# Strategic Health Plan for the Te Tairawhiti District

## Hauora Titiro Whakamua

### Health Looking Forward

## 2005-2010

# E tipu e rea

### Grow up o tender shoot

The enduring relevance of these words from the renowned Te Tairawhiti leader Sir Apirana Ngata as a rallying cry for all people in Te Tairawhiti are just as pertinent now as when first spoken more than 80 years ago. Although they were directed at the young, the message is loud and clear for us all – always take every opportunity to grow and develop in all aspects of life.

The words capture the theme of this the revised District Strategic Plan for Health and Independence in Te Tairawhiti: Ever-developing, ever-improving health and independence for all Te Tairawhiti people.

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# Executive Summary

This Strategic Health Plan is entitled Hauora Titiro Whakamua: Health Looking Forward. It is a chart for a voyage to a goal of oranga/wellbeing for all Te Tairawhiti people. The plan outlines the current status of the Te Tairawhiti population for health and independence then proposes the conceptual philosophy of **AWHI** as a way to move forward to achieve our goal.

The **AWHI** model structures action on health and independence from personal responses **A**u/me, through **W**hanau/family, to **H**apu/community and **I**wi/Te Tairawhiti. The model guides the vision for the Te Tairawhiti of the future. One in which:-

- ✓ All people will choose to be smokefree.
- ✓ All children will be fully immunised.
- ✓ All people will have teeth free from decay.
- ✓ All babies will be fully breast-fed.
- ✓ All people will use safety belts in vehicles.
- ✓ All drivers will be without the influence of alcohol or drugs.
- ✓ All sex will be consensual and safe.
- ✓ All whanau/families will be free from violence.
- ✓ All people with impairments will lead independent inclusive lives.
- ✓ All people will be physically active.
- ✓ All people will be within their goal weight.
- ✓ All people will be free from mental illness.

To achieve the goal and create a Te Tairawhiti that embodies the vision, the plan recognises eleven guiding principles that will be applied to all actions by Tairawhiti District Health (TDH):

1. Prevent ill health.
2. Reduce health inequalities.
3. Support whanauora.
4. The right care in the right place at the right time.
5. Optimise our resources.
6. Develop the workforce.
7. Work with other sectors, agencies and communities.
8. Implement continuous quality improvement.
9. Support people to live independently.
10. Local solutions.
11. Monitor health improvements.

Analysis of the Health Needs Assessment for Te Tairawhiti and feedback from stakeholders has identified four top health gain priorities. These are:-

- Reduce the rate and effects of heart disease and stroke.
- Reduce the rate and effects of diabetes.
- Reduce the rate and effects of cancer.
- Reduce the rate and effects of severe mental health and addictions.

To achieve the goal, visions and action on the health gain priorities there are seven service development priorities:-

- Primary health care
- Population health
- Child and youth health
- Older persons health
- Elective services
- Pacific health services
- Rural health

# The Treaty of Waitangi

The objectives stated in the New Zealand Health Strategy apply to the whole population and match the eight Maori health priorities that target the disparities between Maori and non-Maori health status. The Government and TDH recognise the Treaty of Waitangi as this country's founding document and acknowledge the special relationship between Maori and the Crown under the Treaty.

Central to the Treaty relationship and the implementation of the Treaty principles within the context of the NZPHD Act 2000, is a common understanding that Maori will have an important role in developing and implementing health and disability strategies for Maori. The Crown and Maori will relate to each other in good faith, with mutual respect, co-operation and trust. This is reaffirmed in He Korowai Oranga (the Maori Health Strategy) which emphasises the relationship must be based on:

- **Partnership:** Working together with whanau, hapu and Maori communities to develop strategies for improving health status of Maori. (Article 1)

- **Participation:** Involving Maori at all levels of the sector in planning, development and delivery of health and disability services that are put in place to improve the health status of Maori**.** (Article 2)

- **Protection:** Ensuring Maori wellbeing is protected and improved as well as safeguarding Maori cultural concepts values and practices (Article 3)

TDH has the support of both its Iwi and Maori health partners in the development and finalisation of this Strategic Plan.

# Statement from the Chair and Chief Executive

This Strategic Health Plan – Hauora Titiro Whakamua: Health Looking Forward – represents the synthesis of the collective thoughts of the Te Tairawhiti people, health and disability support service providers, and the Board and staff of TDH to turn the goal of oranga – health for all – into a reality.

The health and independence status of Te Tairawhiti people now is such that we must all seize the challenge of making significant changes in the way we conduct our lives and support our whanau/families to do the same if we are to achieve our goal.

Our plan gives a way forward, however, it is completely dependent on people to make it happen. It depends on individuals to achieve their own health potential, to secure the potential of their whanau/families and to work to achieve this for their hapu/community.

Tairawhiti District Health will play a strong part in the achievement of the plan through the funding and provision of services as guided by the plan's pathway. We expect and will receive the support of all other service providers, agencies, and local and central government in contributing the service and wider determinants improvements that will be necessary for success.

In essence, our plan is simple: Take responsibility for your own and your whanau/family's health and independence. This remains the challenge in all aspects of our lives. The determination that is at the heart of Te Tairawhiti people means that we will succeed.

E tipu e rea: We are growing up – stronger and healthier.

Ingrid Collins
Chair, Tairawhiti District Health

Jim Green
Chief Executive, Tairawhiti District Health

**Signatories**
This Strategic Health Plan for the Te Tairawhiti District is signed by:

______________________________
The Honourable Peter Hodgeson
**Minister of Health**

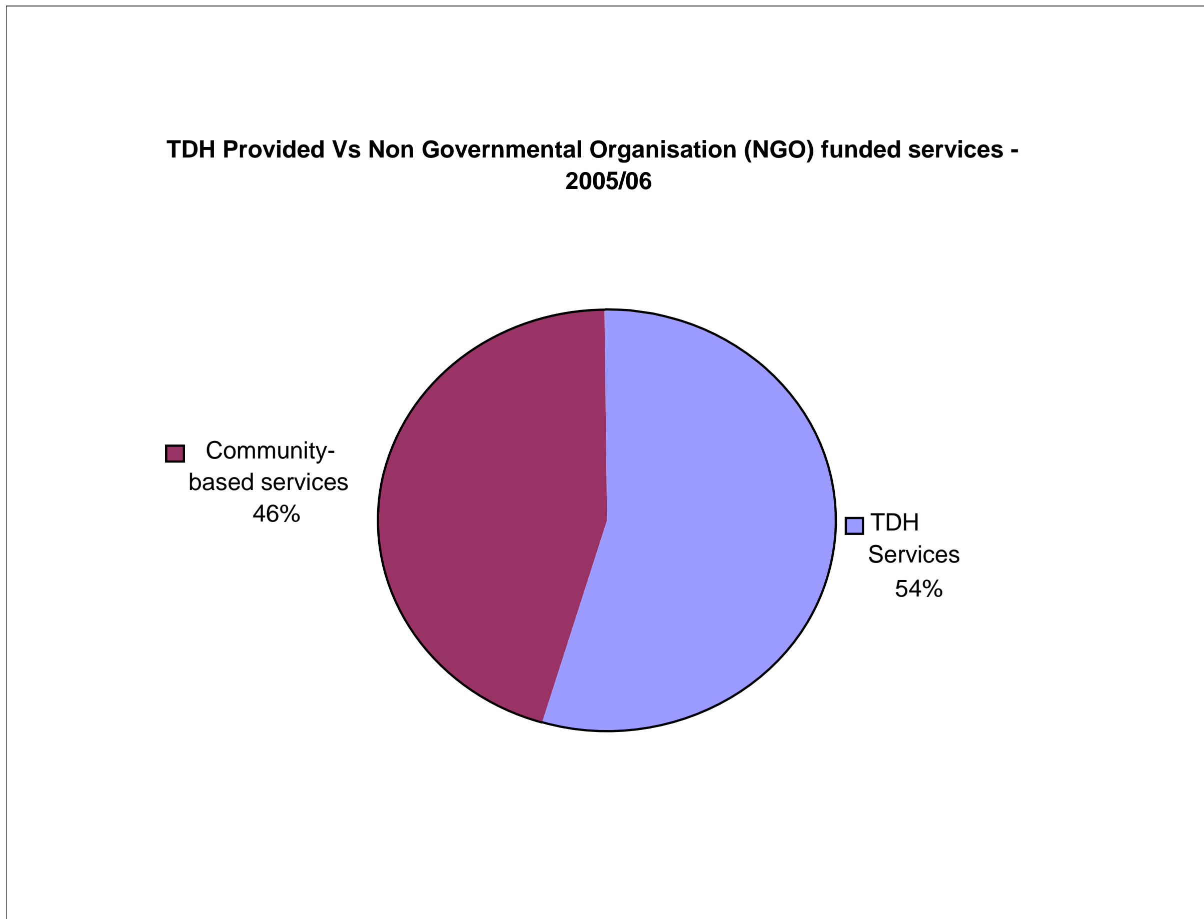
______________________________
Ingrid Collins
**Chair, Tairawhiti District Health**

# Introduction

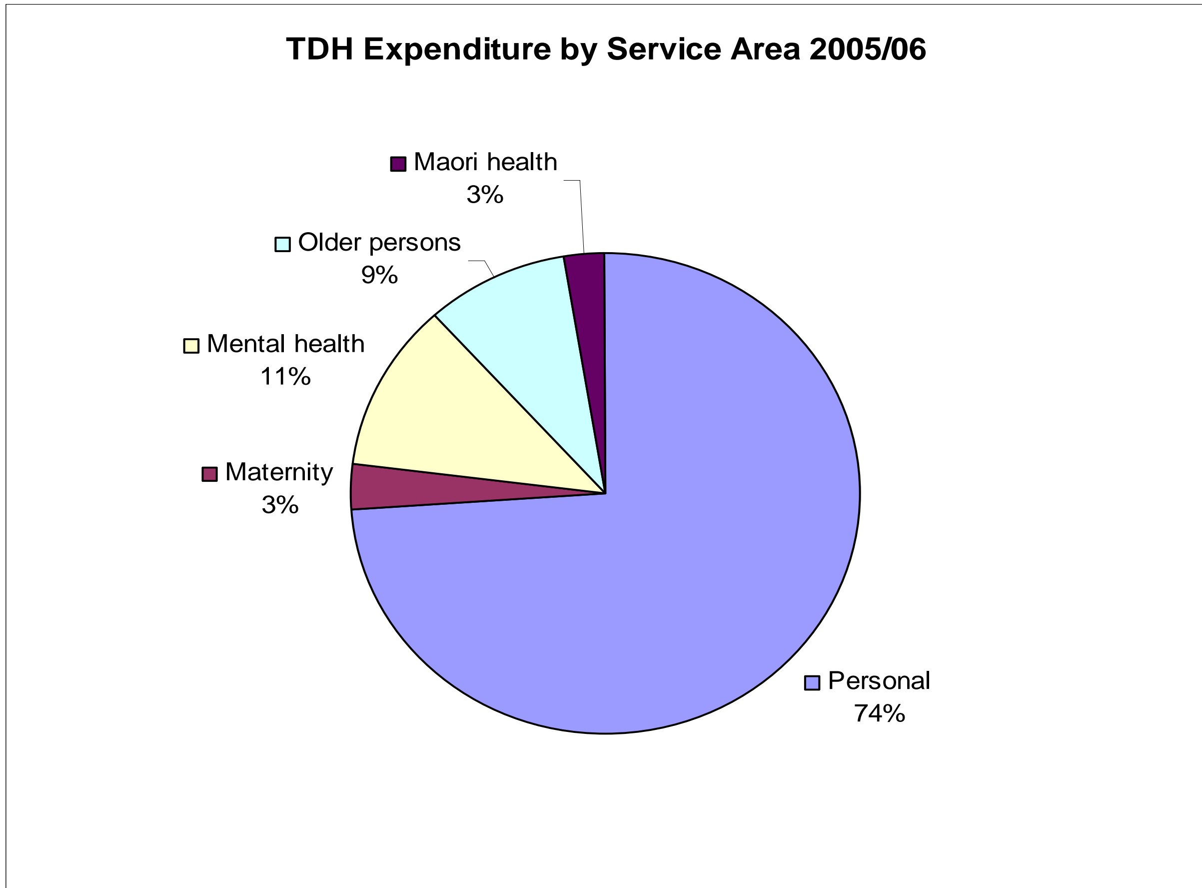
# Our District Health Board

TDH is responsible for funding most publicly funded health and disability support services in the Te Tairawhiti District and for Te Tairawhiti people who need these services out of Te Tairawhiti. While the funding is provided by Central Government, it is up to the Board to decide within the guidelines provided what health and disability support services are needed and how to fund these services to best meet the health and disability needs of our population.

The chart below shows that of the $100 million funding that TDH plans to distribute for health and disability support services in 2005/06, 54% of that funding is for services provided by TDH itself and 46% funds our Non-Governmental Organisations who provide a range of Maori health, primary health care, mental health and older persons services.



Of the $100 million that TDH uses to fund health services, the distribution of services is demonstrated in the graph below. Nearly 74% of our funding goes towards what are termed personal health services, which cover General Practitioners services, laboratory services, pharmaceutical services including the funding of drugs, dental services and hospital services (medical, surgical, child health, maternity and related support services). Mental health services and older persons services represent 11% and 9%, respectively, of the total TDH expenditure. Specific services targeted at Maori (not including those provided as part of mainstream services) account for 3% of funding.



# Our District Strategic Plan

The Te Tairawhiti Strategic Health Plan sets out the strategic direction TDH intends to follow in all aspects of its operations over the planning timeframe of the next five years and beyond. There is one constant aim – to achieve the TDH mission:

## Mahia nga mahi I roto I te kotahitanga kia piki ake te oranga o Te Tairawhiti

### Working together to lift the wellbeing of Te Tairawhiti

As the mission implies, TDH is taking a holistic approach by considering the totality of 'wellbeing', recognising that it incorporates a wider aspect than simply the physical health and independence of people. This plan reflects an all-encompassing, multi-sectorial approach to wellbeing. It recognises that all the peoples of Te Tairawhiti need to work together with their DHB in order to attain the overall goal of health and wellbeing for everybody.

The plan provides the overall planning themes for the years ahead. These will be reflected in TDH's District Annual Plans, making the themes happen, laying out the year's actions and documenting how progress will be measured.

This plan identifies areas that need addressing in order to improve the wellbeing of the people of Te Tairawhiti. It gives priorities for attention and sets out the themes for action. However, it also recognises and builds upon the many positive aspects of the Te Tairawhiti district that are already in place and operating effectively. The large Maori population provides the basis of cohesion for health improvement. The many established and flourishing providers have momentum for change. The collaborative nature of the community lends itself to community action on health. Te Tairawhiti has a number of very active and committed voluntary organisations that provide an invaluable service to their communities. Te Tairawhiti has a well-defined population, with networks already established.

These positives are already resulting in health and independence improvement. We have the sound structure on which to build further.

## How We Developed It

This revised Strategic Plan has been developed from the initial Strategic Plan for Te Tairawhiti, updated information from the Health Needs Assessment carried out in 2001, and the results of consultation with Te Tairawhiti people. It is based on the government's key strategies: The New Zealand Health Strategy and the New Zealand Disability Strategy.

The plan has been guided by the specific input of Maori through consultation with Te Runanga o Turanganui a Kiwa, Te Runanga o Ngati Porou, Te Waiora o Nukutaimemeha (Maori Caucus), Maori Health Provider organisations and Maori within the community.

The plan also incorporates the thinking of many key sector and community groups including the small but growing Pacific community in Te Tairawhiti.

There were two rounds of consultation and a tabloid version of the draft plan disseminated widely to encourage community feedback. A series of hui and meetings were held with stakeholder groups and the public in general to encourage guidance on the health and disability issues important to Te Tairawhiti people.

## Our Mandate

The purpose of TDH is to fulfil the three roles of all DHBs, namely Owner and Governance, Funder and Provider as appropriate in the context of Te Tairawhiti.

The mandate for TDH is contained within sections 3(1) (a), 3(2), 6 and 23(b) of the New Zealand Public Health and Disability Act 2000:

- To improve, promote and protect the health of the resident population of Te Tairawhiti;
- To promote the inclusion and participation in society and the independence of those people of the resident population with disabilities;
- To reduce health disparities within the resident population by improving the health outcomes of less healthy population groups;
- To facilitate a community voice in matters relating to health and disability support services for the resident population and the access thereto; and
- To achieve the best care or support for those of the resident population in need of health or disability services that are reasonably achievable within the funding provided.

During the first four years of operation, TDH has successfully balanced these requirements as a DHB against the clear and urgent health and independence needs of the Te Tairawhiti population by carefully applying the defined resources available through the Population Based Funding Formula. While the updates to the Health Needs Assessment show that progress has been made in a number of areas, the task is even stronger for TDH to provide the leadership for health and independence, particularly reducing inequalities.

# Our Conceptual Philosophy

This District Strategic Plan for Te Tairawhiti is based on the concept of **AWHI**. The word awhi signifies a concept of caregiving – of supporting the health needs of our own bodies and those of our whanau/families, hapu/communities and iwi/district. The concept is universal to Maori and to the other peoples who make up the unique district of Aotearoa/New Zealand that is Te Tairawhiti. The concept is best conceptualised through the acronym of the word as contained in the following table, which draws both from the Maori and non-Maori paths for the continuum of human association.

As people in Te Tairawhiti, we have a collective responsibility to ensure the best start in life for tamariki/children, safe nurturing for our rangatahi/youth, responsibility of action for ourselves and our whanau/families and care for our pakeke/older people.

## Our Concept: AWHI

| | |
|---|---|
| **A**u ora/Me | **Personal responsibility for health – Treasuring and nurturing of the health given to all as a start in life. Health defined in the Whare Tapa Wha model – Tinana (Physical), Hinengaro (Mental), Waiora (Spiritual), Whanau (Family).**<br>As shown by:-<br>Healthy Eating, Healthy Action, Smokefree, teeth brushing, safety belts, Diabetes Free Annual Check, moderate alcohol intake, drug free, antenatal care, screening participation, anger management, work/life balance, stress management. |
| **W**hanau ora/Family | **Responsibilities of all to contribute to and ensure the whanau remain healthy and supported.**<br>As shown by:-<br>Whanau/family healthy eating and action, smokefree homes, role modelling smokefree, safety restraints in vehicles, teeth brushing for families, immunisation for children, host responsibility, zero family violence, family inclusion, family activities. |
| **H**apu ora/Community | **Hapu and wider community responsibility for action on health and independence. Maintenance of whakapapa (family identity) through whakawhanaungatanga (strengthening family relationships).**<br>As shown by:-<br>Smokefree marae and local communities, community activity, healthy marae kai, host responsibility, health promotion, job creation, social identity development, health research. |
| **I**wi ora/Te Tairawhiti | **Total Iwi and Te Tairawhiti action on health and independence. Helicopter view, intersectoral relationships with Government/ social agencies/ Council/ volunteer groups.**<br>As shown by:-<br>Smokefree Te Tairawhiti, 100% safety belt usage, active Te Tairawhiti, influencing national policy, economic development, Te Tairawhiti Social and Economic Development Taskforce, health research. |

# Our Values

TDH has identified the following values to maintain in its roles of owner, funder and provider.

### Wellbeing/Hauora pai rawa

Wellbeing extends beyond health care in that all activities should be to promote and improve the wellbeing of the community. This includes the concept of increasing the participation of disabled people within society.

### Partnership

Between Te Tairawhiti Maori and the Board of TDH.

### Quality - Striving for Excellence

Resources will be used in the best way possible to ensure that health and disability services meet people's needs, are culturally appropriate, well co-ordinated, clinically sound and effectively delivered.

### Integration

To ensure that health and disability services in Te Tairawhiti are well co-ordinated and interact effectively, ensuring that gaps are eliminated and resources are well utilised.

### Choice

Personal: To empower and enable people of Te Tairawhiti to determine their overall wellbeing/hauora pai rawa

Collective: To encourage active community participation in determining the range of health and disability services available.

### Responsiveness - He tangata

Using the New Zealand Health, Disability, Maori, Primary Care Strategies and other sub-strategies as living documents, TDH will endeavour, through active community participation, to be responsive to identified local needs in those aspects of its operations. To be meaningful, community consultation should be participative, open and honest. There should be a common process of involving and informing people.

### Financial Responsibility

To meet and exceed projected outputs within available financial resources.

# Our Community Visions

We know, and have clearly heard from the people of Te Tairawhiti, that the Te Tairawhiti of tomorrow must be different to that of today. The health and independence status and inequalities will be changed through our collective actions. We have looked out and developed a set of visions of the future. These visions are designed to challenge but most of all to motivate us all to succeed.

For health and independence, the visions need to have relevance to the whole population – providing benefits at all levels of the AWHI model. We acknowledge that social issues exist, however, we will work with all people and intersectorally to develop strategies that will address the underlying behaviours that impact negatively on good health and wellbeing.

In the Te Tairawhiti of tomorrow:-

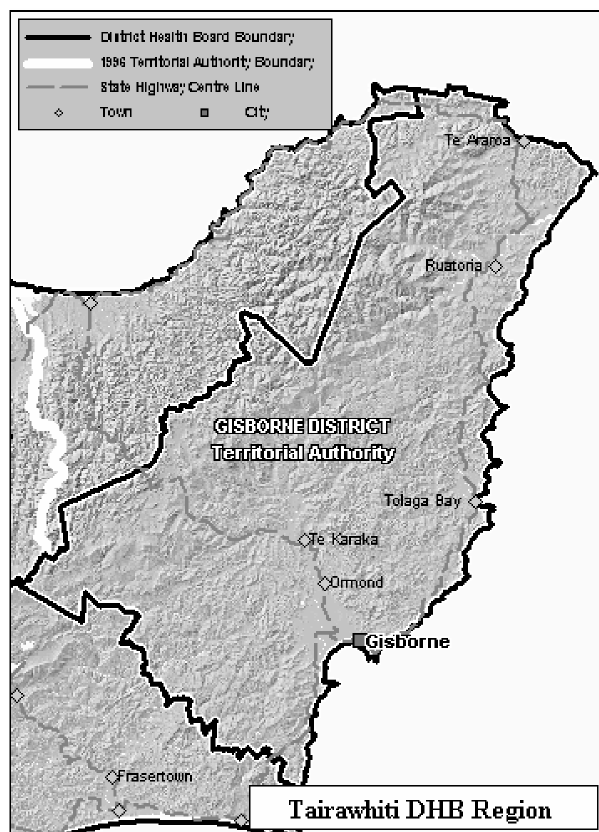
- ✓ All people will choose to be smokefree.
- ✓ All children will be fully immunized.
- ✓ All people will have teeth free from decay.
- ✓ All babies will be fully breast-fed.
- ✓ All people will use safety belts in vehicles.
- ✓ All drivers will be without the influence of alcohol or drugs.
- ✓ All sex will be consensual and safe.
- ✓ All whanau/families will be free from violence.
- ✓ All people with impairments will lead independent inclusive lives.
- ✓ All people will be physically active.
- ✓ All people will be within their goal weight.
- ✓ All people will be free from mental illness.

In this world, our health and independence services will be focussed on prevention and our need for treatment services vastly reduced.

# Our Population

## Our Geography

Te Tairawhiti is New Zealand's most eastern region. Its position makes it among the most isolated regions in New Zealand. Covering a land area of 8,351 square kilometres, it accounts for 3% of New Zealand's land area. In the west, Te Tairawhiti is bounded by the Raukumara Ranges where it shares its boundary with the Bay of Plenty. The ranges extend northeast to form the spine of the East Cape Peninsula. In the south the region borders Hawke's Bay. Te Tairawhiti's northern and eastern boundary is marked by the Pacific Ocean. The region's tallest mountain is Mt Hikurangi (1,752 metres), which is the first point on the mainland that the emerging sun shines on. Maori legend states that the mountain was the resting place of Maui's canoe after he hauled up the North Island. Te Tairawhiti's climate is warm and sunny with mild winters and average rainfall.




Only 32% of Te Tairawhiti's roads are sealed, compared with 57% nationally. This has implications for physical access to health services for rural residents.

Te Tairawhiti is the most sparsely populated North Island area, with a population density of 5.5 people per square kilometre. In comparison, neighbouring regions Bay of Plenty and Hawke's Bay have population densities of 18.0 and 10.1 people per square kilometre, respectively.

Approximately 30% of the population are rurally based, which is higher than most regions in New Zealand. Nationally, 85.4% of people live in an urban area compared to 71.2 % of Te Tairawhiti residents. In addition to this, Te Tairawhiti is isolated from the rest of the North Island geographically. Napier is 216km south and Whakatane is 202km northwest of Gisborne.

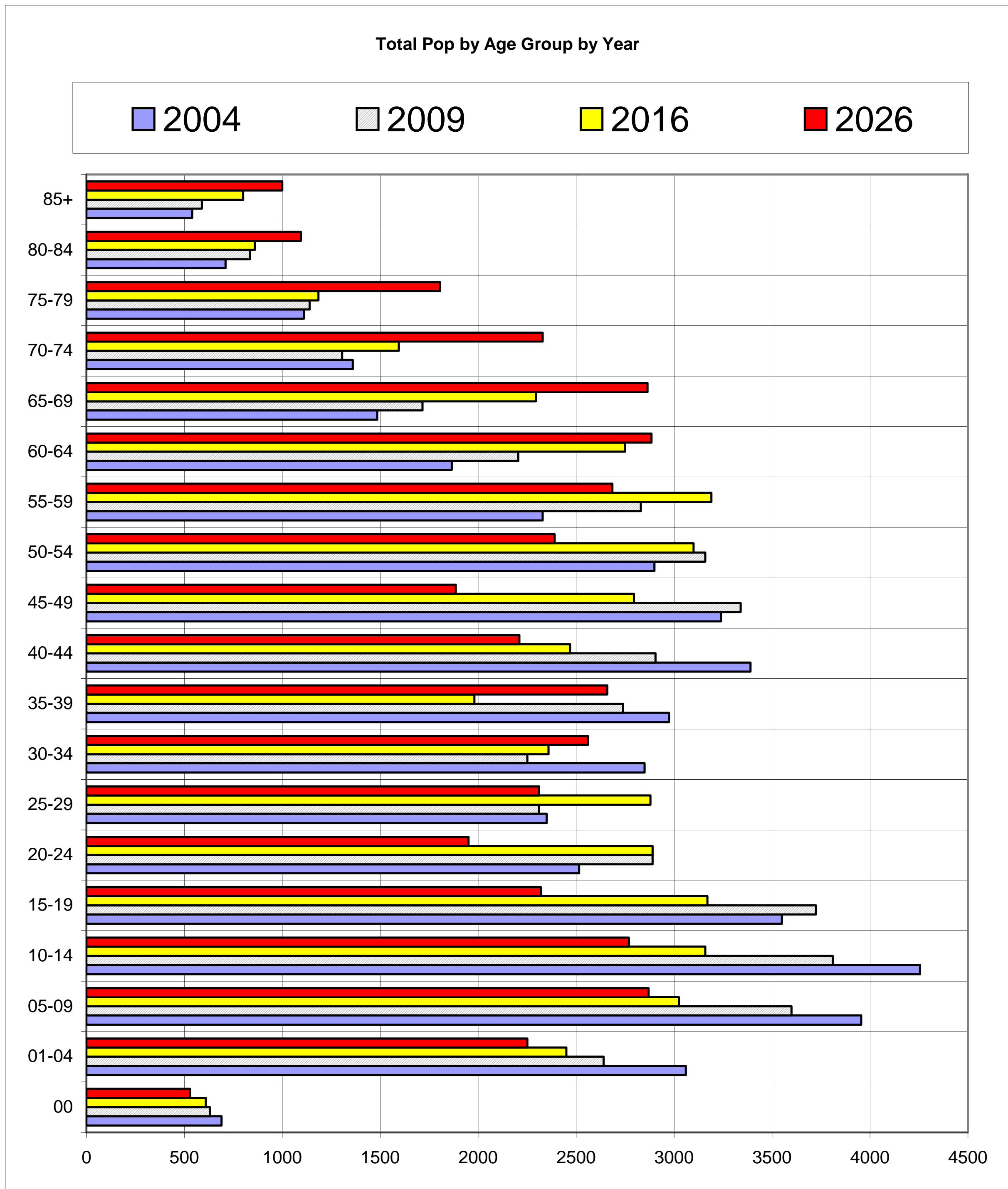
The high population of Maori in the district identified the following iwi affiliations in the 2001 census.

| | |
|---|---|
| Ngati Porou | 9,098 |
| Te Aitanga a Mahaki | 4,365 |
| Rongowhakaata | 3,612 |
| Ngai Tamanuhiri | 1,173 |

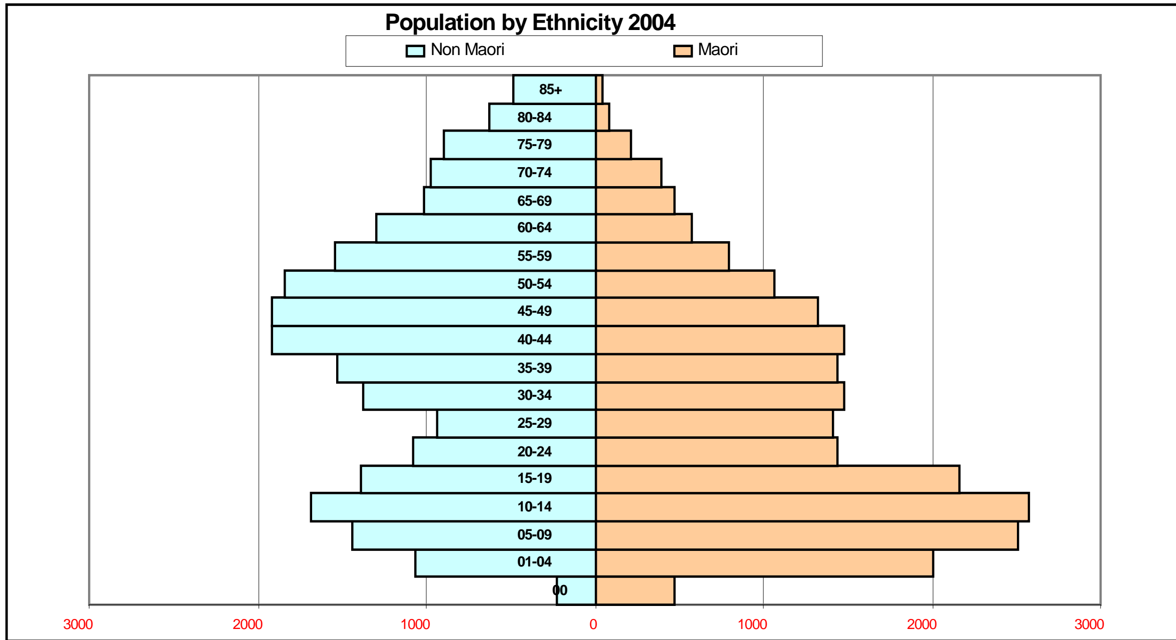
# Our Population

- Te Tairawhiti's population (as of the 2001 census) was 43,974.
- Te Tairawhiti has the greatest proportion of Maori (46.4%) than any other region in New Zealand.
- Pacific people make up 2.7% of the Te Tairawhiti population, a significant increase from 1.1% in 1996.
- The total population of the Te Tairawhiti district is projected to fall by 3.5% over the next 12 years.
- The population age structure of Te Tairawhiti shows a large proportion of young people (29% of males and 26% of females aged 0-14yrs) whilst the proportion aged 30-44yrs remains low. Te Tairawhiti has the largest youth population nationally and also has a high level of people aged 65+ compared to New Zealand as a whole.
- Age profiles for the region show that Maori still have a younger population structure than non-Maori. This can be attributed to a higher birth rate and lower life expectancy.
- By 2026, the number of people over 65 years of age will have doubled with one in four people in the 65+ age group by then.
- One-parent families comprised 27.5 percent of all Te Tairawhiti families, the highest percentage for any district.
- While the unemployment rate in Te Tairawhiti is currently less than 5%, the unemployment rate for Maori in Te Tairawhiti is 9%.
- Te Tairawhiti had the third lowest median income in the country at $15,000 per annum. Te Tairawhiti still experiences higher levels of deprivation than New Zealand as a whole, with almost half (47.5%) of the population living within deciles 9 and 10. This trend is exacerbated when split by ethnicity. 78% of Maori in Te Tairawhiti live within deciles 9 and 10, while this figure reaches 86% for Pacific peoples.

The following bar graph shows the way in which our population is expected to change over the next 22 years. Note the steadily increasing numbers of older people in the population and the decrease in the young.




The following pyramids show the differences between the Non Maori population, and the Maori population for the years 2004, 2009 and 2016.


Population by Ethnicity 2004
Non Maori
Maori
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
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20-24
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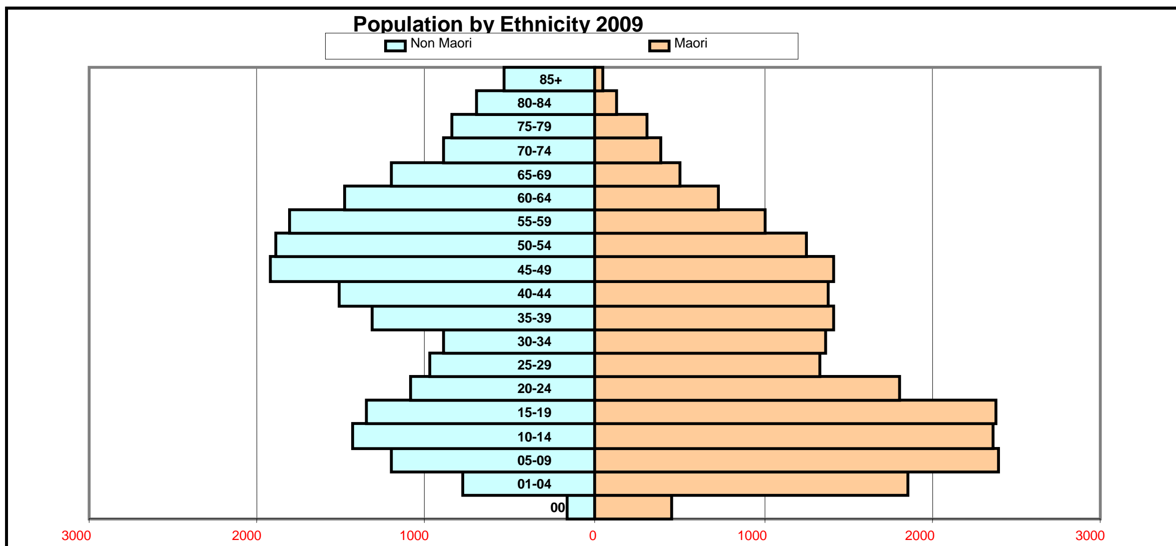
Population by Ethnicity 2009
Non Maori
Maori
85+
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65-69
60-64
55-59
50-54
45-49
40-44
35-39
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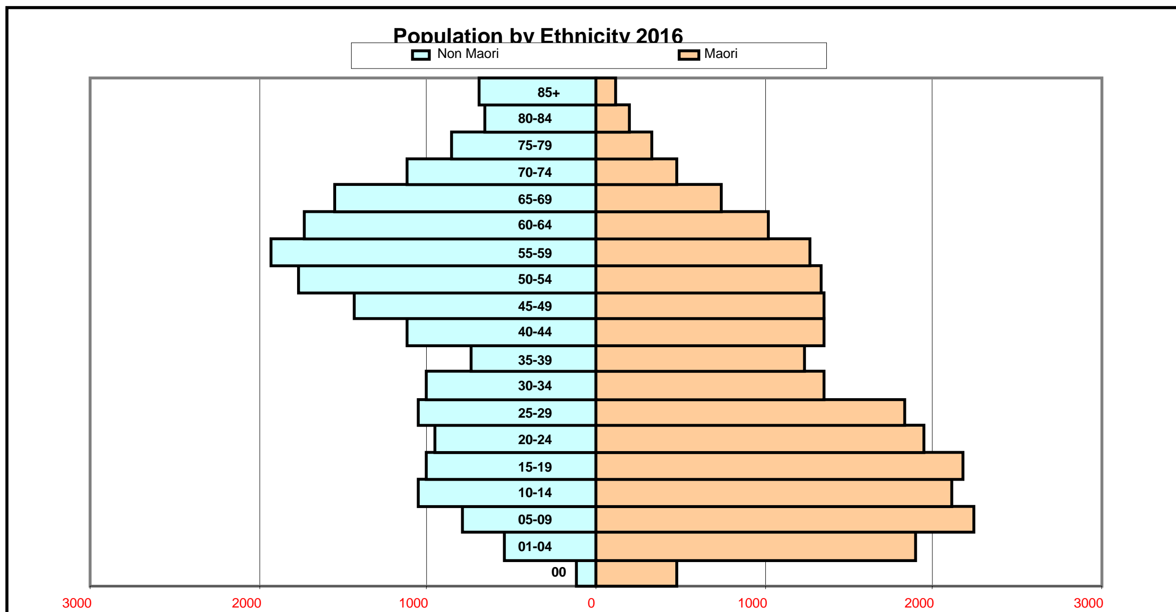
Population by Ethnicity 2016
Non Maori
Maori
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
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# Our Health

## Our achievements to date

While our current health status is relatively poor compared to other DHBs nationally, there have been some health improvements during the life of the first strategic plan which TDH intends to build upon. These include:

- A reduction in rate of dental caries (tooth decay) in 5 year olds.
- A reduction in the rate of dental arrears for school-dental children.
- A doubling in the rate of people receiving a free Diabetes check.
- Significant quality improvements within the hospital and NGO providers
- Reduced smoking rates amongst young people and an increase in the number of young people who have never smoked.
- Improved child immunisation rates with one of the highest immunisation rates nationally.
- Less people waiting for elective services.
- Significantly more primary health-based services and initiatives, mostly formed out of the Primary Health Care Strategy.
- Innovative cross-sectoral programmes such as housing retrofitting.
- More mental health services, including additional consumer advocacy roles.
- Greater inter-sectoral collaboration across sectors and agencies.

## Our current health

Due to our significantly youthful population, as well as our high rates of Maori people and people living in high deprivation areas, Te Tairawhiti experiences some of the worst health status nation-wide.

Below is information which has resulted from our health needs analysis, and which will guide some of the key priorities and strategies in this plan.

- We have the second highest rate of teenage pregnancies nationally.
- We have the highest rate of ambulatory sensitive hospitalisations[1].
- We have the third worst rate of children caries free at age 5.
- We have a significantly higher overall mortality rate compared with the national rate (594 versus 469 per 100,000). When split by ethnicity, the non-Maori rate is similar to the national rate for non-Maori, yet the Maori rate is significantly higher than the national rate for Maori. Both male and female mortality rates are higher than the national averages.
- We have the highest asthma discharge rate for children under 5 and those aged 5-14.

[1] Ambulatory sensitive hospitalisations result from diseases and conditions sensitive to interventions delivered through primary healthcare and are, therefore, avoidable.

- We have the second highest rate of injuries for children aged 5-15, and the third highest rate of injuries amongst under 5 year olds.
- We have the second highest rate of preventable injury hospitalisations for children under 5 years of age.
- We have the highest rate nationally of people discharged with rheumatic heart disease.
- We have the fourth highest rate of children under 2 discharged with pneumonia.

The Table below shows a summary of our health status compared to the health of others nationally – Maori and all.

| | **Higher or Lower than National Average – Te Tairawhiti District** | **Where known Higher or Lower than National Average – Te Tairawhiti Maori** |
|---|---|---|
| Morbidity and Mortality Rates | Higher | Higher |
| Life Expectancy | Lower | Lower |
| Alcohol related mortality and hospitalisation | Higher | Not known |
| Hospitalisation rates for unintentional injuries | Higher | Not known |
| Burns and poisonings in children | Higher | Higher |
| Asthma Admissions – Children under 5 | Higher | Higher |
| % of people who smoke over 15 years | Higher | Higher |
| Teenage Pregnancy Rate | Higher | Lower |
| Low Birth Weight babies | Higher | Lower |
| Physical activity | Lower | Lower |
| Hospitalisation rates for suicide | Higher | Higher |
| Alcohol and drug use as primary cause of serious or fatal motor vehicle accidents | Higher | Not known |
| Death rate for cancer | Higher | Higher |
| Hospitalisation for cardiovascular disease | Lower | Higher |
| Acute Rheumatic fever Discharges | Higher | Higher |
| Acute Rheumatic fever Readmissions | Lower | Lower |
| Stroke Discharges 55+ | Higher | Higher |
| Stroke Readmissions 55+ | Lower | Lower |
| Acute Myocardial Infarction Admissions | Higher | Higher |
| Ischaemic Heart Disease Admission | Lower | Lower |
| Chronic Rheumatic Heart Disease Admissions | Lower | Lower |
| Hospitalisation for stroke | Higher | Not known |
| Hospitalisation for diabetes | Higher | Higher |
| Oral health – carries free rate 5 year olds | Lower | Lower |

# Our Challenges

We face a number of challenges in the next 5-10 years in our responsibility to fund and provide health and disability services for our population. These are:

- Availability of funds to apply to new initiatives when there is an underlying level of need. The extent of morbidity in the population necessitates a relatively high proportion of funding for treatment services making freeing up of resources for prevention more difficult.
- Provision of services is more costly owing to the rurality of the region. Isolation drives up recruitment and retention costs and diseconomies of scale.
- Historically some groups in the population do not access services or leave access to a later, less clinically effective stage for reasons related to physical access to services, e.g. lack of transport, and perceptions about the appropriateness of services, particularly mainstream services.
- While Te Tairawhiti has seen good initiatives to improve access of services by particular groups of the population, e.g. Maori providers, there is still a recognized gap between the needs of people and the availability of services.
- Availability of specialist clinical staff including those with the skills and knowledge required to deliver services to Maori in a rural setting.
- By 2026, more than 20% of the Te Tairawhiti population will be over 65, putting significant strain on the health dollar.
- The growing obesity epidemic and the burden this will place on our limited health dollar through increased incidence of diabetes, heart disease and cancer and our ability to lead full lives and participate in the community.
- The significant proportion of our population who smoke, thereby jeopardising their health and the health of their whanau/families, inevitably leading to premature death and higher dependence on health services.
- Significant workforce shortages predicted both in the primary care and secondary sector, driven by the ageing of the population and the predicted increase in chronic diseases (particularly diabetes, heart disease and cancer).
- TDH does not have the spare resources to 'buffer' unplanned financial risks such as those created by the way in which funding flows when Te Tairawhiti people receive services out of district.
- New and more expensive technologies, assessments and pharmaceuticals will continue to put further strain on the limited health dollar.
- Continued difficulty of integrating services across the continuum and ensuring all health providers work collaboratively with a common purpose and vision

# Our Guiding Principles

Given Te Tairawhiti's geographic and population breakdown, it is not difficult to understand why Te Tairawhiti experiences some of the worst health status nationally. Behind the statistics is reality of life for a large proportion of our population who live in a state of health and wellbeing that is simply unacceptable. Fortunately the health status figures identified in the previous section are very amenable to change and urgent action must be taken in those areas where hospitalisations and the development of chronic disease can be prevented and appropriately managed. It is the information identified through the health needs analysis and the messages we have received from Te Tairawhiti people which has directed the development of the following eleven principles which will guide our service planning over the next 5 years.

1. Prevent ill health
2. Reduce health inequalities
3. Support whanau ora
4. The right care in the right place at the right time
5. Optimise our resources
6. Develop the workforce
7. Work with other sectors, agencies and communities
8. Implement continuous quality improvement
9. Support people to live independently
10. Local solutions
11. Monitor health improvements

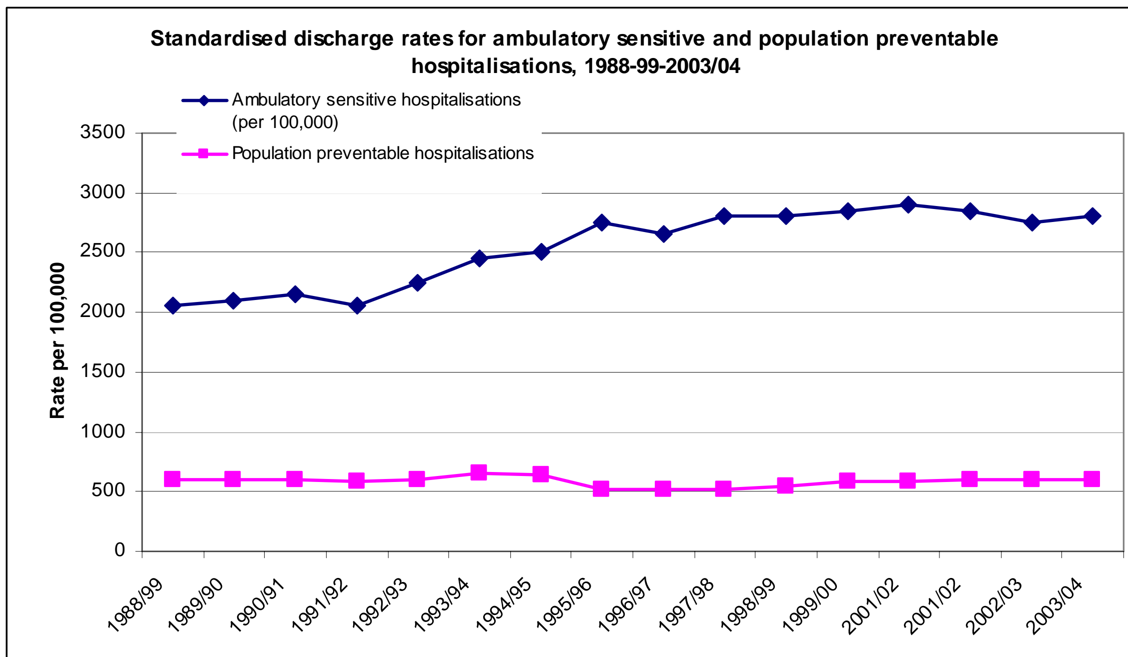
## 1. Prevent Ill Health

The development of ill health, and the subsequent hospitalisation of people with chronic diseases, is, in many cases, preventable. The two types of avoidable hospitalisations are:

- Population preventable which are hospitalisations which could be prevented through population health strategies such as health promotion activities directed towards smoking, nutrition, physical activity and obesity.

- Ambulatory sensitive which are hospitalisations which result from diseases and conditions sensitive to interventions delivered through primary healthcare and are, therefore, avoidable.

On average, more than 30% of hospital admissions are either ambulatory sensitive or population preventable. The table below shows that the rate of ambulatory sensitive hospitalisations, in particular, has significantly increased nationally since 1998/99. Furthermore, there are clear ethnic disparities in these figures, with preventable hospitalisation three times higher for Maori and Pacific peoples than others.




The latest national figures suggest Te Tairawhiti has the highest rate of population preventable hospitalisations for all age groups (except under 5s and 5-15 year olds, where we have the second highest rate nationally). However, with respect to the 5-15 year olds, we have the highest rate of Maori population preventable hospitalisations than any other DHB.

With respect to ambulatory sensitive hospitalisations, Te Tairawhiti has the highest rate of such hospitalisations for all age groups.

The three critical issues in relation to chronic diseases are:

- The need for the effective prevention of chronic disease in populations.
- Inequalities in the distribution of chronic disease across population groups.
- The speed at which the diabetes epidemic is increasing, partly because of increasing numbers of older people, but mostly the increasing number of younger people affected by the disease, which is associated with an obesity epidemic.

The bulk of our chronic diseases and cancers are preventable through changes in lifestyle factors and excellent access to quality primary care. Particular areas for TDH to focus its prevention activities are: improved nutrition, reduced obesity, increased physical activity and reduced smoking. Smoking is the single largest preventable factor in premature death, disability and disease. Obesity may well overtake this in the next five years. By supporting and enabling people to increase control over these factors, TDH can slow the rate of progression of such diseases as heart disease, diabetes, respiratory disease, oral health and cancer in our community. The best solutions are those where individuals, caregivers, supporters and health workers work alongside each other to achieve the best outcomes. Healthy people and families are better able

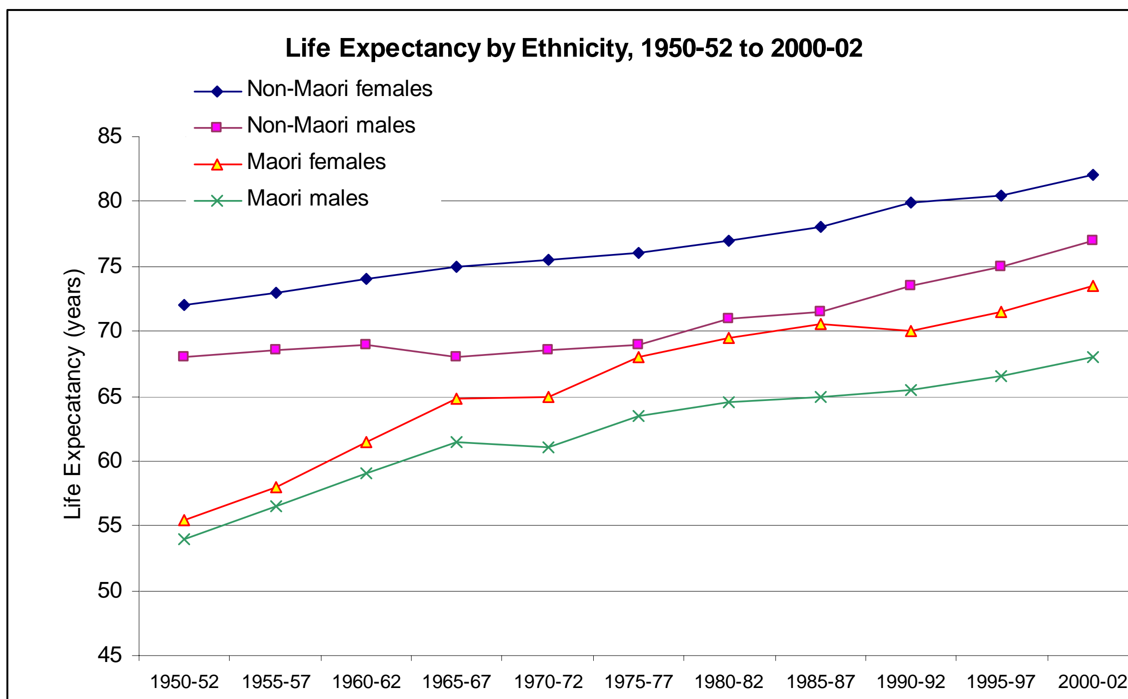
to contribute to our communities and achieve better health outcomes for education, employment and well-being.

To help us prevent ill health we will focus on the following:

- Develop programmes in collaboration with key agencies and providers to prevent illness and maintain healthy lifestyles with a specific focus on “Healthy Eating Healthy Action”.
- Build healthy public policy.
- Enable people to understand how to prevent illness and how to keep healthy by good nutrition, exercise, stopping smoking and reducing obesity.
- Improve the early identification of chronic diseases to ensure these do not progress to become chronic conditions through screening and a strong primary care sector focusing resources and action on high-risk populations.
- Identify who does what best.

# 2. Reduce Health Inequalities

Despite the overall improvements in the health of New Zealanders over the past 20 years, the benefits of improved health are not shared equally across population groups. For instance, a newborn Maori male can expect to live 69.0 years compared to a newborn non-Maori male who can expect to live 77.2 years. Similarly, a newborn Maori female can expect to live 73.2 years compared with a newborn non-Maori female who can expect to live 81.9 years.



Infant mortality rates also show inequalities between Maori and total populations, with the infant mortality rate in 2002 at 7.4 deaths per 1000 live births compared to 5.6 for the total population.

Other significant areas of inequality include:

- Population preventable hospitalisations increased among Maori and Pacific peoples from 1996/97 to 2002/03 to a greater degree than among non-Maori non-Pacific peoples.
- Ambulatory sensitive hospitalisations, although lower for the total population than at the peak in 2000/01, consistently increased for Maori and Pacific peoples. These types of admissions are also more common among people from high deprivation areas.
- Avoidable mortality is similarly patterned by ethnicity and deprivation.
- Diabetes and cardiovascular disease also show ethnic disparities.
- Cancer mortality is making a significant contribution to inequalities between Maori, Pacific peoples and other ethnic groups.

Health inequalities are avoidable. With a strong understanding of the factors that protect and promote health and wellbeing (such as social, cultural and economic determinants of health) TDH can make inroads. To help us reduce health inequalities we will focus on the following:

- Improve access to primary and community health services by ensuring low cost services for those with greatest health need.
- Ensure provider development is targeted to the providers working with those with greatest health needs.
- Continue to work with rural communities to improve access to services.
- Ensure our funding prioritisation systems incorporate an assessment of health equity so that all funding decisions seek to reduce, not increase, health inequalities.
- Support providers demonstrating leadership and innovation in reducing access barriers and delivering services.
- Develop and support a highly qualified and competent Maori health workforce.
- Advocate for action to improve the determinants of health: employment, housing, education etc.
- Strong focus on health promotion and public health approaches
- Develop specific cultural competencies for all non-Maori workforce to assist with improving access.

# 3. Support Whanauora

We acknowledge the special relationship between Maori and the Crown under the Treaty of Waitangi, and the implications for Maori Health.

The concept of whanauora is a state of wellness centred on the whanau/family that is central to the life of Maori and equally relevant to all people of Te Tairawhiti.

Whanauora is a goal and a way of approaching actions to improve health and independence in Te Tairawhiti.

We recognise and will drive through all of our activities as a DHB, opportunities to improve whanauora in every action we take as well as in our relationships with other sectoral players. Throughout this plan we have not sought to define at every point the specific Maori health objectives inherent in every dimension. Instead the plan stands in its own place as a unique Te Tairawhiti document exuding whanauora as at the heart of **AWHI**.

To help us foster whanauora and major health gain, we will:

- Involve whanau/hapu in decision making as partners to effectively ensure that decisions lead to whanau health improvement and support the achievement of Maori Health aspirations.
- Recognise that there is a range of other community groups in Maori society that make valuable contributions to the advancement of Maori Health, and representatives of those groups will also be included in planning and delivery of services.
- Work through any access barriers that may exist for Maori, including cost, culturally appropriate services, and travel.
- Continue to support Maori provider development and Maori workforce development.
- In partnership with Maori, we will work with other government sectors to address wider determinants of Maori Health and co-ordination of the delivery of those services to whanau.

# 4. The Right Care in the Right Place at the Right Time

The health care system is complex and people need to find the right care at the right time, in the right place. The old model of health care (based on bricks and mortar) is shifting to one based on community care, provided by multiple providers. This shift has created a significant complexity for people accessing services and for providers who need ready access to people-focused information so they can provide a continuum of care for that person. Achievement of this will only occur with the successful implementation of electronic integrated care systems and committed collaboration, communication and consultation with providers.

Ensuring the right care in the right place at the right time will involve:

- Investment in and implementation of electronic integrated care systems.
- Continually reviewing the appropriateness of hospital-based services that could be more appropriately provided by community-based providers.
- Continuing to review the way in which services are funded and ensure funding strategies do not aggravate integration possibilities by creating duplication or gaps in service delivery.

- Supporting the implementation of the primary health care strategy.
- Developing and implementing appropriate models of care focused on delivering the best health outcomes to population groups.
- Focusing service configurations on improving the continuum of care for patients and their families.

# 5. Optimise Our Resources

Population Based Funding attempts to equally distribute the health dollar nationally. TDH currently receives funding that is deemed appropriate for its population profile. In order to allow us to absorb future cost growth in the health sector, we will continue to ensure that we plan, fund, and provide health services in a manner which optimises our resource without compromising quality and health outcomes.

To help us optimise our resources we will focus on the following:

- Ensure we use high quality evidence to make decisions regarding cost effectiveness.
- Continue to manage the growing expenditure in community pharmaceuticals and laboratory services through optimising our funding frameworks.
- Continue to manage the growing expenditure in older persons services by supporting and implementing innovative solutions such as Ageing in Place initiatives.
- Ensure funds are targeted in a way which balances our need to prevent ill health and provide services today for our people.
- Ensure the publicly funded health dollar supports public infrastructure ahead of private infrastructure.
- Continually review the mix and range of services provided in Te Tairawhiti to ensure financial sustainability of health services.
- Continue to develop innovative ways of working to manage the hospital budget, by tapping into in-house expertise in the development of new clinical roles and pathways, and collaboratively working with other DHBs in sharing service innovations.
- Work with the Ministry of Health to review and adapt the Population Based Funding Formula to ensure that small rural-based DHBs with high disparities are adequately compensated in any revision of the formula.

# 6. Develop the Workforce

Our health priorities will not be achieved without an appropriately skilled workforce. We intend to continue to build the capacity of the health workforce to meet the needs of the diverse populations. The health workforce must be reflective of and skilled at working across a diversity of cultures.

To help us develop the workforce, we will focus on the following:

- Workforce planning, education and regeneration leading to a skilled and trusted health workforce, reflective of the community.
- Build sector capability, particularly with our Maori Health providers.
- Identify the likely impacts for future models of health care on the health workforce and plan for workforce changes to accommodate them.
- Improve workforce information and data collection to assist with workforce planning.
- Work with education providers to provide programmes specifically focused on the health needs of Te Tairawhiti.
- Developing and maintaining a healthy work environment for all TDH staff.

# 7. Work with Other Sectors, Agencies and Communities

We know that the health sector is only one player in improving the health of our population. There are significant social and economic factors that impact on our health, as well as the physical environment in which we live. TDH intends to further develop the way in which it participates in intersectoral activity and advocacy.

The acceptance of the Common Interest across communities will encourage collaborative ventures amongst groups and providers. TDH will also foster collaboration outside the district through learning from the experiences of other DHBs, contribution to regional collaborative ventures, and national working groups. However, the focus will always be on bringing this information or advancement back to Te Tairawhiti.

To help us improve collaboration we will focus on the following:

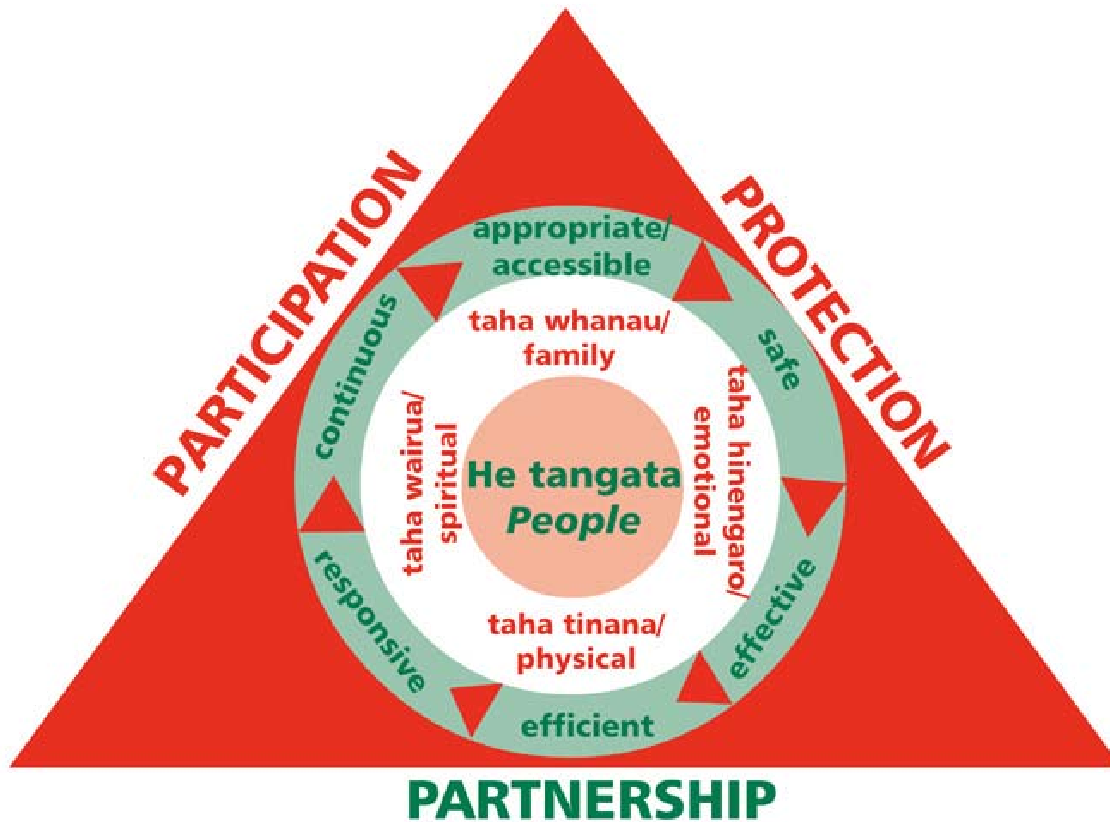
- Ensure TDH continuously acts as an advocate for 'healthy' public policy changes.
- Work with our partners in education, housing, welfare and local government to increase opportunities for people to improve health.
- Involve people and communities in decisions that affect them wherever possible.

# 8. Foster Continuous Quality Improvement

All people have a right to use quality health services based on the principles of safety, effectiveness, appropriateness, consumer participation, access, efficiency and cultural competence. TDH has a responsibility both as a provider of services and a funder of services to ensure an environment and culture of on-going quality improvement exists within TDH and amongst health and disability support providers in Te Tairawhiti.

The TDH quality model has the receiver of services – patients/consumers, staff and other key stakeholders – as its focus. The model formally adopts the concepts of Te Whare Tapa Wha described by Mason Durie (1994) to ensure that physical, emotional, spiritual, and family needs are considered.

The dimensions of quality, that are the core of standards for New Zealand and international healthcare, have been incorporated to demonstrate the integration of these standards in what we do every day. The directional arrows demonstrate this is a continuum, supporting continuous quality improvement. The Treaty of Waitangi principles of protection, partnership and participation form the base of the model. Care that is responsive and continuous occurs when there is active participation by all involved.




For the adoption of continuous quality improvement by TDH and all health and disability support providers in Te Tairawhiti we will:-

- Ensure publicly funded health and disability service providers are held accountable for the services they deliver through strong monitoring and auditing systems.
- Ensure all publicly funded health and disability service providers are accredited with an appropriate standards accrediting body by 2008.
- Ensure all providers develop, implement and monitor a comprehensive annual programme of continuous quality improvement.
- Ensure TDH continually monitors and updates its major incident and emergency plan identifying how essential services will be delivered in the event of a national health-related emergency

# 9. Support People to Live Independently

Government surveys show one in five people will have an impairment at some point in their lives, with 96% of people with an impairment living in the community. For Te Tairawhiti, this means that approximately 9,000 people live with disability. Maori have a higher prevalence of impairment requiring assistance (14%) compared with non-Maori (9%). The health sector has a responsibility to make a positive difference to the lives of people with impairments, and remove barriers to better participation and independence where these can be removed.

To support people to live independently in Te Tairawhiti, we will:

- Improve responsiveness to the needs of people with impairments who utilise health services.
- Lead development of awareness about disability issues both within TDH and in the community so the goal of a totally inclusive society can be achieved.
- Ensure all health providers develop and implement accessibility plans for their services.
- Ensure TDH as a provider of services guarantees the rights of people with impairments are met.
- Foster leadership by people with impairments through continuing consultative forums with people with impairments and their families.
- Support lifestyle choices, recreation and culture for people with impairments.
- Improve awareness of disability support services and access to these services, particularly for Maori and Pacific people with impairments.

# 10. Local Solutions

TDH has a key role in leading and supporting local health strategy development and will endeavor to best utilise existing activities and skills in this area. Where practicable, TDH will endeavour to ensure local provision of services, using local expertise, local resources and local solutions, while ensuring that funding goes into the local economy.

This will reduce the likelihood of people having to go out of the district for treatment, thereby lessening the stress and anxiety for patients and their families. For those patients who do need to access services out of the district (eg, heart surgery), TDH will provide support to the patient and families to ensure their travel experiences are as non-disruptive as possible.

TDH recognises that the priority of nationwide goals may at times not match the priority of local community needs. Therefore TDH will develop frameworks that recognise the national goals and combine these with local priorities.

# 11. Monitor Health Improvements

Our efforts will be in vain if we are unable to measure health improvements. Many of the interventions and proposed solutions will require a strong discipline of data collection and sharing, monitoring and evaluation to ensure that our efforts are aimed at improving health status and reducing health inequalities.

To enable TDH to monitor health status improvements we will:

- Implement agreed health information sharing agreements with our providers that ensures data is captured, gathered and shared for monitoring purposes.
- Ensure new service agreements and pilots have a strong outcome evaluation component to them focussing on monitoring health improvements.

# Our Top Health Gain Priorities

Health and independence services are potentially limitless. TDH has a responsibility therefore to prioritise its funding in areas where the highest benefits will be achieved. Based on the health needs of the Te Tairawhiti people, the following are proposed as our top four health gain priorities:

- Reduce the rate and effects of heart disease and stroke.
- Reduce the rate and effects of diabetes.
- Reduce the rate and effects of cancer.
- Reduce the rate and effects of severe mental health and addictions.

## 1. Reduce the Rate and Effects of Heart Disease and Stroke

### What is the situation?

Cardiovascular disease is the leading cause of premature death in Te Tairawhiti amongst all ethnic groups. Cardiovascular disease includes a broad range of conditions related to the heart and blood vessels (e.g. stroke and ischemic heart disease). It accounts for more than 40% percent of all deaths. Maori have the highest rates of death for all categories of cardiovascular disease, with the coronary heart disease mortality rate for Maori three times higher than for non-Maori.

The major modifiable factors for cardiovascular disease are smoking, hypertension, high serum cholesterol, diabetes, obesity, lack of exercise and poor diet. People with coronary heart disease also benefit significantly from the use of aspirin, beta-blockers, ACE inhibitors and lipid modifying drugs.

While data for 2004 shows a significant decline in daily smoking and total smoking prevalence (monthly or more often) amongst Te Tairawhiti Year 10 students, Te Tairawhiti District has the highest rate of adolescent smokers in the country. Te Tairawhiti young people have the highest rate of daily and monthly smokers, and the lowest rate nation-wide of young people who have never smoked.

Furthermore, while less Maori adolescents smoke now than in 1999, the ethnic relative difference in adolescent daily smoking has increased during that time. That is, the gap in smoking uptake amongst Maori and non-Maori adolescents is now higher than it was in 1999, demonstrating that the biggest impact in smoking cessation messages has been taken up by non-Maori adolescents. Compounding the high adolescent rate is also the fact that Te Tairawhiti experiences the highest parental smoking rate nation-wide, hence the impact on adolescent smoking rates. The strongest predictor of smoking is parental habit. Targeted smoking interventions must be aimed at all age groups, to ensure strong modeling by parents impacts on their children/whanau.

## What we plan to do

Heart disease and stroke are largely preventable through lifestyle changes. TDH will work with other providers to improve disease prevention through health promotion, promoting lifestyle changes and ensuring excellent primary care management of people (including increasing uptake of medications) within a continuum of care. Local PHOs are potentially the most effective means of cardiovascular risk management, with a population health approach to its prevention. Specific approaches will include:

- Increase physical activity and improved nutrition with an emphasis on identified high need populations, particularly childhood and whanau nutrition with activity initiatives in schools and communities.
- Support healthy active lifestyles by working collaboratively with local government to improve urban design.
- Develop Health Promoting schools to ensure children are fit, healthy and ready to learn.
- Ensure appropriate uptake of statins and other medications in general practice for patients at risk of heart disease.
- Work with PHOs, Maori Health providers and TDH to develop a cardiac continuum of care that identifies people most at risk of heart disease, implement programmes at a primary health level to manage that risk, through to appropriate secondary intervention and rehabilitation services to assist people to return and stay in their own homes and communities for as long as possible.
- Implement stroke treatment guidelines across the primary and secondary sectors.
- Reduce smoking rates across all age groups through increased smoking cessation and prevention programmes.
- Working with whanau, communities and Maori Health providers to enable vulnerable families to make informed choices about lifestyle changes and disease management.
- Continue to implement and monitor the TDH smokefree policy, extending it through collaboration with other providers and agencies towards SmokeFree Te Tairawhiti.
- Include smokefree standards in all agreements with service providers.
- Implementation of clinical pathways in primary care, including electronic management care tools.
- Measure our improvements.

## We will have been successful if by 2010 we can see

- An improvement in the rate of physical activity and nutrition amongst children
- Implementation of a Schools Accord with all primary and secondary schools in Te Tairawhiti.
- A 5% reduction in avoidable admissions, particularly for Maori and Pacific peoples for heart disease and strokes.
- A 5% reduction in smoking initiation by young people, particularly Maori and Pacific young people.
- A 5% reduction in the adult smoking rate.

- Stroke Guidelines have been fully implemented across the continuum of care.
- 100% of our publicly-funded providers have smoke-free policies in place.
- 100% of Te Tairawhiti public places are smokefree.
- 80% of patients with heart disease and stroke will be managed through agreed clinical pathways, including electronic care management.

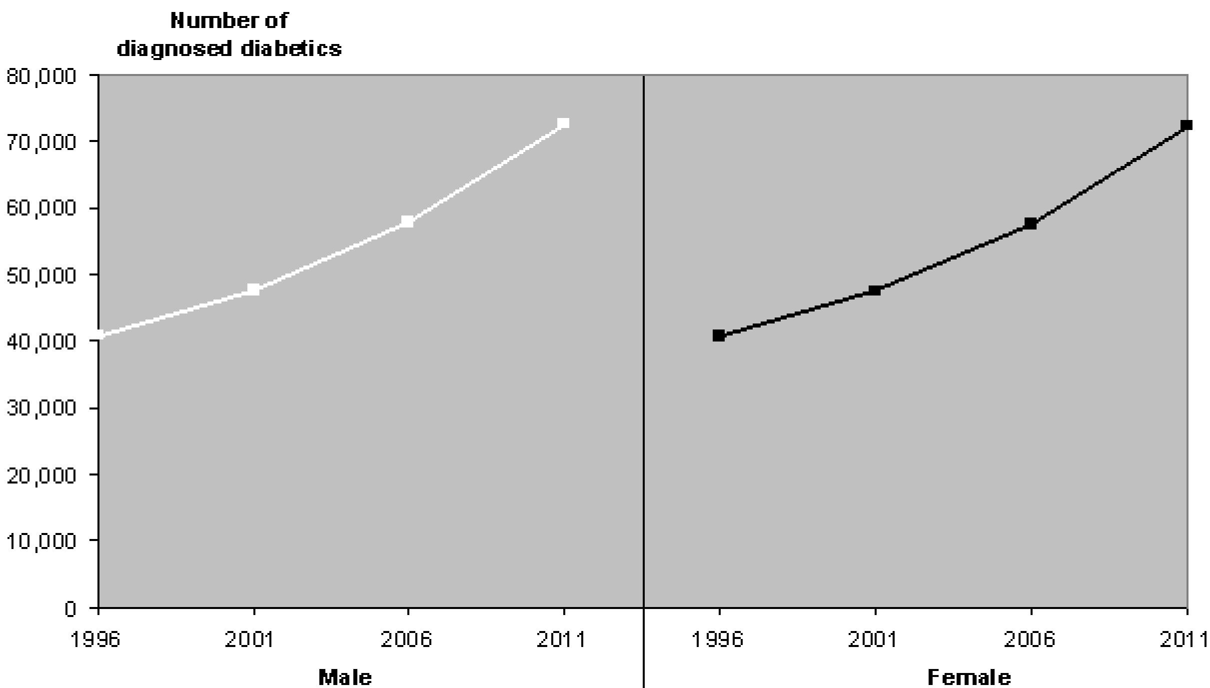
# 2. Reduce the Rate and Effects of Diabetes

## What is the situation?

New Zealand is currently experiencing an unprecedented growth in obesity. Obesity is a major risk factor for Type 2 diabetes, the most common form (90%). Diabetes is a chronic disease that leads to serious complications, such as heart disease, kidney failure, stroke, and blindness. Diabetes is a disease of inequalities, with Maori and Pacific peoples at significantly greater risk of having diabetes than other New Zealanders. Further, Maori develop diabetes a decade or two earlier than non-Maori. Maori males are about 6.5 times more likely to die and Maori females 10 times more likely to die from diagnosed diabetes than New Zealand Europeans. Pacific peoples are five times more likely to die from diagnosed diabetes than New Zealand Europeans.

The graph below shows that the diabetes epidemic is forecast to grow rapidly over the 15 years from 1996 to 2011. It is predicted that there will be a 1.8 fold increase in the number of existing diagnoses and a more than doubling in the number of new diagnoses by 2011. The relative increase is forecast to be greater for Maori and Pacific peoples than for Europeans, further contributing to the health inequality between these ethnic groups.

Forecast increase in number of (diagnosed) people with diabetes, 1996 to 2011:




Taking these figures at a local level, it is estimated that there are approximately 1750 people with diabetes in Te Tairawhiti – a proportion of these people have not as yet been identified. The composition and ageing of the population, as well as the predicted increase in obesity, will mean a doubling of the prevalence rate by 2020, resulting in about 3500 people in Te Tairawhiti with type 2 diabetes by then – unless we intervene now.

The model suggests that slowing the growth of the obesity epidemic to half its current rate – probably the best we could realistically achieve – would translate into 10% fewer people living with diabetes in 2011 than projected, assuming the current trend in obesity continues unabated.

## What we plan to do

Given Type 2 diabetes is largely preventable and if diagnosed early is largely manageable with proper lifestyle modifications and adequate monitoring in primary care, TDH proposes to strategically focus on disease prevention and management through:

- Increased physical activity and improved nutrition with an emphasis on identified high-need populations, in particular, childhood and whanau nutrition and activity initiatives in schools and communities.
- Supporting healthy, active lifestyles by working collaboratively with local government to improve urban design.
- Developing Schools Accords to ensure children are fit, healthy and ready to learn.

- Ensuring appropriate uptake of statins and other medications in general practice for patients at risk of diabetes.
- Working with PHOs and Maori Health providers to ensure early detection and management of people diagnosed with Type 2 diabetes through uptake of free annual checks, integrated disease management and implementation of best practice guidelines.
- Diabetes management activities implemented effectively in a consistent framework across primary and secondary care.
- Ensuring good access to podiatry and retinopathy, particularly for high need populations.
- Working with whanau, communities and Maori Health providers to enable vulnerable families to make informed choices about lifestyle changes and disease management.
- Reducing smoking rates across all age groups through increased smoking cessation and prevention programmes.
- Continuing to implement and monitor the TDH smokefree policy.
- TDH to include smokefree standards in all agreements with service providers.
- Implementation of clinical pathways in primary care, including electronic management care tools.
- Measure our improvements.

## We will have been successful if by 2010 we can see

- An improvement in the rate of physical activity and nutrition amongst children.
- Implementation of a Schools Accord with all primary and secondary schools in Te Tairawhiti.
- A 5% reduction in avoidable admissions, particularly for Maori and Pacific peoples for heart disease and strokes.
- A 5% reduction in smoking initiation by young people, particularly Maori and Pacific young people.
- A 5% reduction in the adult smoking rate.
- 80% of all eligible people are enrolled in the ‘Get Checked’ programme.
- 5% decrease in HB1AC levels across ‘Get Checked’ patients.
- 80% rate of retinopathy for all ‘Get Checked’ patients.
- 80% of patients with diabetes will be managed through agreed clinical pathways, including electronic care management.

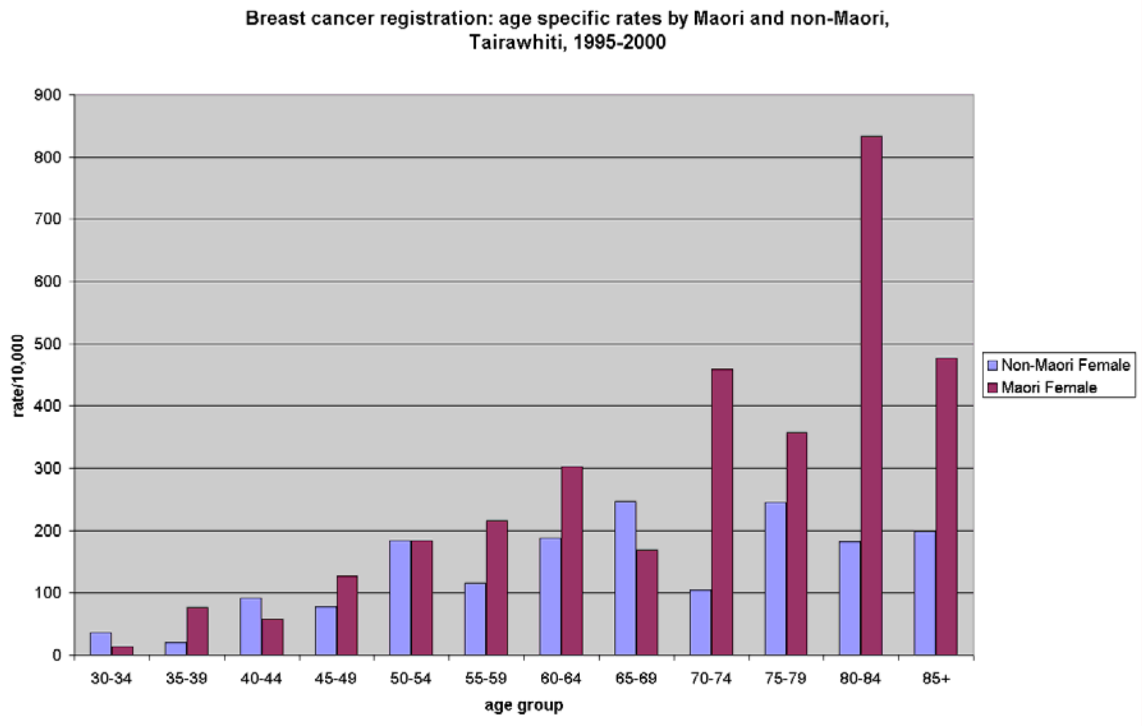
# 3. Reduce the Rate and Effects of Cancer

## What is the situation?

Cancer is the second highest cause of premature mortality amongst New Zealanders. One in three New Zealanders will at some point in their lives be affected by cancer, either personally or through a relative or friend. The burden of cancer is expected to increase significantly, with Maori and people with low socio-economic status more likely to be affected by cancer now and in the future.

Maori and Pacific peoples have significantly higher death rates of lung cancer, breast cancer, cervical cancer and prostate cancer than non-Maori (the age standardised rate for Maori is about 1.4 times that of non-Maori). Most important in this is that the peak age of presentation for Maori women is much older. With respect to cervical cancer, accessing the screening programme is the critical factor for a disease that is 90% preventable by screening if caught early enough.

The chart below shows that the age specific rates for cancer in Maori are *higher* in all but three groups: 30-34, 40-44 and 50-54, with the age standardised rate for Maori breast cancer rates at 2.2 times that of non-Maori.




At least one third of cancers are preventable, and another third of cancers can be effectively treated if detected at an early enough stage. Lifestyle changes such as improving nutrition and increasing physical activity may reduce the impact of cancer such as colon, breast cancer and prostate cancer (three of the most common cancers in New Zealand). Eliminating smoking would be the single most effective intervention for reducing all cancers. Further, if all women attended regular cervical smears, we could prevent 90% of cervical cancer.

## What we plan to do

With an improved continuum that extends from prevention through to screening, diagnosis, treatment and palliative care, the rate and effects of cancer can be greatly reduced. Increased fruit and vegetable consumption in childhood has protective effects against some cancers in adulthood. TDH proposes to implement a Te Tairawhiti-specific cancer prevention, detection and treatment continuum that will see:

- Development and implementation of child and adolescent nutrition and activity initiatives in schools and communities.
- Increased physical activity and improved nutrition with an emphasis on identified high need populations.
- Supported healthy active lifestyles by working collaboratively with local government to improve urban design.
- Developed Schools Accords to ensure children are fit, healthy and ready to learn.
- Increased smoking cessation and prevention programmes.
- Working with whanau, communities and Maori health providers to enable vulnerable families to make informed choices about lifestyle changes and disease management.
- TDH to include smokefree standards in all agreements with service providers.
- Continued implementation and monitoring of the TDH smokefree policy.
- Ensured good access to effective screening services to enable early detection of cancers, particularly amongst Maori and Pacific peoples.
- Ensured timely assessment and treatment of cancer for Te Tairawhiti people through continued collaboration with cancer treatment DHB partners.
- Improve access to appropriate palliative case services.
- Ensure access to timely treatment services.
- Measure our improvements.

### We will have been successful if by 2010 we can see

- An improvement in the rate of physical activity and nutrition amongst children.
- Implementation of a Schools Accord with all primary and secondary schools in Te Tairawhiti.
- A 5% reduction in avoidable admissions, particularly for Maori and Pacific peoples for heart disease and strokes.
- A 5% reduction in smoking initiation by young people, particularly Maori and Pacific young people.
- A 5% reduction in the adult smoking rate.
- Improved access to palliative care services.
- A 20% increase in uptake of breast screening and cervical screening programmes, amongst Maori and Pacific women.
- Waiting times for radiation treatment of cancers meet Government expectations.

## 4. Reduce the Rate and Effects of Severe Mental Health and Addictions

### What is the situation?

One in five people will have a mental illness of some kind or another during their lifetime. The mental health disease burden is projected to increase in the next 15 years and, by 2020, depression is predicted to become the second leading cause of disability.

The effects of mental health are far-reaching and often extend much wider than the individual affected, permeating families and communities, as well as society as a whole. Mental health for individuals is often connected to the wellness of families and communities, and to whanauora.

Maori are disproportionately high users of mental health and addiction services and often access those services at a more severe and acute stage than non-Maori. This is a similar issue for Pacific peoples.

We also know that, as a collective group, people with mental illness and addictions have poorer health status than the general population. This is related to the social and economic factors associated with mental illness and addiction as well as some of the treatment options.

## What we plan to do

TDH is responsible for providing and funding specialist services for people with mental health or alcohol and drug problems. For adults, this is about 3% of the population, and for children and youth about 5% of the population.

Good mental health outcomes are dependent on a wide range of well-connected health services, and access to the wider social services that support recovery and social inclusion. Furthermore, it is becoming increasingly important to implement effective mental health promotion and prevention programmes to reduce the personal, social and economic costs of poor mental health. The primary care sector, as the first point of contact for many people, is also critical in improving access to appropriate services and potentially preventing problems from becoming more severe, particularly amongst Maori who have traditionally had poor access to appropriate early intervention services.

We propose to address our significant mental health burden through:

- Addressing our substantial service gaps by increasing mental health provision for children and young people, older persons, persons with high and complex needs, and people (including young people) with alcohol or drug problems.
- Improving integration between linked services, ensuring there is smooth transition and care between and within providers.
- Improving the infrastructure of providers to deliver services – particularly as they relate to workforce development and information systems.
- Ensuring the district has the appropriate balance of clinical and non-clinical services.
- Improving access to primary mental health services for people with or at risk of developing a mental illness.
- Ensuring services are responsive to the needs of service users, particularly Maori and their families.
- Ensure all providers meet the National Mental Health Standards.

- Ensuring health gain for people with mental illness and addictions through the lowering of barriers to access to primary care and the introduction of targeted programmes of health improvement.
- Improve recording of client access across all services.
- Work intersectorally to reduce availability of illegal substances.
- Measure our improvements.

## We will have been successful if by 2010 we can see

- Access to mental health services, particularly for Maori, are improved so that people with significant mental illness are engaged with appropriate primary care and specialist services.
- Increased recognition and resolution of mental heath problems by primary health care providers occurs, with 90% of people with mild to moderate mental health issues managed appropriately through primary care.
- People with mental illness, particularly Maori, receive the right care in the right place at the right time.
- Families and consumers are better engaged in services.
- Mental health services reach the targets of 3% of the adult population and 5% of the child and youth population accessing services.
- All providers are fully compliant with the National Mental Health Standards.
- All providers fully compliant with reporting to Mental Health Information Collection.

# Our Top Service Development Priorities

Along with our top four health priorities, TDH proposes that the following areas are the focus of our service development priorities.

- Primary health care
- Population health
- Child health
- Youth health
- Older people's health
- Elective services
- Pacific health
- Rural health

## 1. Primary Health Care

### What is the situation?

Primary health care is in most cases the first option for people when they are ill or injured. National figures suggest Te Tairawhiti has the highest rate of population preventable hospitalisations for all age groups. For Te Tairawhiti, more than 35% of admissions are potentially avoidable if people receive timely, high quality primary care services. Therefore a strong primary health care system is central to improving our health and, in particular, removing inequalities in health.

TDH spends nearly $10 million each year on community pharmaceutical and laboratory services. This represents about 10% of our total budget. A key issue for the future is how to manage the burgeoning pharmaceutical and laboratory costs in this district to ensure services are managed and delivered in the most cost-efficient manner.

A key objective in establishing Primary Health Organisations (PHOs) was to improve access for high-need populations, in particular to primary care through low-cost services and additional services to improve access funding. The Te Tairawhiti population is now fully covered by low-cost PHOs, although the extent of uptake by high-need populations has been variable. The key challenges for the primary health care sector in the future will concern increasing access to care for at-risk people, workforce shortages (particularly general practitioners and practice nurses), changing models of care, and delivering on population health outcomes.

### What we plan to do

To reduce our very high rates of ambulatory sensitive hospitalisations and improve our approach to preventing people from developing chronic diseases we propose:

- Low-cost access to a family doctor or nurse continues and is enhanced.
- Continuing to support additional services and funding in areas that target improving access of high-need populations and better prevention and management of our top four health priorities (cancer, heart disease, diabetes, mental illness).
- Working with PHOs to develop workforce plans and innovative modes of care.
- Supporting PHOs in the development of information systems that will support better clinical decision-making at a practice level and integration of information systems with secondary care.
- Supporting the development of multi-disciplinary teams in general and pharmacist services in primary care in particular.
- Supporting improved management of pharmaceutical and laboratory spending.
- Ensuring the funding of pharmaceutical and laboratory services is cost efficient and supports quality improvement and integration.
- Improve diabetes and heart disease management through PHOs for Maori and Pacific peoples, particularly with respect to enrolment in 'Get Checked' programme and statin prescribing.
- Extension of prescribing rights to other practitioners including optometrists.
- Measure Primary Health improvements.

### We will have been successful if by 2010 we can see

- Pharmaceutical and laboratory growth continued with 2% growth per annum.
- Improved uptake by Maori and Pacific peoples of Services to Improve Access, 'Get Checked' programmes, and other disease management programmes.
- Pharmacists and other health professionals involved in the delivery services in the primary care setting.
- PHO utilisation data shows an increase in utilisation by Maori, Pacific and children in high deprivation areas.
- 80% of patients with heart disease, stroke and diabetes will be managed through agreed clinical pathways, including electronic care management.
- 5% reduction in ambulatory sensitive hospitalisations for all age groups.

## 2. Population Health

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

- General socio-economic and environmental conditions
- Social and community influences
- Living and working conditions
- Individual lifestyle factors
- Age, sex, and hereditary factors
- Gender and culture

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. Many of these determinants of health lie outside the health sector. Gains in health status will only, therefore, be achieved through the co-ordinated action of policy makers and service providers in many sectors. A population health approach also takes into consideration the environment in which we live. This includes both physical and social environments. Social environments include the people and the context in which people operate. This could include whanau, schools, churches, choirs, sports teams and clubs, and a range of other environments.

Promoting healthy communities is also about enabling people to increase control over their own health. Particular areas for focus are improved nutrition, reduced obesity, increased physical activity, reduced smoking, and ensuring the safety and well-being of our children. If the community does not slow or reverse the child and obesity epidemic currently taking place, or make gains in reducing smoking uptake by young people, most of our health delivery will be in vain.

## What we plan to do

Many of the health issues facing Te Tairawhiti can be tackled by effective population health approaches. Indeed, a recurring theme throughout this plan is around prevention through population health approaches. Collaboration between TDH and PHOs, public health providers, Maori providers, local government, and Government departments will ensure we can influence the wider determinants of health.

TDH intends to put a significant focus of its new investments and activity in supporting healthy communities. That will involve:

- Facilitate key relationships across sectors and organisations, and implement inter-collaborative initiatives aimed at population health improvements.
- Ensure more children and adults are making consistently healthy food choices and being active more often.
- Implement a number of initiatives aimed at reducing the reliance of tobacco smoking and exposure to secondhand smoke.
- Work with primary health sector to build on the population health approaches.
- Support families and communities to provide environments that ensure the health, safety and wellbeing of our children and young people.

## We will have been successful if by 2010 we can see

- A 5% decrease in adult obesity rates.
- An improvement in the rate of physical activity and nutrition amongst children
- A 5% reduction in the rate of young people who smoke daily and monthly, and a 5% increase in the number of young people who have never smoked.
- A 5% decrease in the rate of population preventable hospitalisations.
- 100% of schools and health providers are smokefree.

- A 20% increase in the uptake of breast screening and cervical screening amongst Maori and Pacific women.

# 3. Child Health

## What is the situation?

Significant health inequalities exist amongst our children, with Maori, Pacific and children from lower socio-economic families experiencing relatively poor health. Nationally we are in the midst of a childhood obesity epidemic, which is set to increase significantly over the next 10 years unless urgent action is taken now.

Te Tairawhiti's children have some of the poorest health outcomes nationally, with one of the highest asthma rates, accidental injury rates, pneumonia rates, ambulatory sensitive hospitalisation rates and population preventable hospitalisation rates in the country. Our Maori children in particular suffer disproportionately more from these health issues than non-Maori children. Our children also have one of the highest rates of tooth decay nationally.

On the positive side, Te Tairawhiti boasts some of the highest immunisation rates nationally – particularly when taking into account our high Maori rates – thereby demonstrating that collective action and focus can make a difference to the lives of children and their families.

There is considerable potential to improve health and reduce inequalities by investing in maternal and child health. Health promotion and disease prevention initiatives aimed at keeping children healthy now and as they grow, and working across sectors to include factors outside of health, are key to making a positive difference.

## What we plan to do

- Increase physical activity and improve nutrition with an emphasis on identified high-need populations, particularly childhood and whanau nutrition with activity initiatives in schools and communities.
- Place a greater focus on health promotion, prevention and early intervention, where services are focused on building on the strengths of families, whanau, hapu, iwi and communities to facilitate health-promoting environments aimed at keeping children well and maximising potential.
- Develop Schools Accord to ensure children are fit, healthy and ready to learn.
- Support whanauora and Well Child providers to deliver accessible, timely services of high quality to our children and their whanau.
- Ensure continued low cost access to primary care for children.
- Implement the national immunization register and advocate that its use be extended to recording well child and oral health visits.
- Continue to support smokefree initiatives.
- Improve oral health education in schools, pre-schools and amongst well child providers.

- Continue to support inter-collaborative mechanisms such as Strengthening Families and Family Start.
- Support strategies to increase breastfeeding rates.
- Ensure DHB-wide implementation of family violence policies and protocols across all health providers.
- Continue to support and advocate for innovative inter-sectoral initiatives which can have direct impacts on the health of our families/whanau (e.g. housing retrofitting, etc).
- Build sector capability to deliver high quality services.

### We will have been successful if by 2010 we can see

- Childhood immunisation rates remaining high, with 90% of all children in Te Tairawhiti receiving all scheduled immunisations.
- An improvement in the rate of physical activity and nutrition amongst children
- Improved six-week and three-month breastfeeding rates by 10%.
- All children receiving their full entitlements of Well Child/Tamariki Ora services.
- A 5% reduction in child ambulatory sensitive admissions.
- A 5% reduction in population health sensitive admissions.
- A 5% reduction in the childhood asthma admission rate.
- A 5% improvement in the 5- and 12-year caries-free rate.
- A 5% decrease in the childhood rate on injuries and poisonings.

## 4. Youth Health

The majority of young people are healthy most of the time. Generally, this age group is at the peak of physical health. But the years between 12 and 24 are also the years when the chances of being caught up in risk-taking behavior are high and where the negative consequences can be life-long. While most young people appear to deal successfully with the developmental changes that occur during this period, there is evidence that many do not.

Compared with other age groups, young people have:

- Higher rates of mental illness.
- Higher rates of alcohol and drug use and abuse, particularly among young men (with approximately 79% of 14-to-17-year-olds noting they drink alcohol regularly; around 23% of deaths in the 15-to-24-year age group attributable to alcohol; and around 10% of young people dependent on cannabis by the age of 21).
- A higher rate of suicide and suicide attempts.
- Higher rates of sexually transmitted infections.
- Higher rates of smoking.

Morbidity and mortality data show also that young New Zealanders have higher rates of suicide, teenage pregnancy, abortion and injuries – especially from traffic accidents

– than their counterparts in other OECD countries. In Te Tairawhiti, our young people experience some of the worst health status nationally, including the highest number of smokers nationally, a high teenage pregnancy rate, and high rates of sexually transmitted diseases.

The literature on youth health clearly shows that improving young people's health requires us to allow young people the following:

- a sense of contributing something of value to society.
- a feeling of connectedness to others and society.
- a belief that they have choices about their future.
- a feeling of being positive and comfortable with their own identity.

Improving youth health is therefore an individual, whanau, hapu, iwi and community responsibility to ensure young people are nurtured with the correct protective factors.

## What we plan to do

Te Tairawhiti can support young people to develop the skills and attitudes they need to assume a positive role in society, both now and in the future. This will involve:

- Work with providers, Maori and wider communities to ensure young people have positive connections with many social environments, including family and whanau, peers, community, school, training, tertiary education and work, and promoting these connections.
- Increase access to youth-targeted primary care.
- Ensure continued low-cost access through primary care.
- Increase appropriate smoking cessation and prevention programmes aimed at young people.
- Increase availability, access and appropriateness of sexual and reproductive health services.
- Improve access to appropriate alcohol and drug prevention programmes in schools and communities.
- Improve uptake and access to free dental care for adolescents under 18 year of age.
- Work intersectorally to reduce availability of illegal substances

## We will have been successful if by 2010 we can see

- Improved access points for young people in primary care.
- A 5% reduction in the youth/teenage pregnancy rate.
- A 5% reduction in the Chlamydia infection rate.
- A 5% reduction in the rate of young people who smoke daily and monthly, and a 5% increase in the number of young people who have never smoked.
- Higher access rates to drug and alcohol prevention services.
- An increase in the adolescent oral health enrolment rate.
- 5% decrease in our suicide rate.

# 5. Older People's Health

## What is the situation?

Our population is becoming increasingly older. An ageing population places more demands on health and disability support services as older people represent the highest users of these services. In 2002, about 39% of health expenditure was for the 12% of the population aged 65 years and over. By 2021, nearly 18% of the population will be over 65 years of age and will consume 50% of the health expenditure.

At the same time, older people are healthier and living longer than previously. Most older people prefer to remain in their home and entry into residential care is occurring at a later age and for shorter periods than previously. There is also a growing diversity in the older population, with more Maori and Pacific peoples reaching the older age groups, and this will only continue over time. Accompanying these trends will be the need to develop programmes and services that allow 'ageing in the home', and culturally appropriate services that are responsive to the cultural, social and spiritual needs of older Maori.

Combating issues of loneliness and social isolation are critical factors in supporting our older people to live fulfilling independent lives as they age.

## What we plan to do

- Support collaborative approaches with other agencies aimed at keeping older people physically active.
- Support older people to stay independent for longer by supporting the development of innovative approaches to 'ageing in place'.
- Improve information for older people and their families/whanau so they are able to make well-informed choices regarding the range of services through single point of entry.
- Support the development of services to meet the needs of older Maori and their families.
- Support the development of a workforce which meets the needs of older people and include a focus on home-based rehabilitation and support.
- Improve the quality and safety of older persons' services.
- Ensure continued low cost access to primary care for older persons.
- Ensure admissions to hospital services are integrated with any community-based care and support that an older person requires.
- Ensure older people with high and complex health and disability support needs will have access to flexible, timely and co-ordinated services and living options that take account of family and whanau carer needs.

## We will have been successful if by 2010 we can see

- All aged care sector providers meet certification and the Health and Disability Sector Safety Standards.
- The aged care sector workforce is fully trained.
- The existence of a range of options supporting older persons to live independently in their own homes.
- An integrated continuum of care of older persons services is implemented.
- A single point of entry service is established.
- A range of services exist for those older persons with high and complex health and disability support needs.
- A 5% reduction in the rate of ambulatory sensitive admissions for older people.
- A 10% increase in the proportion of funding for services for older people in the community as opposed to residential care.

# 6. Elective Services

## What is the situation?

The elective services policy requires that people seeking elective services will have clarity and certainty as to if and/or when they will receive them. The policy also seeks to ensure that patients with the greatest need and ability benefit are seen first, with no one who meets criteria waiting longer than six months for assessment and treatment.

## What we plan to do

- Aim to ensure that 95% of people who meet access criteria receive their first specialist assessment within six months of referral.
- Aim to ensure that 95% of people who are assessed as requiring treatment are treated within six months.
- Improve the relationships and interactions between primary and secondary care.
- Support the development of innovative solutions and programmes in primary and community care aimed at meeting booking system requirements.

## We will have been successful if by 2010 we can see

- All patients requiring elective services and who meet the entry criteria have timely access to such services with no one waiting longer than six months for an assessment or treatment.

# 7. Pacific Health

## What is the situation?

Te Tairawhiti has seen a doubling of its Pacific people's population in less than five years. Currently there are more than 1000 Pacific people, representing many different cultures with as many differences as similarities.

Pacific people experience significant health inequalities compared with non-Pacific. While overall health has improved over the past 20 years, Pacific people's mortality and morbidity rates continue to be significantly higher than non-Pacific. The top seven modifiable causes of life years lost to premature death or disability for Pacific people are:

- Diabetes
- Ischaemic Heart Disease
- Chronic Obstructive respiratory disease
- Stroke
- Lung Cancer
- Breast Cancer
- Depression

Many of the health problems facing Pacific peoples are related to their low socio-economic status and lifestyle factors (particularly diet and exercise). There is also evidence of poor access by Pacific people to early primary care and mental health services, thus further compounding health outcomes. For instance, Pacific women have an uptake of cervical and breast screening that is one-third lower than the general population. This is likely to account for their significantly higher mortality rates of breast and cervical cancers than the general population.

## What we plan to do

While the Pacific population is comparatively small in Te Tairawhiti compared to other districts nationally, TDH has a role in reducing the significant health inequalities amongst Pacific peoples. To achieve this we will:

- Develop cultural competencies for the non-pacific community workforce to improves access and reduce barriers.
- Ensure mainstream services support the development of the Pacific Health workforce.
- Ensure primary and community-based providers have a clear focus on improving Pacific Health outcomes.
- Improve Pacific people's access to preventative, primary and mental health services.
- Develop a strategic partnership with the Pacific community to ensure it is regularly involved in health planning, service development and implementation.
- Improve the uptake of national screening programmes for Pacific women (breast screening and cervical screening).

## We will have been successful if by 2010 we can see

- A 20% increase in the uptake of breast screening and cervical screening amongst Pacific women.
- An improvement in the rate of physical activity and nutrition amongst Pacific children.
- All health providers have implemented cultural awareness programmes related to Pacific people.
- Pacific people are involved in the development and implementation of health services for their communities.
- PHO Utilisation data shows an uptake in the utilisation by Pacific people.
- 80% of all eligible Pacific people are enrolled in the 'Get Checked' programme.

# 8. Rural Health

## What is the situation?

Te Tairawhiti is unique when taking into account its geographic considerations. Its relative isolation from the rest of New Zealand means that travel to other centres for tertiary care is not easy. Low population density in its rural areas means that any health care set in such areas tends to be at a distance from most people. Travel times are high and communities small, often too small to sustain any form of locally-based health and disability services. Timely access is therefore a challenge, but one which TDH approaches with resolve and absolute determination.

While the health of rural people in New Zealand overall compares favorably with that of urban people, the health of many rural Maori is poor when compared with urban Maori. The health of rural Maori is also poorer than their non-Maori counterparts. For Te Tairawhiti, with its significant rural population (and in particular Maori on the East Coast), there are considerable levels of variation in the services available to rural residents. This is particularly so in terms of accessibility of general practitioners, nurses, midwives, and other primary and mental health community-based providers. Another factor with rurality is the viability of many of the services available for people living in remote areas and the on-going difficulties in recruiting and retaining health care providers. There is also the issue of distances from secondary care and specialist services for many of our residents.

Research consistently shows that people living in rural areas have the following three concerns when it comes to health service delivery:

- Dependability – people need to know services will be available for them.
- Responsiveness to need – rural people need to know that services will be responsive to their needs, no matter how isolated they are.
- Appropriateness – while there is often acceptance from rural people that they will need to travel for health services, services must be appropriate for that population and include the range of screening services, for instance, that exist for urban people.

## What we plan to do

TDH is committed to ensuring that people living in rural areas have equitable access to quality health services. We will do this in the following manner:

- Continue to support Maori health providers in rural and remote areas to meet the needs of the rural Maori population.
- Strengthen rural community-based health services to meet the increased need for community-based care.
- As part of the Clinical Services Plan, identify future models of care and service delivery (including location of services) to ensure future rural health needs are met in a sustainable and cost efficient manner.

## We will have been successful if by 2010 we can see

- A sufficient number of primary care team members (general practitioners and nurses) in rural Te Tairawhiti.
- People discharged to rural communities with appropriate support.
- Rural people able to access services at an appropriate time.
- Improved access to rural screening services.

# Funding Services in the Future – How will we decide?

The health sector operates in a continually changing environment. Health care costs will continue to rise in the future, particularly with the ageing population and the projected growing burden of disease. At the same time, TDH will be tasked with making decisions about the types and mix of services to fund to meet that need – but always within the funding it receives from the Government. Prioritisation provides an opportunity to allocate or reallocate funding, on the basis of evidence, to services that are more effective in improving health and reducing inequalities.

When making decisions about which services will be funded in the future, TDH will consider the following decision-making principles:

## Effectiveness

Publicly-funded health and disability services should be effective. Effective services are those that produce more of the outcomes we desire, such as reductions in pain, the maintenance of daily activities, greater independence, and the prevention of premature death. Services that are shown to be more effective than others should be given higher priority.

## Value for money

Publicly-funded health and disability services should be cost effective. Services that deliver the larger gains in health outcomes and equity should be given higher priority.

## Equity

Publicly-funded health and disability services should reduce significant health inequalities by improving access, affordability and capacity to benefit. Services that reduce disparities in health status between different groups should be given higher priority.

## Whanauora

Publicly-funded health and disability services should take consideration of whanauora. Whanauora means considering effectiveness, value for money and equity for Maori from a Maori perspective. It also recognizes that prioritization processes should enable Maori to participate in and contribute to strategies for Maori Health improvement and foster the development of Maori capacity to participate in the health and disability sector. Services that incorporate the principles of whanauora should be given a higher priority.

## Acceptability

Publicly-funded health and disability services should be acceptable to the community. Services that have been consulted on and are compatible with local and national strategies (for instance, the New Zealand Health and Disability Strategy) should be given higher priority.

# Financial Management

## Capital Expenditure

The expected levels of capital expenditure for the five years are outlined in the table below.

| Year | $ millions |
|---|---|
| 2005/06 | 2.79 |
| 2006/07 | 2.77 |
| 2007/08 | 2.87 |
| 2008/09 | 4.06 |
| 2009/10 | 2.86 |

"Base line capital replacement" accounts for approximately $2.75 M per year. There are currently a number of potential projects under development. One of these has been reflected in the financial statements at its estimated cost in year 2008/09. No business cases have yet been developed and there is a high degree of uncertainty as to whether any will proceed and, if they do, where the funding will be derived from.

## Long Term Management of Assets

The asset strategies adopted by TDH are set out in the Asset Management Plan, which was initially developed in 2004 and is currently being updated. The update is due for completion by the end of October 2005, and will be reviewed by Board's Audit Committee in November. The strategies incorporated into the Plan include consideration of the level of service that the various assets are able to support, lifecycle management plans for longer term assets, and a rigorous assessment process to ensure a sound financial and, where appropriate, clinical decision is made for all capital purchases.

TDH will apply a "maintenance and enhancement" approach that should not see the need for any major capital development over the term of the District Strategic Plan. This links well with the perceived lack of operating surplus, which will constrain TDH's ability to provision effectively for the eventual replacement of the infrastructural assets.

The prioritisation of capital requirements allows for:

- planned capital expenditure on essential equipment replacement;
- allowance for urgent equipment replacements following breakdowns where it is uneconomic to effect repairs;
- allowance for furniture and fitting replacement as and when required;
- allowance for information technology purchasing based on the information services strategic plan (ISSP);
- capital expenditure on existing facilities only where it is necessary;
- capital expenditure on new facilities only where there is a robust business case which confirms the ability to manage any additional capital and operating costs,

and identifies the proposed source of capital funding, if it is outside the base line capex envelope.

## Consolidated Statement of Financial Performance

The prospective Financial Statements are presented at the end of this section.

## Assumptions

1. Year One has been extrapolated from the first quarter results of the 2005/06 year. Years Two through Five have been projected on the assumption of a 2% increase in revenue and based on relatively stable population size and demographic, with additional funding being made available in years four and five. Costs are projected at a 3% increase in costs in years two and three, reducing to 2% in years four and five.
2. Financial forecasts have been prepared in real dollar terms.
3. The potential impact of any changes to PBFF allocations and/or adjusters has been disregarded for planning purposes.
4. In the longer term, demand-driven expenditure will be managed by further developing symbiotic relationships with Te Tairawhiti Primary Health Organisations and utilising conserved resource targets to encourage heightened consideration in clinical decision-making of the desirability of constraining demand-driven expenditure within budget parameters.
5. There may be new investments made by or through the Ministry of Health relating to Personal Health, Mental Health, Older People's and/or Maori Health services, which have not been included in the projections.
6. Funding for Older People's services will be managed within budget parameters through the development of budget management within the needs assessment and services co-ordination agency.
7. Funding responsibilities for younger persons' disability support services and for Public Health (apart from the residual Meningococcal Virus project) will not be devolved in the period through to 1 July 2010.
8. It is assumed that funding will keep pace with the health care and disability support service requirements of the resident population, with an allowance for general cost inflation.
9. The 2005-06 rate of 8% has been used to calculate Capital Charge.
10. No allowance has been made for the potential impacts of further FRS-3 Revaluations on Asset values, Capital Charge, Depreciation or capital provisioning.
11. No allowance has been made for any potential reduction in funding resulting from TDH being categorised as an "over funded" DHB under the PBFF formula calculation, as the current base calculation and pricing and adjuster framework is under continuous review, and TDH is far from certain that any reduction will actually and eventually be effected.
12. TDH will receive Equity support from Government through to the end of fiscal 2007/08, after which the PBFF model will be re-run with revised "adjusters" to provide TDH with ongoing funding appropriate to the required levels of service.

13. No allowance has been made in the financial projections for any potential accounting impact of the adoption of International Financial Reporting Standards (IFRSs), which will apply with effect for the 2007/08 fiscal year onwards.
14. Any additional funding will be targeted towards prevention, promotion, education and early intervention activities, as outlined previously in the Plan, except for funding targeted to specifically address any agreed under-pricing issues.
15. Unless funding is increased significantly, TDH will have little ability over the term of the Plan to augment new primary care funding with resources re-allocated or integrated from secondary care.

## Tairawhiti District Health
## District Strategic Plan 2005-10
## Prospective Summary Financial Statements

**CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE**

| | 2005/06 Projected $000 | 2006/07 Projected $000 | 2007/08 Projected $000 | 2008/09 Projected $000 | 2009/10 Projected $000 |
|---|---|---|---|---|---|
| **Funds function:** | | | | | |
| Total Revenue | (97,189) | (99,745) | (101,740) | (104,775) | (107,871) |
| Total Expenditure | 98,603 | 101,196 | 102,914 | 105,472 | 108,082 |
| Net Result from operations | 1,414 | 1,451 | 1,174 | 697 | 211 |
| **Governance and Funds Admin:** | | | | | |
| Total Revenue | (1,441) | (1,482) | (1,512) | (1,542) | (1,573) |
| Total Expenditure | 1,444 | 1,477 | 1,506 | 1,536 | 1,567 |
| Net Result from operations | 3 | (5) | (6) | (6) | (6) |
| **DHB Provider function:** | | | | | |
| Total Revenue | (57,803) | (58,410) | (59,579) | (61,270) | (62,995) |
| Total Expenditure | 59,050 | 60,558 | 62,316 | 63,562 | 64,833 |
| Net Result from operations | 1,247 | 2,148 | 2,737 | 2,291 | 1,838 |
| | | | | | |
| **DHB Consolidated:** | | | | | |
| Total Revenue | (105,323) | (108,054) | (110,216) | (113,420) | (116,688) |
| Total Expenditure | 107,987 | 111,648 | 114,121 | 116,403 | 118,731 |
| **Net Result from operations** | **2,664** | **3,594** | **3,905** | **2,983** | **2,044** |
| | | | | | |
| **Supplementary Information:** | | | | | |
| Capital Charge | -1,589 | -1,579 | -1,559 | -1,564 | -1,563 |
| Depreciation | 3,047 | 3,062 | 3,062 | 3,202 | 3,266 |
| Interest on Term Debt | 975 | 968 | 968 | 985 | 1,027 |
| (Gain)/Loss on disposals | 0 | 0 | 0 | 0 | 0 |

## CONSOLIDATED STATEMENT OF MOVEMENTS IN EQUITY

| | 2005/06 Projected $000 | 2006/07 Projected $000 | 2007/08 Projected $000 | 2008/09 Projected $000 | 2009/10 Projected $000 |
|---|---|---|---|---|---|
| Shareholders interest at start of period | (19,698) | (20,034) | (19,441) | (19,536) | (19,553) |
| Surplus/(Deficit) for the period | 2,664 | 3,594 | 3,905 | 2,983 | 2,044 |
| Contributions from shareholders/Crown | (3,000) | (3,000) | (4,000) | (3,000) | (2,000) |
| Distributions to shareholders/Crown | 0 | 0 | 0 | 0 | 0 |
| Movements in Trust & special funds | 0 | 0 | 0 | 0 | 0 |
| **Shareholders interest at end of period** | **(20,034)** | **(19,441)** | **(19,536)** | **(19,553)** | **(19,510)** |

## CONSOLIDATED STATEMENT OF FINANCIAL POSITION

| | 2005/06 Projected $000 | 2006/07 Projected $000 | 2007/08 Projected $000 | 2008/09 Projected $000 | 2009/10 Projected $000 |
|---|---|---|---|---|---|
| Current Assets | 9,360 | 9,262 | 9,557 | 10,018 | 11,556 |
| Current Liabilities | (11,608) | (12,014) | (12,225) | (12,500) | (12,750) |
| Working Capital | (2,248) | (2,752) | (2,668) | (2,482) | (1,194) |
| | | | | | |
| Non-current Assets | 36,873 | 36,561 | 36,448 | 37,446 | 37,180 |
| **NET ASSETS** | **34,625** | **33,809** | **33,780** | **34,964** | **35,986** |
| | | | | | |
| Non-current Liabilities | (14,591) | (14,368) | (14,244) | (15,411) | (15,476) |
| Crown Equity | (20,034) | (19,441) | (19,536) | (19,553) | (19,510) |
| **NET FUNDS EMPLOYED** | **(34,625)** | **(33,809)** | **(33,780)** | **(34,964)** | **(34,986)** |

## CONSOLIDATED STATEMENT OF CASH FLOWS

| | 2005/06 Projected $000 | 2006/07 Projected $000 | 2007/08 Projected $000 | 2008/09 Projected $000 | 2009/10 Projected $000 |
|---|---|---|---|---|---|
| Net Cash flow from Operating activities | 383 | (532) | (843) | 219 | 1,222 |
| Net Cash flow from Investment activities | (2,752) | (2,950) | (3,050) | (4,484) | (3,150) |
| Net Cash flow from Financing activities | 2,785 | 2,766 | 2,866 | 4,063 | 2,860 |
| Net increase in cash | 416 | (716) | (1,027) | (202) | 932 |
| Opening cash balance | 149 | 565 | (150) | (1,177) | (1,379) |
| **CLOSING CASH BALANCE** | **565** | **(150)** | **(1,177)** | **(1,379)** | **(446)** |

## DHB PROVIDER STATEMENT OF FINANCIAL PERFORMANCE

| | 2005/06 Projected $000 | 2006/07 Projected $000 | 2007/08 Projected $000 | 2008/09 Projected $000 | 2009/10 Projected $000 |
|---|---|---|---|---|---|
| **REVENUE:** | | | | | |
| External | (6,682) | (6,816) | (6,952) | (7,091) | (7,232) |
| Internal Funding (ISLA - DHB Funds to DHB Provider) | (51,110) | (51,583) | (52,615) | (54,167) | (55,751) |
| Inter-DHB Provider | (11) | (11) | (12) | (12) | (12) |
| Total Revenue | (57,803) | (58,410) | (59,579) | (61,270) | (62,995) |
| **EXPENSES:** | | | | | |
| Personnel Costs Total | 36,104 | 36,809 | 37,854 | 38,611 | 39,383 |
| Outsourced Services Total | 3,086 | 3,194 | 3,290 | 3,356 | 3,423 |
| Clinical Supplies Total | 8,805 | 9,113 | 9,387 | 9,574 | 9,766 |
| Infrastructure and Non-Clinical Supplies | 11,055 | 11,442 | 11,785 | 12,021 | 12,261 |
| Total Expenses | 59,050 | 60,558 | 62,316 | 63,562 | 64,833 |
| **Net Result from operations** | **1,247** | **2,148** | **2,737** | **2,291** | **1,838** |

**Financial performance targets:**

| | 2005/06 Planned $000 | 2006/07 Planned $000 | 2007/08 Planned $000 | 2008/09 Planned $000 | 2009/10 Planned $000 |
|---|---|---|---|---|---|
| Net Result from operations | >0 | >0 | >0 | >0 | >0 |
| Ratio of debt to debt plus equity | <45% | <45% | <45% | <45% | <45% |
| Debt service cover | >3.0 | >3.0 | >3.0 | >3.0 | >3.0 |