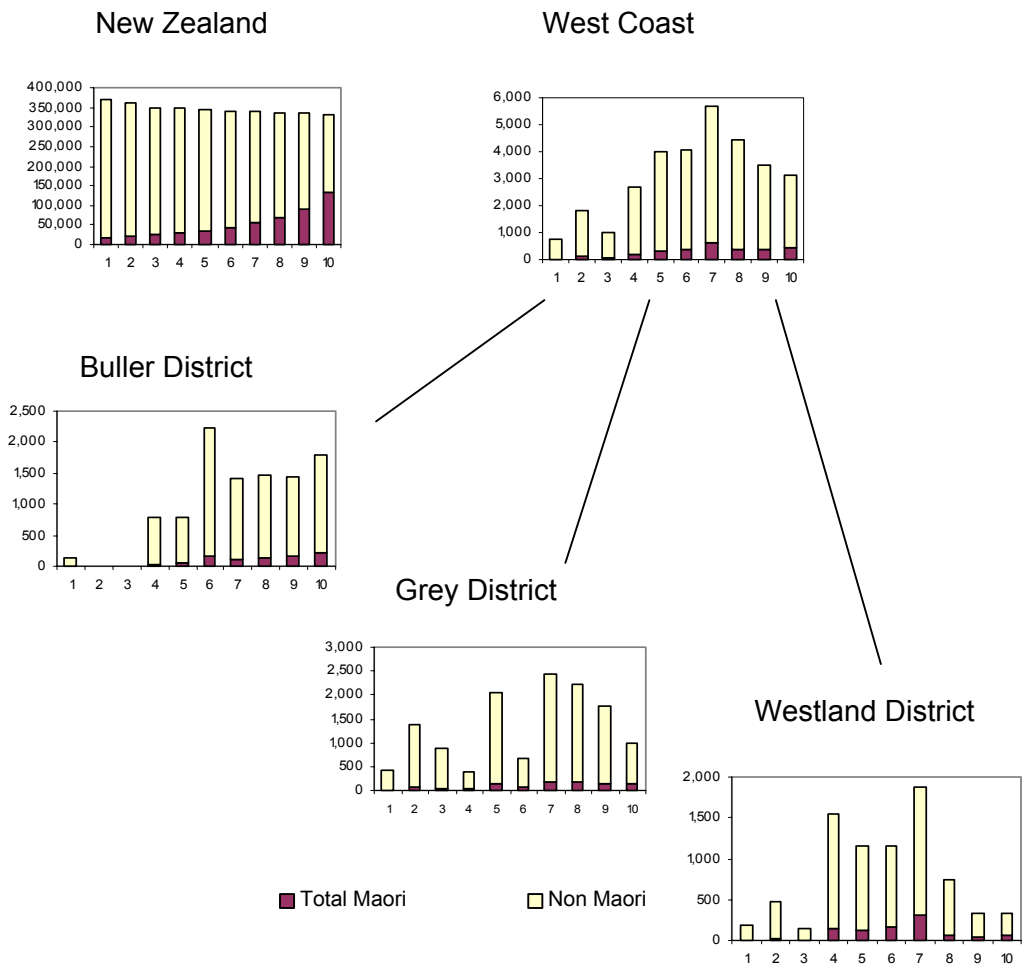
Source: Statistics NZ

	1996 pop'n	% Maori	Equivalised household income	% Unemployed	% Carless	% Phoneless
Buller District	10 512	8.2%	22 347	9.6%	13.9%	12.3%
Grey District	13 698	7.4%	26 706	7.5%	12.4%	7.6%
Westland District	8280	11.6%	27 370	5.4%	11.1%	9.7%
West Coast DHB	32 493	10%	N/A	7.5%	12.5%	9.7%
New Zealand	-	14%	33 325	7.7%	11.5%	4.9%

Note: Equivalised means adjusted for family size.

As stated in the Dunt Report (Health Care Needs Assessment Study. South Island West Coast 1999) socio-economic disadvantage is frequently associated with health disadvantage, although not necessarily with high service use.

There are some pockets of high deprivation around the town of Greymouth, and almost all of the Buller TA is an area of very high deprivation. There are areas of moderate-to-high deprivation in the Grey TA and at either end of the Westland TA.



Deprivation profiles for New Zealand and the West Coast DHB region, 1996

In the graphs above, the horizontal axis shows the NZDep96 index of deprivation scale from 1 (least deprived) to 10 (most deprived) deciles of small area socio-economic deprivation. The vertical axis shows the number of people in each decile. Note the even distribution of people at the

national level by decile (by definition). However, within DHBs the population may be skewed towards either a more or less deprived pattern than the national picture.

The picture for West Coast shows that a major proportion of the population falls into NZDep96 deciles 5 to 10, indicating a *high overall level of deprivation* in the region.

The Buller TA shows extremely high levels of deprivation, with the major proportion of the population in deciles 6 to 10.

Household median income is lower on the West Coast than in New Zealand overall. Income levels for individuals 15 years or over is significantly lower than the rest of New Zealand. The proportion of the population on a benefit is significantly higher than the rest of New Zealand (42% for 1996 compared to the national figure of 38%). West Coast resident population aged 15+ years compared to national figures had a higher percentage of those without qualifications 45% (nationally 35%).

Personal health related lifestyle factors such as tobacco, alcohol, diet and physical activity have profound effects on health and disease. West Coast residents have higher smoking rates compared with other areas of New Zealand. West Coast teenagers have the second highest rate of smoking in New Zealand. There is higher than average levels of drug, alcohol and substance abuse.

The quality of local water supply on the Coast is poor – it is the third highest of 12 localities in the Region with the percentage of water supplies (60.7%) listed as being of marginal quality. This could impact on service usage for gastro-intestinal disease. Heavy metal concentrations were very high in some waterways affected by mining activity. West Coast experiences higher rates than the national average for several enteric preventable communicable diseases. These diseases include giardiasis, cryptospridiosis, yersiniosis, and salmonellosis, which have been linked to drinking water. There have been seasonal outbreaks of campylobacteriosis and crytposporidiosis during the calving season. Water supplies on the Coast are also non-fluoridated which is likely to increase the demand for dental services. There are significant sewage issues on the West Coast including raw sewage discharges in the rivers. Chemical spills appear to be occurring with increasing frequency, which have the potential to create a significant health risk.

West Coast experienced several outbreaks of pertussis (whooping cough) in 2000 and has the highest rates in the country. Notification rates in adults are high. Immunisation rates appear to be too low to provide adequate protection for the whole community.

The Coast has the highest rates for motor vehicle crashes of any locality in the region. Relative risk for cancer (all sites) based on aged standardised rates is significantly increased in both males and females on the Coast compared with the region. Employment is in predominately high-risk industries such as mining, cement, fishing, forestry and foreign tourism. The region had in 1996 15.2% of people employed in the Agriculture/Hunting/Forestry/Fishing sector compared to 9.2% nationally. 18 times as many people were employed in the Mining & Quarrying sector on the Coast; 4.4% compared to 0.25% nationally.

Demographic Summary

- Total population projected to decrease by 2.5% in the next 10 years.
- The proportion of people living rurally is increasing.
- Lowest population density in New Zealand
- Lower proportion (less than 10%) of Maori than in NZ (15%)
- Maori population expected to grow 14.4% in the next 10 years
- Over 55 Maori population expected to grow 64.3% in the next 10 years
- Total over 65 population expected to grow 20.9% in the next 10 years
- Low fertility and birth rates, relative to NZ
- A very small Pacific population
- More males than females, notably in the 40 – 74 years age group
- Higher overall mortality rate than NZ overall
- Higher mortality rate for men than for men in NZ overall

Remoteness

The base hospital is located in Greymouth. On a fine day with clear roads Buller Hospital in Westport is 1.5 hours from Greymouth to the north via the Coast Road and another 1.5 hours on to Karamea. The Coast Road is subject to delays and closure associated with unfavourable weather conditions as is the Karamea Bluff between Westport and Karamea. It is four hours to Haast in the south via similar terrain and 3.5 hours to Christchurch in the east, via the Southern Alps. Reefton is 1 hour away and Hokitika 35 minutes. Bad weather frequently closes Arthur's Pass and also disrupts both fixed wing and helicopter emergency flights. Only 64% of West Coast residents reside within 60 minutes ("The Golden Hour") travel time by car from secondary hospital services. Only 2% are within 180 minutes travel time by car from the nearest tertiary hospital at Christchurch.

Many of the access roads throughout the West Coast are difficult to traverse throughout the winter months and frequently impassable, particularly during periods of inclement weather.

Economy

The West Coast economy continues to be underpinned by natural resource extraction. Despite its structural problems of isolation etc, the West Coast is poised to expand as it has huge coal resources, which have not been fully tapped, and the recent $92 million local development fund when properly invested in sustainable growth sectors will give further dividends to the local economy. A sector that has great potential is the visitor services' industry. With the increase in international tourists coming to New Zealand, the West Coast is well positioned to capitalise on this increase with the green, clean image, which is a major attraction for many international tourists. However this will have implications of

increasing demand on infrastructure (and health services). There is a need for improved infrastructure, developing water and waste disposal systems at an appropriate level to meet existing standards and to meet anticipated peak demand, which is driven largely by tourism.

Public Transport

The West Coast has major problems of public transport due to the large area and diffused population. Unless subsidies are offered, very few organisations would be interested in running passenger services because of low financial returns. The many outlying townships and population centres do not have a public transport service from their closest town to Greymouth, which has the base hospital for the region.

Key Health Issues for Maori

Maori have the highest health needs of any ethnic group in New Zealand, as shown by health status and health determinant (socio-economic) statistics. The historical contribution of colonisation to this situation has been touched on earlier, together with the importance of 'resources following need', and the ongoing maldistribution of health determinants. An example is research that demonstrates that non-Maori are paid higher incomes than Maori when in similar jobs with similar qualifications.

The growing and ageing Maori population will lead towards greater health needs in future, unless resources and determinants of health are redistributed.

Socio-economically, Maori are disadvantaged relative to non-Maori. There may be additional influences on health status related to the experience of being Maori that are important. Regaining tino rangatiratanga and control over socio-economic determinants is a step for Maori towards closing health gaps. DHB activities that would assist this process involve the DHB working closely with Maori and other agencies, both government and non-government.

Although gathering the usual measures of health and health determinants and disparities is important, it was emphasised at the project hui that the usual measures of health fall short in terms of capturing the richness and diversity of Maori understandings and realities in health. Additional suggestions of measures relevant to Maori health service need included:

- Maori consumer satisfaction
- the scope of Maori providers and shared services within DHBs
- funding allocated for local Maori development initiatives
- the organisational promotion of te reo Maori
- the number of DHB staff in Maori cultural training (e.g., cultural safety or responsiveness)
- the quality of services and relationships between DHBs and tangata whenua

- the quality of consultation with local tangata whenua
- Maori access patterns to health services
- access also to traditional Maori health practices.

In essence, the feedback from consultation hui recommended that Maori must be a visible Treaty partner throughout the health needs assessment process, and in the implementation of recommendations at local level. This can only be achieved with adequate resourcing to enable genuine Maori involvement. However, detailed measurement of these factors, together with population measures of health (such as strength of Maori community, measures of cultural identity, number of Maori in positions of influence, and value of resources in Maori ownership), is also suggested for future work that builds on this assessment. More detailed information is presented in the technical report and the project hui report.

At the 1996 Census, 14% of Maori in the West Coast DHB region reported some fluency with te reo Maori compared with 25% for New Zealand overall. The proportion of Maori who are affiliated with an iwi is higher than the proportion of Maori in most DHBs, and in New Zealand overall.

He korowai oranga lists 20 population health objectives for Maori. Some of these have been discussed elsewhere in the report, and others are discussed below (see items in bold). In nearly all areas where comparative data is available, there is a disparity between Maori and non-Maori health. In many areas data for Maori is not presented because numbers are too low to reach clear conclusions.

In terms of child health for Maori, the infant mortality rate on the West Coast appears to be similar to the New Zealand rate, but the statistics are not presented by ethnicity due to low numbers. Hospitalisation rates for injuries to children are not presented by ethnicity, and generally appear to be average, except for poisonings of which there is a very high rate. For tamariki, rates of referral for failed hearing tests are significantly greater for Maori than for non-Maori, and are higher than the national rate for tamariki. Oral health status is another need as shown by higher caries rates in tamariki compared with non-Maori. Although data is not presented by ethnicity, the oral health of children is amongst the poorest in New Zealand.

Health of rangatahi (young people) is a priority area; however, little specific data is available for the West Coast. The teenage fertility rates on the West Coast have been generally higher than national rates over the past decade. Rates are not presented by ethnicity. The rate of complications of pregnancy for the 15 to 24 age group in the total West Coast population appears to be slightly higher than average. As for all of New Zealand, smoking prevalence among Maori, and especially young Maori, is much higher than for non-Maori. Smoking prevalence for Maori on the West Coast, however, is lower than for Maori nationally. Of 26 suicides on the West Coast between 1996 and 1998, only one was Maori.

The all cause rate for injuries to Maori may be lower on the West Coast than for Maori nationally, and appears to be similar to that for non-Maori. For alcohol and drug problems there is no breakdown by ethnicity. The West Coast, however, has one of the highest hospitalisation rates in New Zealand for alcohol-related conditions. With respect to sexual and reproductive health issues for Maori, the rates of foetal and infant deaths appear to be low. However, the number of low birth weight Maori babies may be trending upward, contrary to the national trend.

Major diseases in terms of illness and death for older Maori are diabetes, cancer and cardiovascular diseases. Along with the overall higher rate for West Coast, the mortality rate from cancer among Maori may be higher than the rate for Maori nationally. The hospitalisation rate for cardiovascular disease among Maori may be lower than the rates for both Maori and non-Maori, nationally. The hospitalisation rate for diabetes for Maori may be lower than the national rate for Maori; however, the Maori rate appears to be around three times higher than the non-Maori rate, as it is nationally.

The hospitalisation rate for asthma, for the total West Coast population, is similar to the rate for New Zealand overall, as is the prevalence of asthma in the region, but, again, it is important to note that the national admission rate for Maori is considerably higher than for non-Maori. There is no data available for West Coast, regarding nutrition and obesity. These are risk factors for, amongst other conditions, cardiovascular diseases, diabetes and some cancers, all of which affect Maori disproportionately. The final population health objective is disability support, which is not covered by this project.

The situation of Maori on the West Coast, with respect to some demographic and socio-economic statistics (such as life expectancy, housing and income) and health statistics (such as smoking prevalence, avoidable hospitalisation - including injuries, cardiovascular disease, suicides, and the breast screening rate), appears to be generally better than for Maori in New Zealand as a whole, although the disparity with non-Maori is still clearly evident. Some of the apparently reduced disparity of Maori with non-Maori, however, is a consequence of the generally high levels of deprivation, low incomes, low property prices, and high levels of health needs seen in the total West Coast population. The numerator-denominator effect may also reduce apparent disparity in health status statistics.

The disproportionately low numbers of Maori in the health workforce, both in terms of ‘by Maori for Maori’ and within mainstream services, is evident from this work. Meaningful Maori involvement in all areas of health from management to service provision, in ways that allow Maori control over how Maori health needs are met, was listed as one potential measure of health need for Maori at the project hui. Adequate resourcing of Maori health initiatives was seen as another vital area.