



Taranaki District Health Board Health Needs Assessment 2007

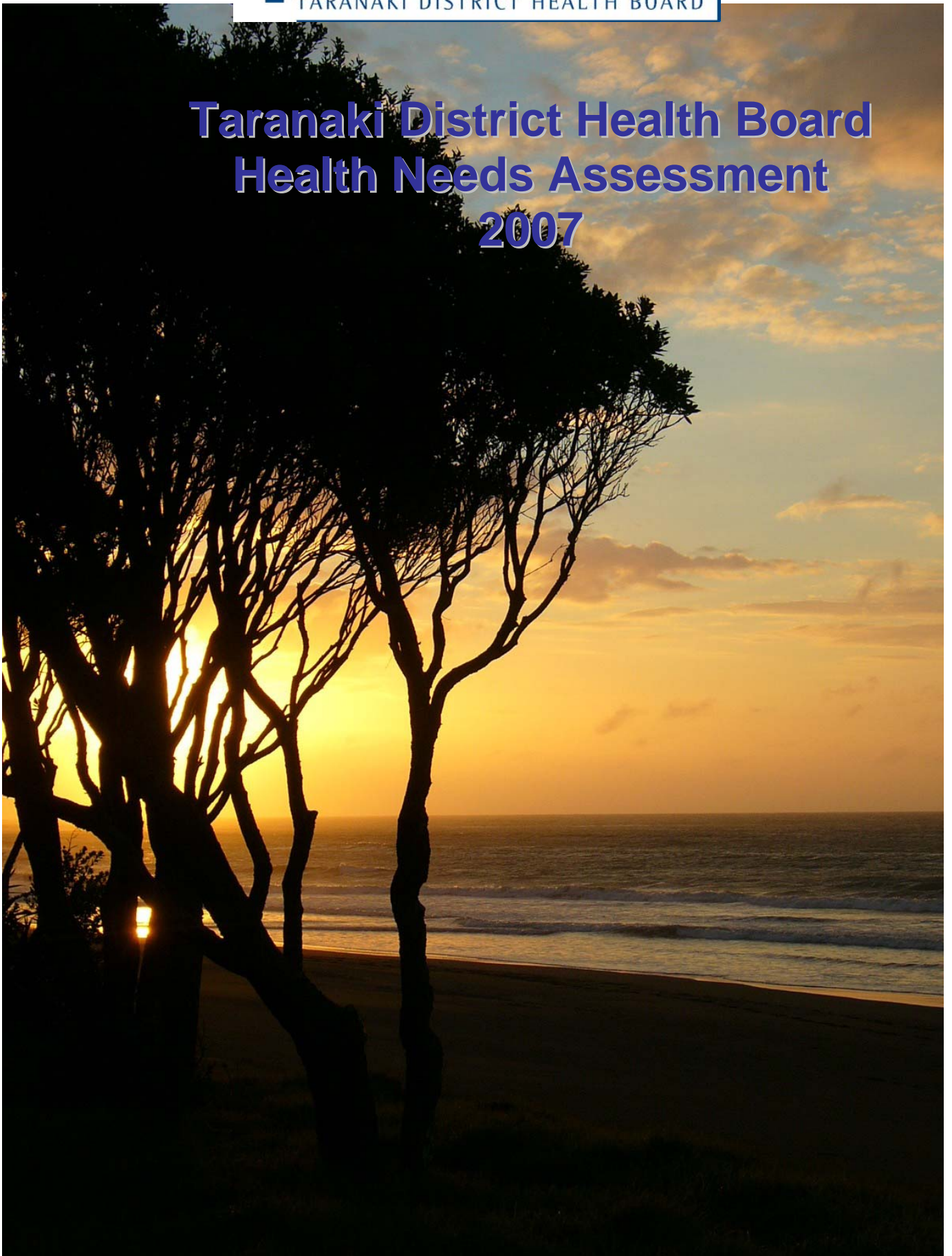


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This report is based on information produced regularly for Taranaki DHB by the Public Health Intelligence unit of the Ministry of Health. Dr Mazin Ghafel of Auckland DHB and Abbas Almurrani provided a significant amount of information for Taranaki following the format of the ADHB Health Needs Analysis (available on the internet).

All these people are thanked for their contribution.

Executive Summary

As a province our health needs are comparable to similar population groups within New Zealand and New Zealanders overall. Significant differences for Taranaki District Health Board's priority areas and common risk and protective factors are described in this report.

Readers will note that most information is several years old and that long time trends are not presented. This report mostly uses the most recent available and validated data from national systems and surveys, and this takes some time to be available. This means that, though we are reporting on priority areas, we are not able to show up-to-date progress; and neither would we expect current efforts to yet show in most health outcome statistics where the lag time between services and benefit may be long. For instance cardiovascular risk screening and intervention in Primary Care will be working now to prevent conditions that may not have occurred for decades. Trends in particular conditions for previous time periods are shown in earlier Taranaki DHB Health Needs Assessment reports.

In addition to the existing TDHB priorities, this report does provide evidence that breast cancer (particularly in Maori women), sexually transmitted illnesses, melanoma, and hazardous drinking could also be considered priorities.

Introduction

This third Taranaki DHB Health Needs Assessment report presents demographic information and indicators for the priority areas in Taranaki DHB's District Strategic Plan (2005-2015) and District Annual Plan (2007/08). The indicators present information on the health outcomes, demographic characteristics, risk and protective factors and cancer screening service use of the population in the Taranaki DHB region. The report does not attempt to examine in detail any specific issue, or areas outside of the Taranaki DHB's stated priority areas. The information in this report is largely based on information produced regularly for Taranaki DHB by the Public Health Intelligence unit of the Ministry of Health. However, we have also reviewed overall mortality and morbidity information for Taranaki looking for significant issues not included in current strategic priorities¹.

Data sources

1. Statistics New Zealand

Demographic and socio-economic data are based on the 2001 Census population sourced from Statistics New Zealand. In the health indicators section, the denominators used are the interpolated Census population (line drawn from Census populations to achieve population estimates for the same year as the numerator year).

2. New Zealand Health Information Service (NZHIS)

Mortality and hospitalisation data were extracted from the relevant NZHIS datasets. Cancer registration data are sourced from the New Zealand Cancer Registry.

3. 2002/03 New Zealand Health Survey (2002/03 NZHS)

Prevalence of some diseases, and risk and protective factors were extracted from the 2002/03 NZHS. Data from the survey were collected over a 12 months period during 2002 and 2003.

4. Royal New Zealand Plunket Society

Exclusive and full breastfeeding rates are provided at 3 months and 6 months for 2004. Exclusive breastfeeding is defined as the infant has only had milk from the breast or expressed breast milk and prescribed medicines given from birth. Full breastfeeding is defined as the infant has taken breast milk only, and no other liquids or solids, except for a minimal amount of water or prescribed medicines in the past 48 hours.

5. National Screening Unit

Breast Screen Aotearoa:

Due to the limited age range for which breast screening is conducted, the breast screening coverage rate is age-specific rather than age-standardized rate. The rate is presented for women aged 50-64 years.

National Cervical Screening Programme:

The screening round is three years, and the time period for which data are presented is three years period. The rate is presented for women aged between 20 to 69 years.

¹ Using national data sources 1, 2, 9 from the list above and courtesy of Auckland DHB's Planning and Funding Unit

6. School Dental Services

Data presented from the School Dental Service for oral health indicators are for children at age five, for both fluoridated and non-fluoridated areas in 2003 and 2004. Data extracted from this source are thus denoted with 2003 and 2004 in this report.

7. Action on Smoking and Health (ASH)

Data on smoking prevalence for youth were obtained from the Action on Smoking and Health National Year 10 Smoking Survey 2005. The ASH survey is a sample of year 10 students aged 14-15 years.

8. Ethnicity

In the demographic section, ethnicity data are stratified by Maori, Pacific, Asian, and European/Other. The "European/Other" category includes European and other ethnicities not counted in the Maori, Pacific and Asian categories. In the health indicators section, data are stratified by Maori and non-Maori due to the small numbers in other ethnic groups, consequently the non-Maori category includes Europeans, Pacific people, Asian people and other ethnicities.

9. NZDep2001

NZDep2001 is small area deprivation index. NZDep2001 score is calculated from a collection of socio-economic indicators (ie. income, transport, living space, home ownership, employment, qualifications, support and access to a telephone), which measure the level of deprivation in the area in which a person lives. NZDep2001 scores are usually expressed as deciles (deciles 1 represents the least deprived, deciles 10 the most deprived).

Demographic Information

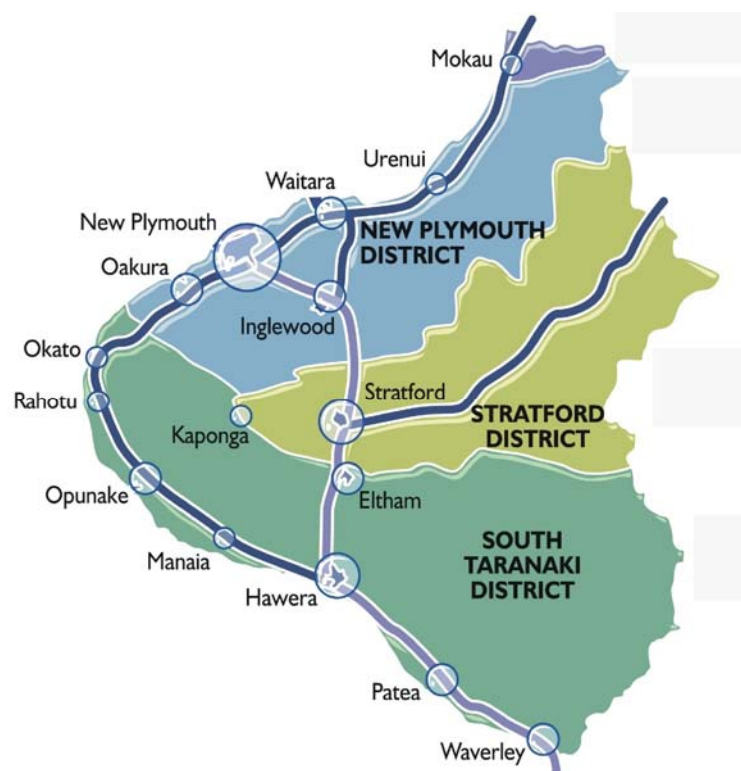
Who We Are

Taranaki District Health Board (DHB) is the Crown entity established under the New Zealand Public Health and Disability Act 2000.

Who We Serve

Taranaki DHB's area of responsibility covers 7,273 square kilometres on the mid west coast of the North Island and is distinguished by Mt. Taranaki in the centre of the region. Taranaki includes three territorial local authority districts; South Taranaki, Stratford, and New Plymouth. Taranaki DHB also provides services to the Mokau area of the Waikato region.

There are a few densely populated centres such as New Plymouth City in North Taranaki, Stratford in Central Taranaki, and Hawera in South Taranaki. The rest of the population is scattered in and around small rural centres.



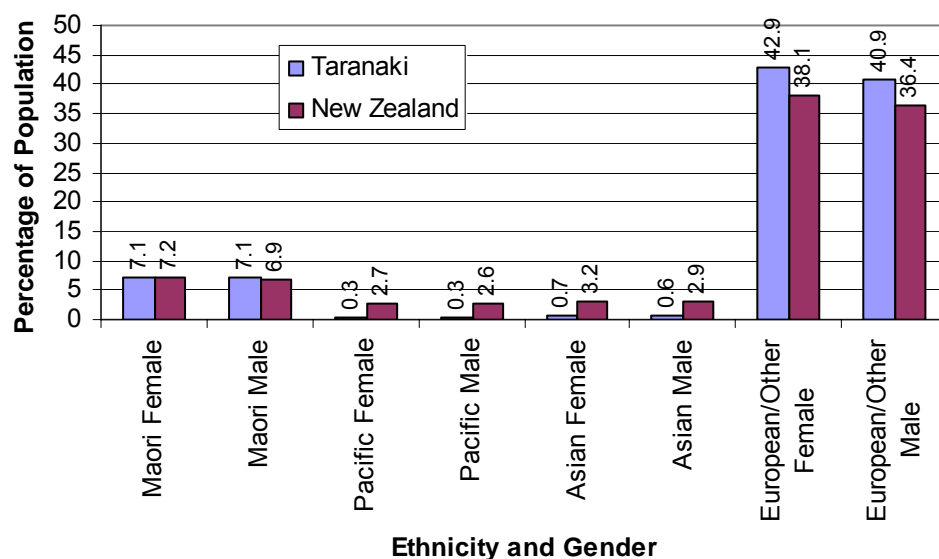
Diversity

An initial analysis of 2006 census figures indicate that 104,274 people live in the Taranaki DHB region, an increase of 1230 individuals (1.2%) when compared to the 2001 figures.

Compared to the New Zealand average, the Taranaki population has a much smaller population of Pacific (1.3%) and Asian people (2.1%) and a higher proportion of European (74.1%).

The population of Māori people living in Taranaki (15.2%) is similar to the rest of the country.

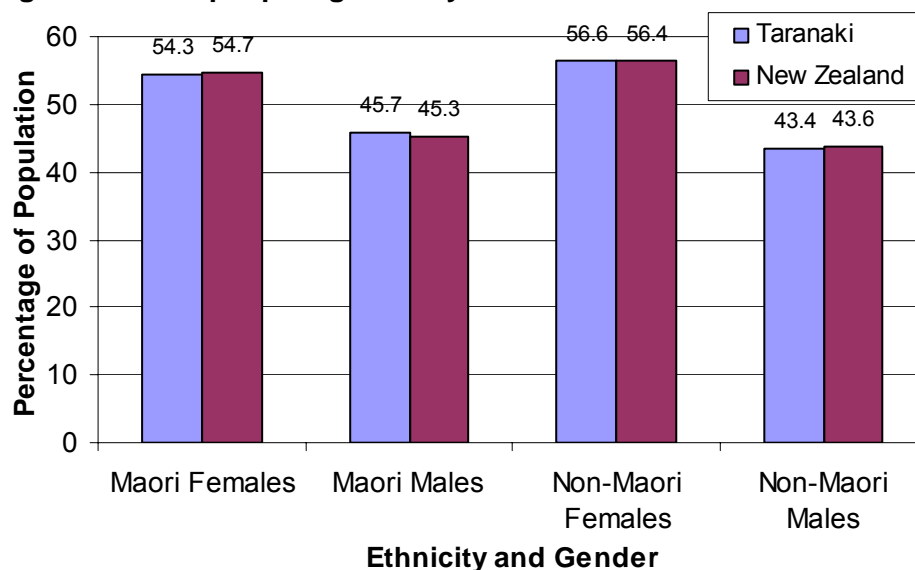
Figure 1: Gender & Ethnic Distribution in Taranaki and New Zealand, 2001



Source: Statistics New Zealand

According to the 2001 Census there are a total of 597 Māori and 14,052 non-Māori aged 65+ years in the Taranaki region. Similar to the New Zealand average, there are more females than males for both Māori and non-Māori.

Figure 2: Older people aged 65+ years in Taranaki and New Zealand, 2001

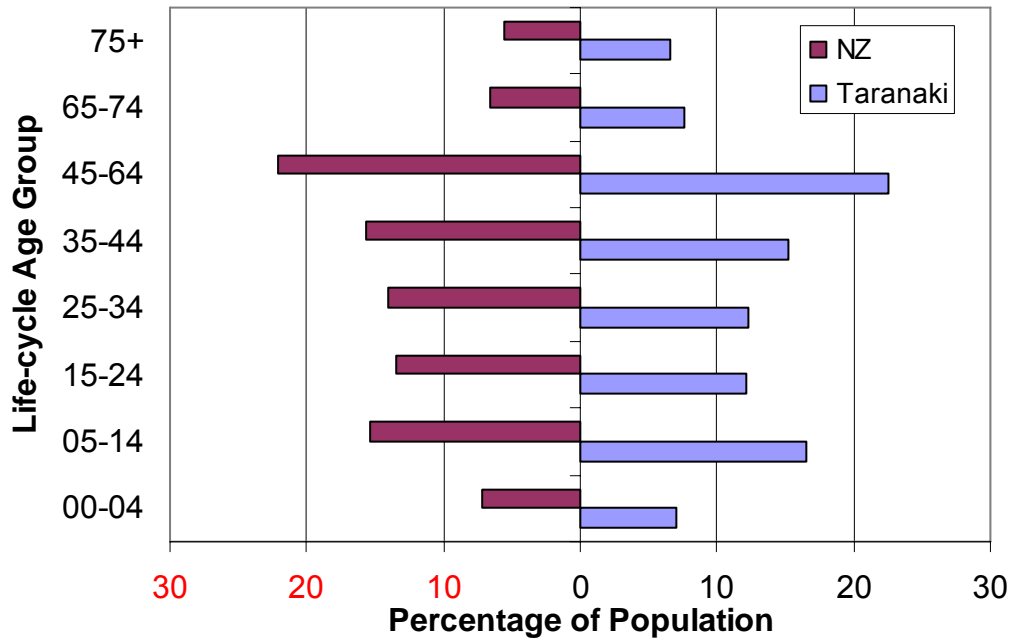


Source: Statistics New Zealand

Age Structure

2001 Data indicates that there are relatively lower proportions of Taranaki people in the 15 to 34 year age group (24.4%) compared to the New Zealand average (27.6%). However the proportion of people over the age of 65 years (14.2%) is greater than the national average (12.1%).

Figure 3: Life-cycle age distribution in Taranaki and New Zealand, 2001

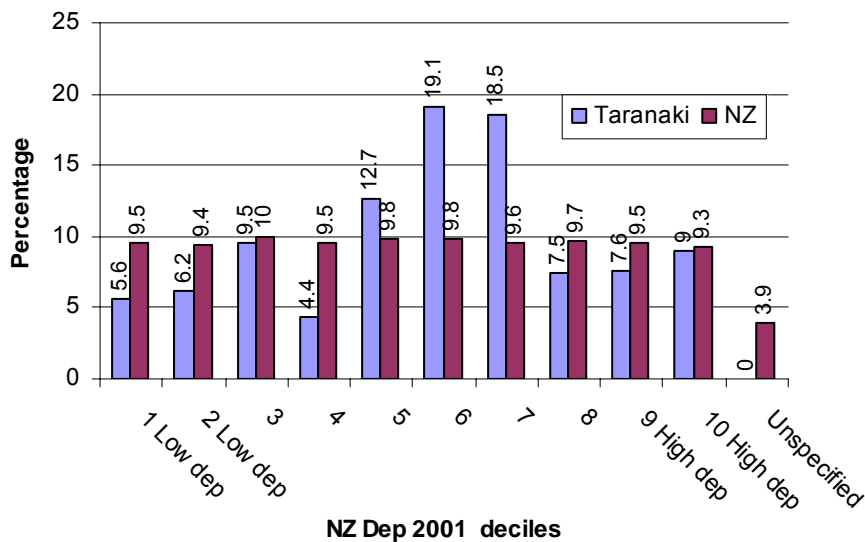


Source: Statistics New Zealand

Deprivation

Socioeconomic deprivation is measured according to NZDep2001. There is a smaller proportion of people in Taranaki who live in the most affluent and in the most socioeconomically deprived areas in comparison to New Zealand overall (Fig 4a). Although Taranaki has comparatively more people of middle level deprivation compared to New Zealand overall, proportionally Taranaki (62%) has more people in the high deprivation half of the population than New Zealand (50%).

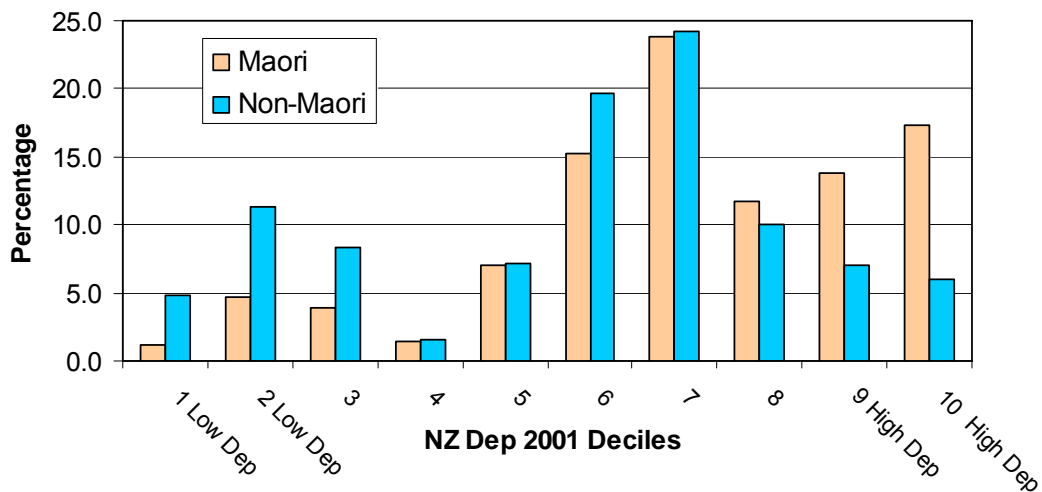
Figure 4a: Deprivation Distribution in Taranaki DHB and New Zealand, 2001



Source: Statistics New Zealand

Within Taranaki, a higher proportion of Maori live in the most socioeconomically deprived areas in comparison to non-Maori (Fig 4b), with the difference being most marked in the two most deprived deciles and three least deprived deciles.

Figure 4b: Deprivation Distribution in Taranaki DHB Maori and Non-Maori, 2001



Source: Ministry of Health NZDep2001 Population Distributions; Deprivation Profiles for District Health Boards.

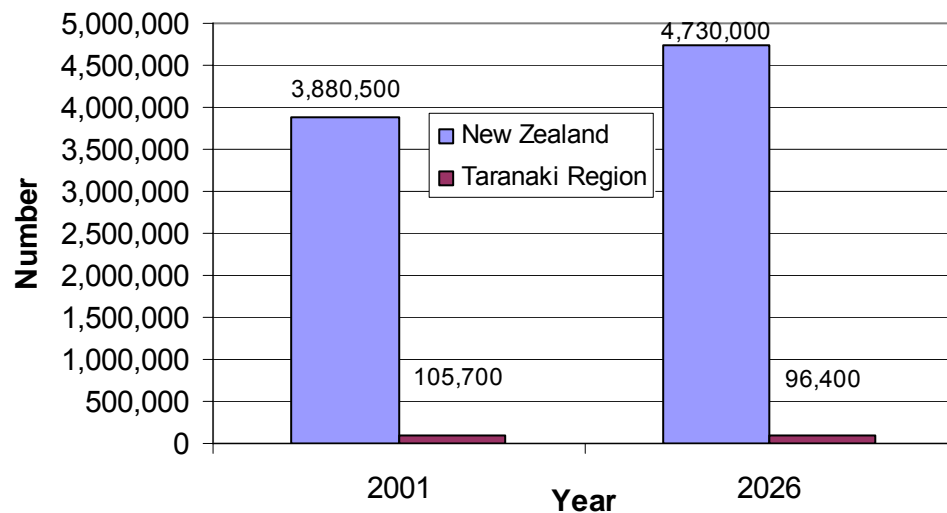
Projected Changes to our Population

The population of Taranaki is predicted to decrease slowly over the next five years and then more rapidly until 2021. By 2021, the Taranaki population is predicted to reduce by 8.4%. However the population of New Zealand is predicted to continue to grow and to increase by 17.2% over the same period.

Although the overall population is projected to decline, Maori and to a lesser extent Pacific people, are projected to increase (Fig 5b).

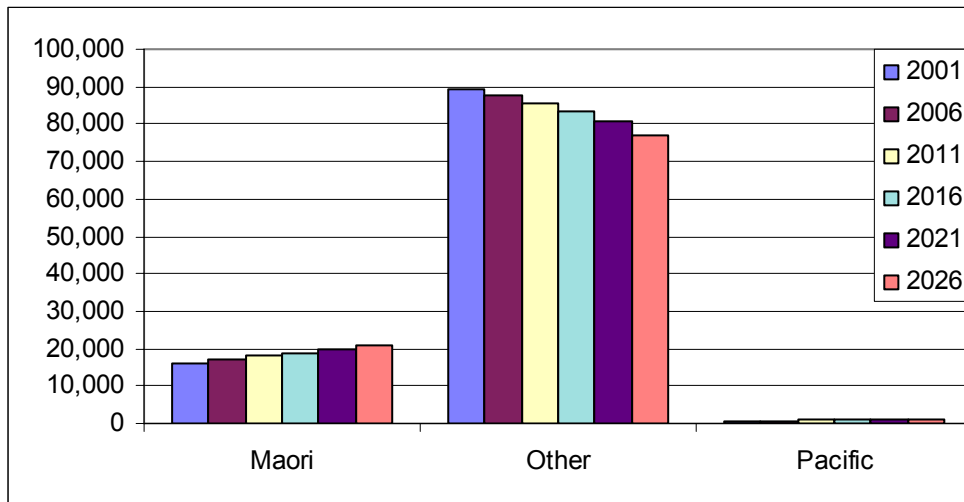
The number of people over the age of 45 years is predicted to increase in Taranaki from 2001 to 2021, particularly those over the age of 65 years.

Figure 5a: Projected Resident Population Change 2001-2026



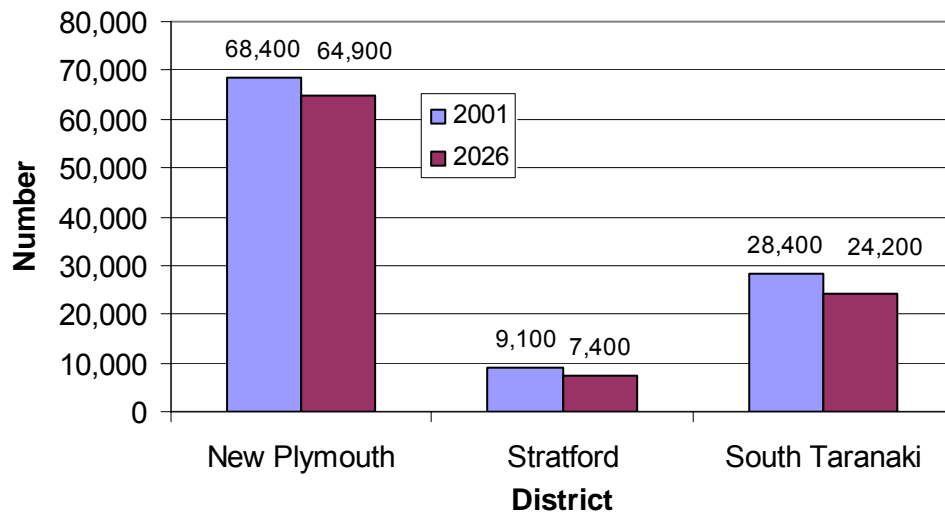
Source: Statistics New Zealand

Figure 5b: Projected Resident Population Change 2001-2026, Taranaki by Ethnic Group



Source: Statistics New Zealand (Medium Projection : Assuming Medium Fertility, Medium Mortality, Medium Inter-Ethnic Mobility, and Medium Migration)

Figure 6: Projected Resident Population Change 2001-2026 by Taranaki District



Source: Statistics New Zealand

Area	Projected Population		Change 2001-2026	
	2001	2026	Number	Percent
Taranaki Region	105,700	96,400	-9,400	-9
New Plymouth District	68,400	64,900	-3,600	-5
Stratford District	9,100	7,400	-1,700	-18
South Taranaki District	28,400	24,200	-4,200	-15
New Zealand	3,880,500	4,730,000	849,500	22

Children & Young People

Our children are our future. By ensuring children and young people stay well and enjoy healthy lifestyles now, they will have better health as adults and live longer lives. Poor health in the childhood and adolescent years often leads to poorer health as an adult. Habits developed in early life very often carry on into adulthood.

Children and young people respond to illness, injury and disability in different ways to adults. This means that any illness, injury or disability that they suffer can have very long term impacts often into their adult life. Not all children and young people in Taranaki are equally healthy. Some live in poor housing, in families with low incomes and have poorer health as a consequence.

In Taranaki, more children and young people are developing conditions that are preventable, such as Type II Diabetes. This type of diabetes is linked to obesity, but can be prevented through good nutrition and increasing levels of physical activity.

Our strategic aims for children and young people

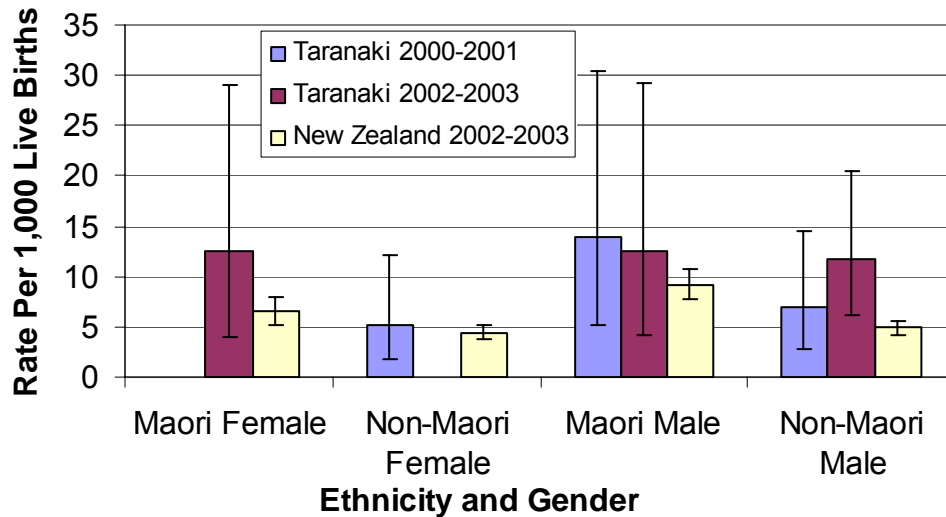
- Children and young people have healthy lifestyles and are not developing the risk factors associated with certain diseases. Risk factors such as smoking, alcohol and illicit drug use, and obesity are described in the “Risk and Preventive Factors” section later in the report.
- Fewer children and young people develop diseases that are preventable through vaccination
- Fewer children and young people are admitted to hospital for injuries
- Services are well-co-ordinated across all agencies and the services are child and young person friendly

Readers with a particular interest in this section are also advised to consult the recent series of Paediatric Society of New Zealand reports on child and youth health in Taranaki. A “Child and Youth Health Action Plan” for the next 5 years is currently under development based on this information and local informants. It will be available in due course.

Mortality

The Māori total infant mortality rate was higher than for non-Māori in Taranaki, but numbers are low and differences are not statistically significant. Non-Māori males in Taranaki (2002-03) had a significantly higher rate of infant mortality than their counterpart in New Zealand. Trends are not discernable between two-year periods.

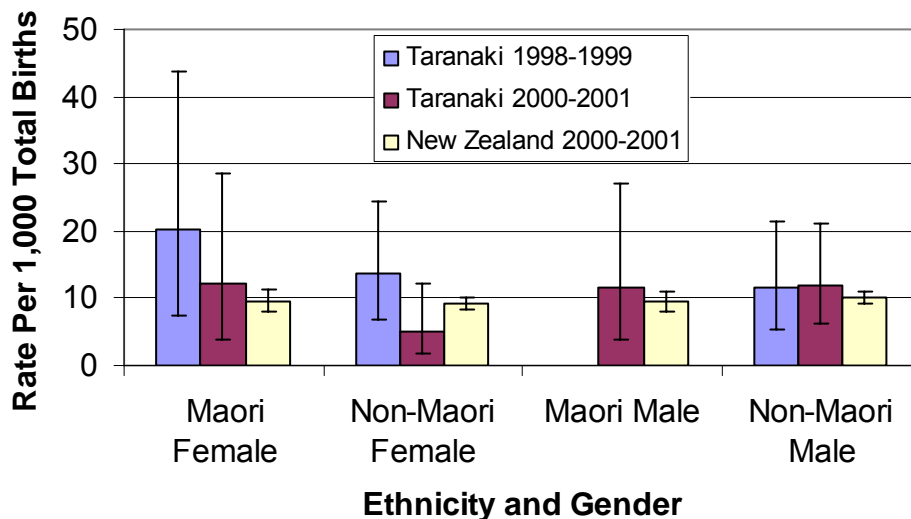
Figure 7: Infant Mortality Rates



Source: New Zealand Health Information Service

There were no statistically significant differences in perinatal mortality between ethnic groups, Taranaki and NZ, or over the two-year periods.

Figure 8: Perinatal Mortality

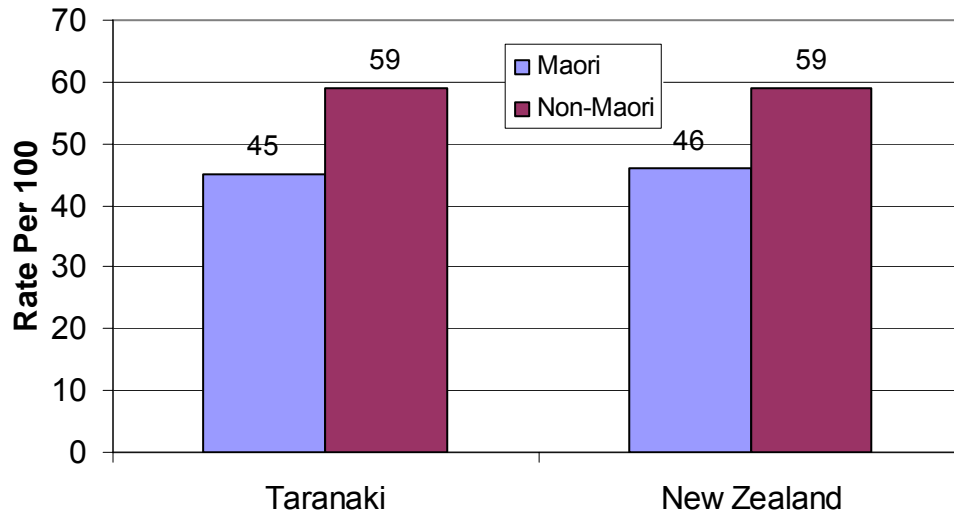


Source: New Zealand Health Information Service

Breastfeeding

Breastfeeding rates for Māori babies (exclusive and full)² at both three and six months were lower than for non-Māori non-Pacific babies in both Taranaki and New Zealand overall.

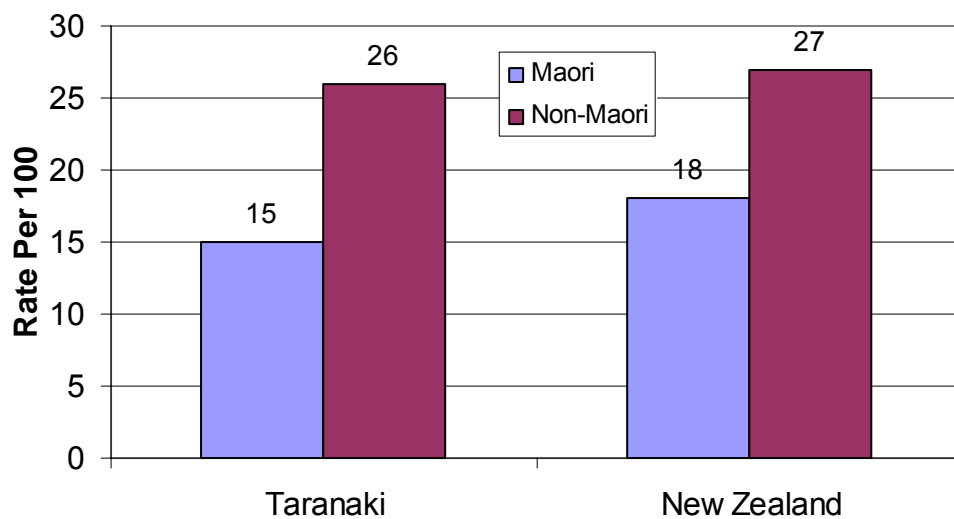
Figure 9: Breastfeeding (exclusive and full) at Three Months, 2004



Source: Royal New Zealand Plunket Society

Note that data are for Māori and non-Māori non-Pacific and confidence intervals were not available.

Figure 10: Breastfeeding (exclusive and full) at six months, 2004



Source: Royal New Zealand Plunket Society

Note that data are for Māori and non-Māori non-Pacific and confidence intervals were not available.

² Definitions:

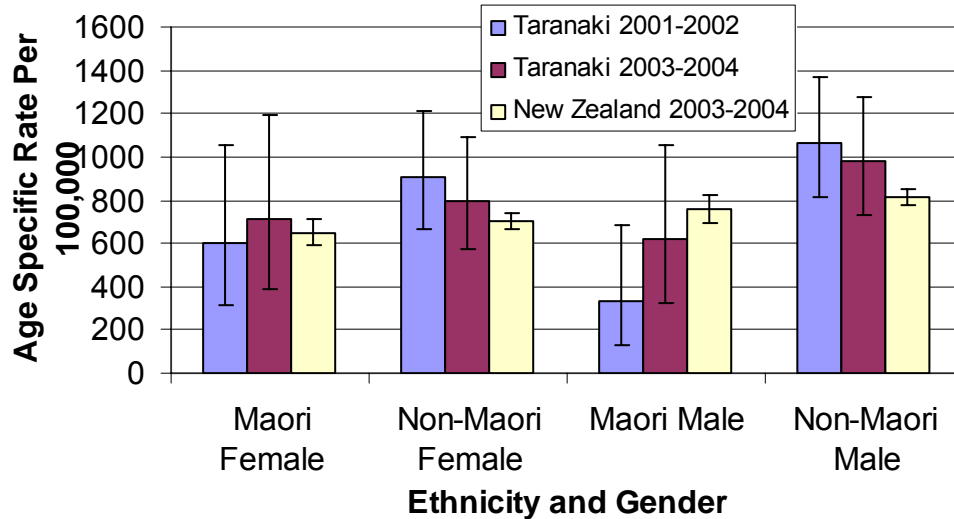
Exclusive - The infant has never, to the mother's knowledge, had any water, formula or other liquid or solid food. Only breastmilk from the breast or expressed breastmilk and prescribed medicine have been given from birth.

Full - The infant has taken breastmilk only. No other liquids or solids except a minimal amount of water or prescribed medicines in the past 48 hours.

Hospitalisations

There were no statistically significant differences in fall and poisonings hospitalisation results between ethnic groups, Taranaki and NZ, or over the two-year periods except for Taranaki males where Maori rates were lower in 2001-02 compared to non Maori rates.

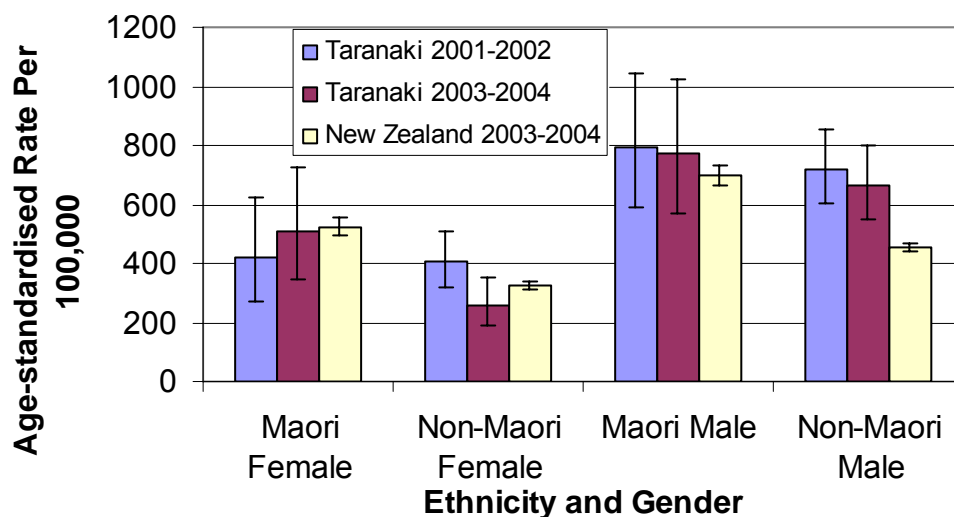
Figure 11: Falls and Poisonings Hospitalisations, 0-4 Years



Source: New Zealand Health Information Service

Non-Māori males in Taranaki had a significantly higher rate of asthma hospitalisation than their counterpart in New Zealand. Other than that, there were no statistically significant differences in asthma hospitalisation between ethnic groups, Taranaki and NZ, or over the two-year periods.

Figure 12: Asthma Hospitalisations, 0-14 Years

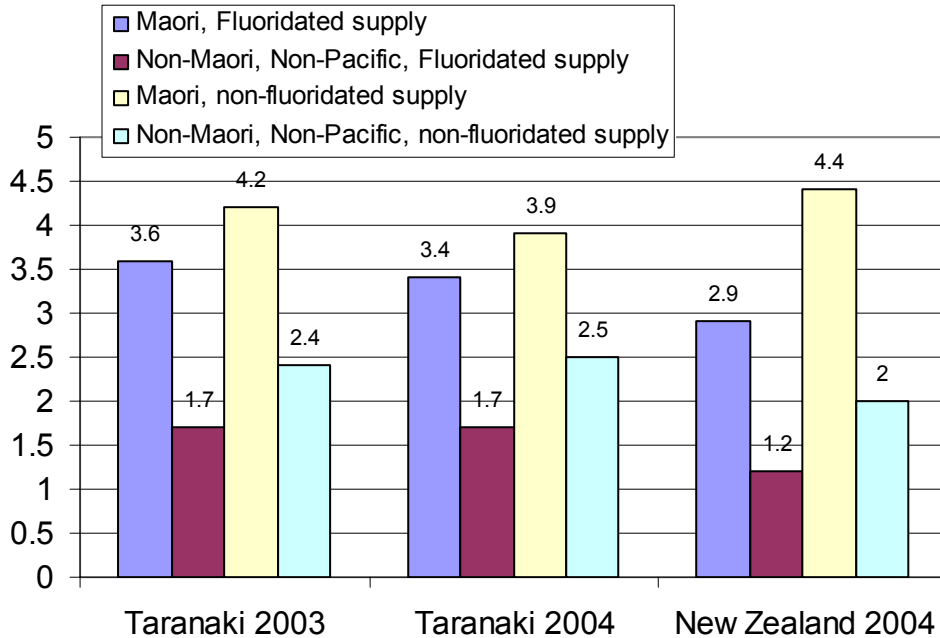


Source: New Zealand Health Information Service

Oral Health

In both fluoridated and non-fluoridated areas, Māori at age five years had higher mean numbers of decay, missing or filled teeth than their non-Māori non-Pacific counterparts in Taranaki. Rates in fluoridated supply areas were consistently lower for both ethnic groups than in non-fluoridated supply areas.

Figure 13: Mean Number of Decay, Missing or Filled teeth at Age 5 Years

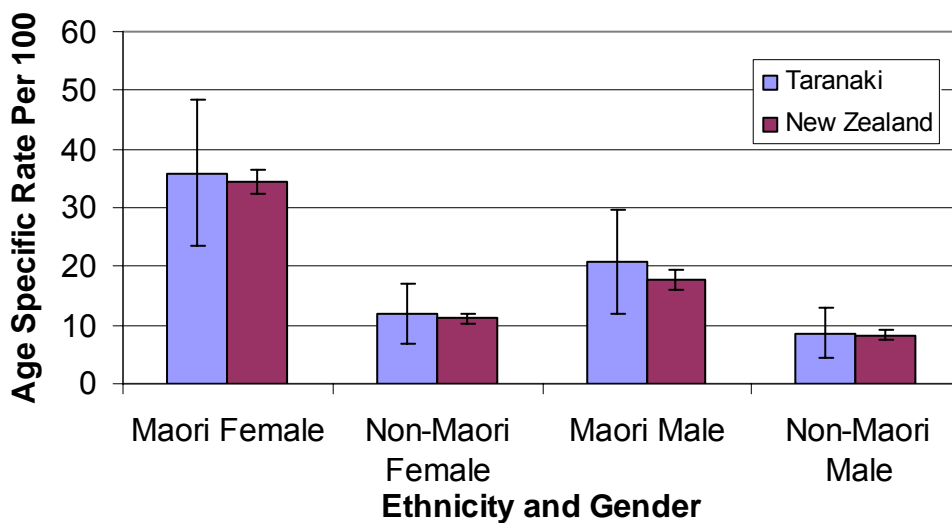


Source: School Dental Service

Smoking

Smoking rates for Taranaki teenagers aged 14-15 years were similar to the national rates. Māori had a significantly higher rate of current smokers than their non-Māori counterparts. More than one quarter of Māori aged 14-15 years were current smokers compared to one in ten for non-Māori in Taranaki.

Figure 14: Prevalence of Current Smoker, 2005

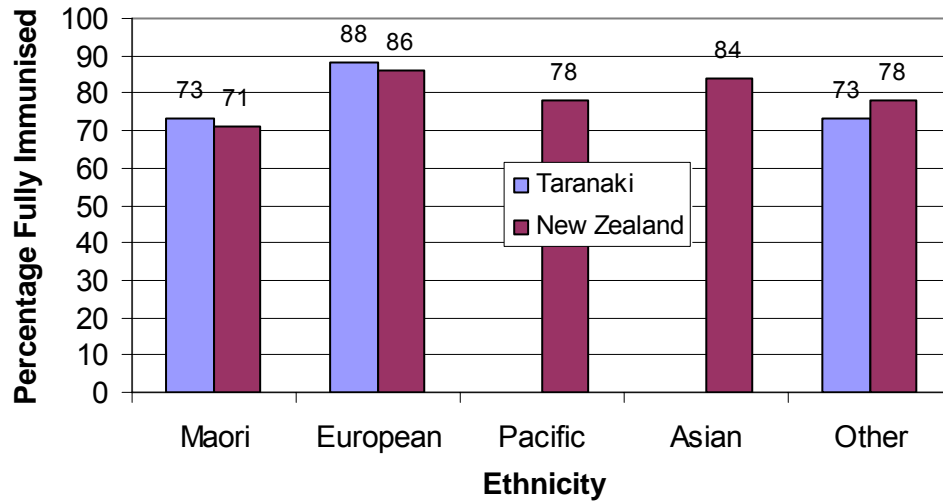


Source: Action on Smoking and Health National Year 10 Survey

Immunisation

Information from the National Immunisation Register shows that Taranaki children are now slightly more likely to be up-to-date with immunisations from the national schedule at 12 months of age compared to New Zealand children overall.

Figure 15: Immunisation coverage at 12 months



Source: National Immunisation Register, 1 April 07 to 1 July 07 data

Older People

The over 65 population in Taranaki is growing faster than the rest of New Zealand. While many older people are fit and healthy, this age group are more likely to have a disability and suffer from a chronic illness than any other age group. Most people acutely hospitalised with a chronic illness are aged between 65 and 74 years.

As people get older they often need some assistance or support to continue living independently. This means that older people need access to good information, flexible and accessible services, and are able to make their own lifestyle and health choices to maintain quality of life in their home environment.

Older people may experience different patterns of mental illness which can be exacerbated by loneliness, being frail and being ill. It is important to enable older people to continue to be part of family, whānau and community life. There is now a focus on locating more services in the community.

The Māori population has a younger age structure than the non-Māori population, with a lower proportion over 65 years. Māori people live on average eight years less than the rest of the population and experience age related health and disability issues at a younger age. However, over the next 10 years the number of Māori over 65 years is projected to increased by 60 percent. To meet this projected growth, Māori provider capacity will need to be strengthened to provide a full range of culturally appropriate health services for older Māori.

Disability Services

Taranaki DHB has responsibility for older people with disabilities (over 65). It is important to remember that disability affects people of all ages and from all groups in Taranaki. The Ministry of Health is responsible for funding and service provision for people under 65 years of age. The DHB will work closely with other agencies to offer the right support to people with disabilities in line with the national direction.

Our strategic aims for older people

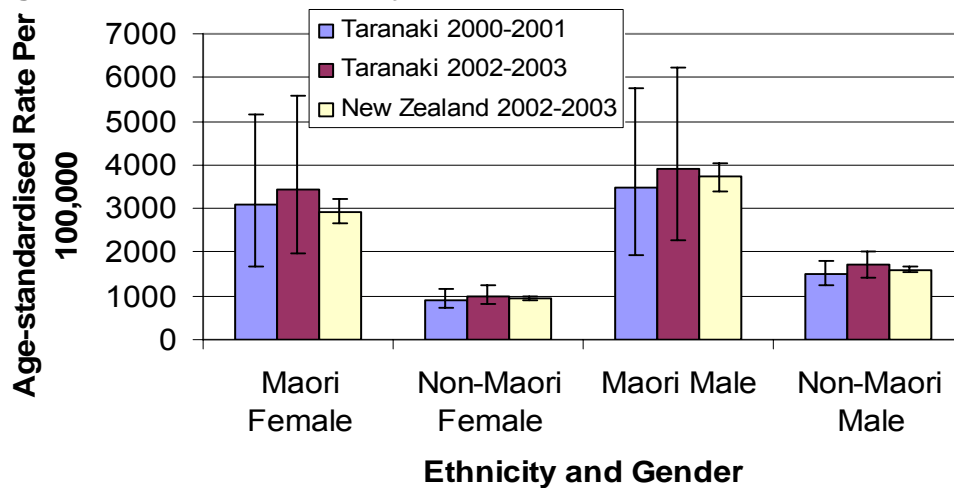
- More older people are healthy and living longer in their own homes
- More older people are able to participate in family, whānau and community life
- Fewer older people are hospitalised
- Hospital and community based services are co-ordinated and appropriate to the needs of older people

Mortality

Avoidable mortality is counts deaths “from diseases for which effective public health and medical interventions are available”³.

Avoidable mortality rates among Māori aged 65-74 years were significantly higher than their non-Māori counterparts in Taranaki (and New Zealand overall). Māori females had over three times the rate of non-Māori females and Māori males had over twice the rate of non-Māori males. Rates were similar in Taranaki to the New Zealand rates.

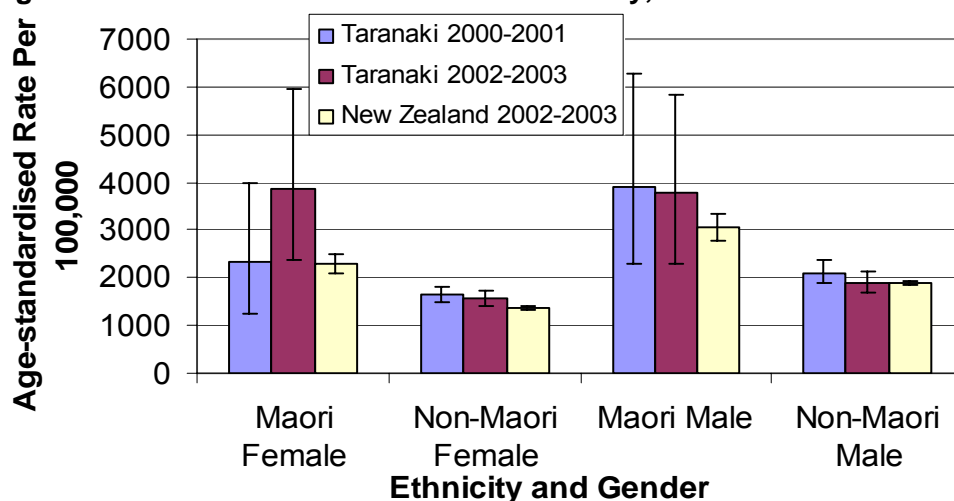
Figure 16: Avoidable Mortality, 65-74 Years



Source: New Zealand Health Information Service

Both Māori females and males aged 65+ years had significantly higher rates of all cardiovascular disease mortality than their non-Māori counterparts in 2002-2003 in Taranaki. Mortality rates for all cardiovascular disease were higher among Māori and non-Māori females in Taranaki than among their counterparts in New Zealand, however this difference was only statistically significant for non-Māori females.

Figure 17: All Cardiovascular Disease Mortality, 65+ Years



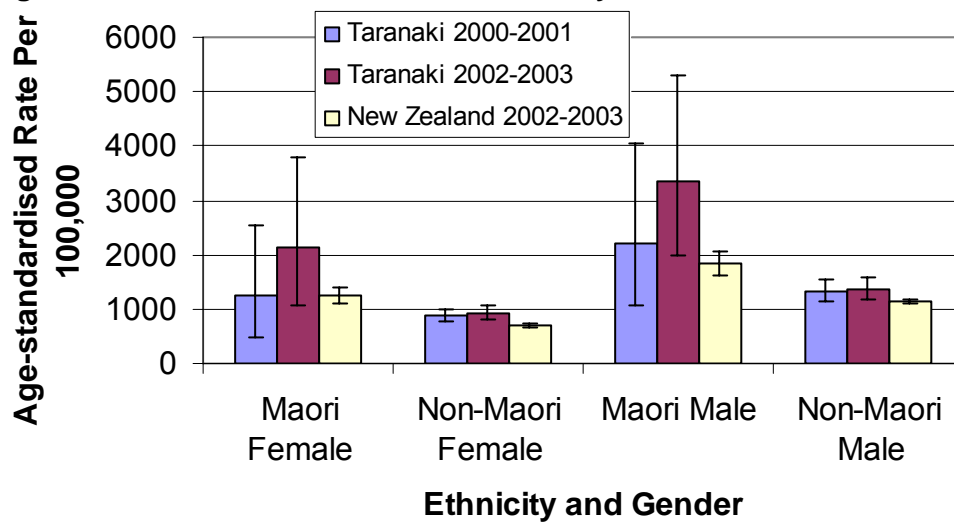
Source: New Zealand Health Information Service

³ Our Health, Our Future - Hauora Pakari, Koiora Roa - The Health of New Zealanders 1999

Ischaemic heart disease mortality rates were significantly higher for Maori males, and significantly higher for Māori females, than their non-Māori counterparts in 2002-2003 in Taranaki. Males had higher rates than females, although these differences were only significant for non-Māori in Taranaki.

Overall, the mortality rates of ischaemic heart disease in Taranaki were higher than in New Zealand, although the difference was only statistically significant for non-Māori females.

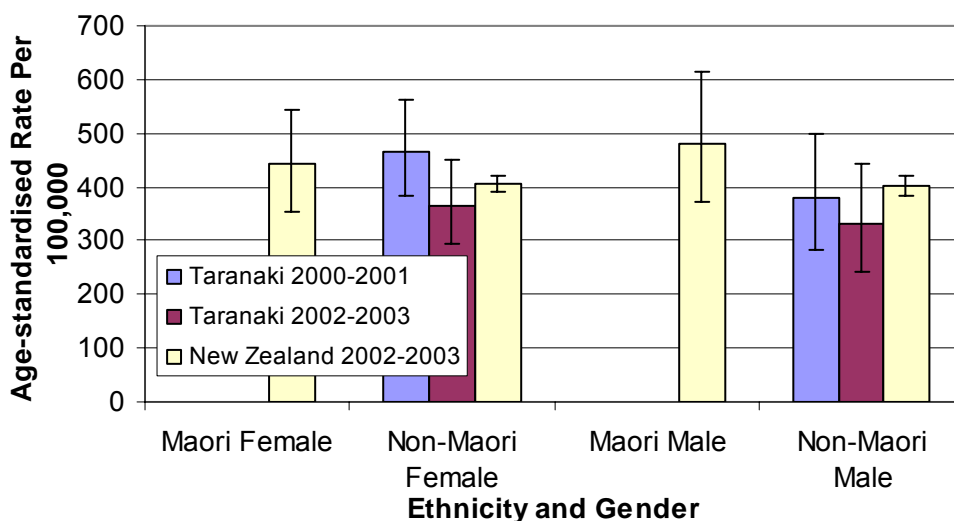
Figure 18: Ischaemic Heart Disease Mortality, 65+ Years



Source: New Zealand Health Information Service

There was no noticeable difference in stroke mortality rates within Taranaki or between Taranaki and New Zealand based on available data.

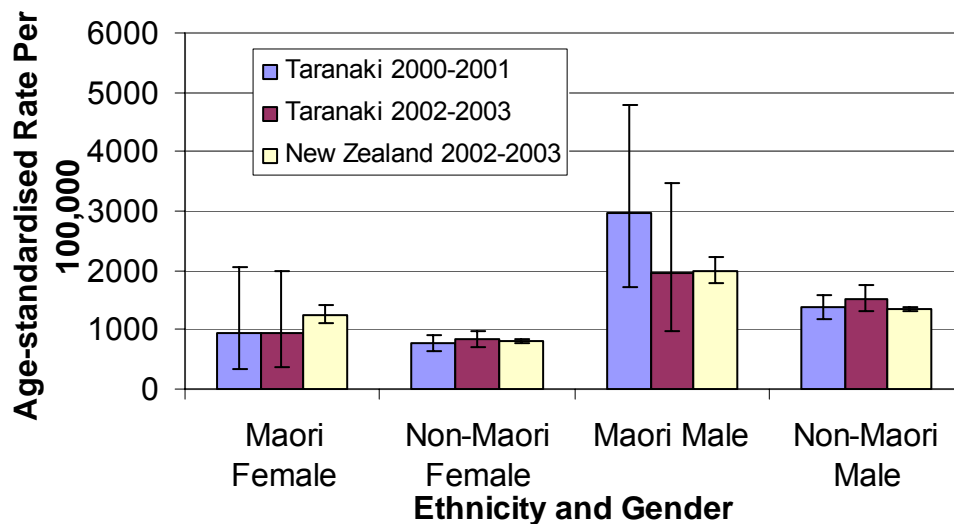
Figure 19: Stroke Mortality, 65+ Years



Source: New Zealand Health Information Service

In contrast to all cancer registrations (see later), the rates of all cancer mortality among Māori were higher than among their non-Māori counterparts in Taranaki. However, these differences were not statistically significant except at the national level. The rates for males were about two times higher than females, although not statistically significantly for Māori in Taranaki.

Figure 20: All Cancer Mortality, 65+ Years



Source: New Zealand Health Information Service

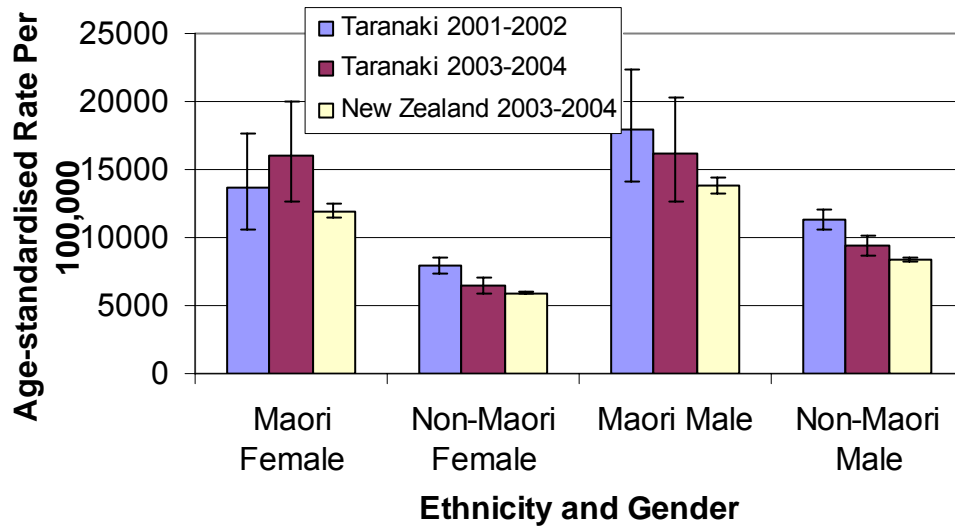
Hospitalisation

Avoidable hospitalisation estimation is used to measure the occurrence of a severe illness that theoretically could have been avoided by either:

- Ambulatory sensitive hospitalisation (ASH) – hospitalisations that could have been avoided by primary care interventions such as early detection and treatment, or immunisation; or
- Preventable hospitalisation (PH) – hospitalisations that could have been avoided by health promotion strategies such as reducing smoking rates.

Both Māori and non-Māori aged 65-74 years in Taranaki had higher rates of ambulatory sensitive hospitalisation than their counterparts in New Zealand. However these differences were only statistically significant for Māori females in 2003/04 and non-Māori males. Māori had significantly higher rates of ambulatory sensitive hospitalisation than their non-Māori counterparts in Taranaki. The rate for Māori females was more than double of that for non-Māori females during 2003-2004.

Figure 21: Ambulatory Sensitive Hospitalisation, people aged 65-74 years

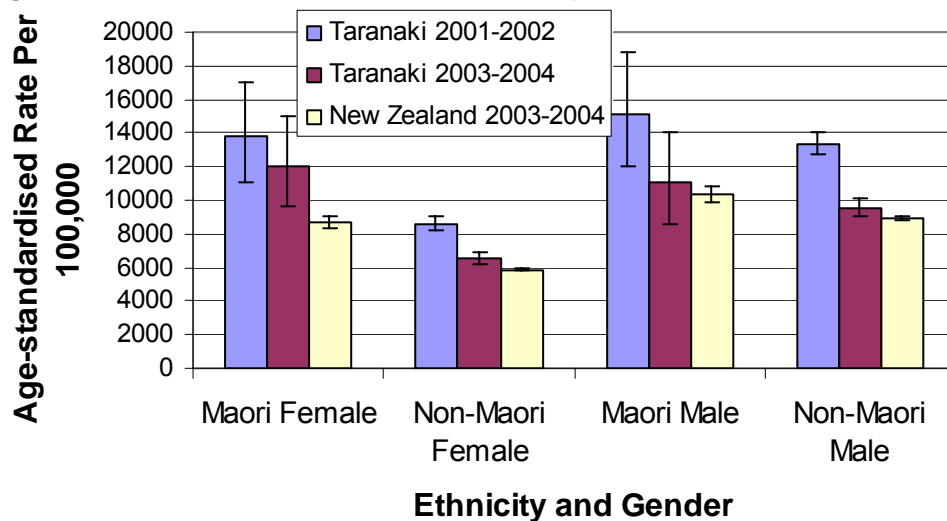


Source: New Zealand Health Information Service

At ages 65+ years, the rates of all cardiovascular disease hospitalisation for Māori females were significantly higher than for non-Māori females in Taranaki. During 2003-2004, the rate among Māori females was almost twice the rate of their non-Māori counterpart. The rates for non-Māori males were significantly higher than non-Māori females.

Compared to their counterparts in New Zealand, Māori females and non-Māori of both sexes in Taranaki had significantly higher rates of all cardiovascular disease hospitalisation.

Figure 22: All Cardiovascular Disease Hospitalisation, 65+ Years

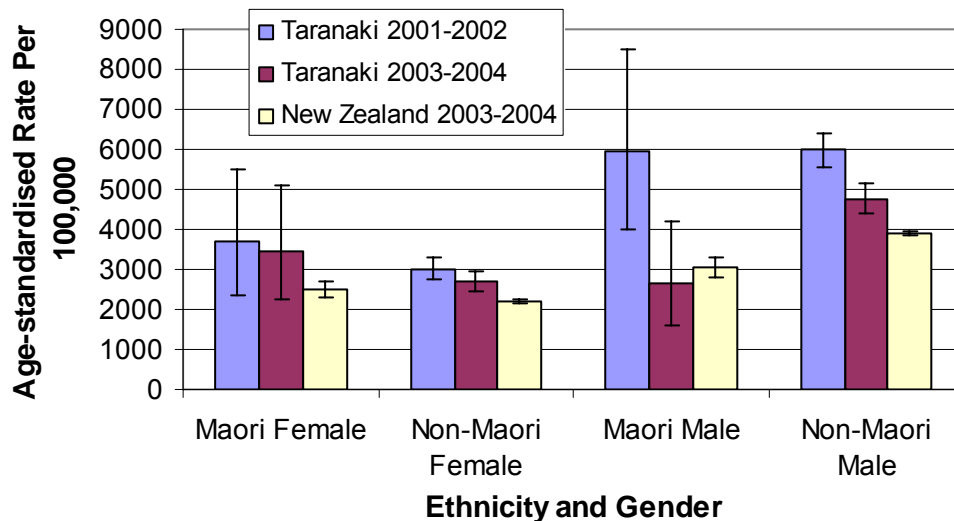


Source: New Zealand Health Information Service

Māori males aged 65+ years had a significantly lower rate of ischaemic heart disease hospitalisation than non-Māori males in 2003-2004 in Taranaki. The reverse was true for Māori females, but this difference was not significant. Non-Māori males had significantly higher rates than non-Māori females.

With the exception of Māori males in 2003-04, the rates of ischaemic heart disease hospitalisation in Taranaki were higher than in New Zealand. However these differences were only statistically significant for non-Māori.

Figure 23: Ischaemic Heart Disease Hospitalisation, 65+ Years

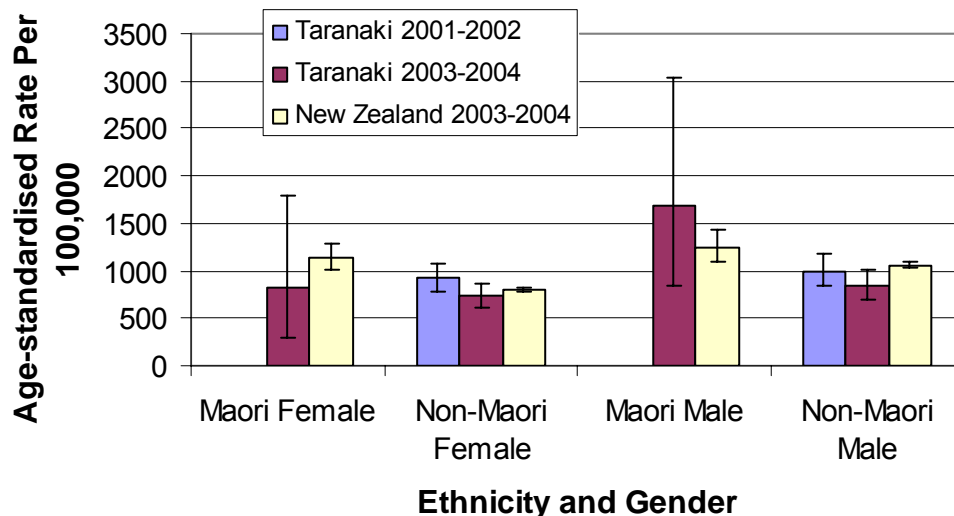


Source: New Zealand Health Information Service

Stroke hospitalisation rates were higher among Māori aged 65+ years than non-Māori in 2003-2004 in Taranaki. However, this difference was not statistically significant.

Compared to their counterparts in New Zealand, non-Māori males in Taranaki had a significantly lower rate of stroke hospitalisation.

Figure 24: Stroke Hospitalisation, 65+ Years

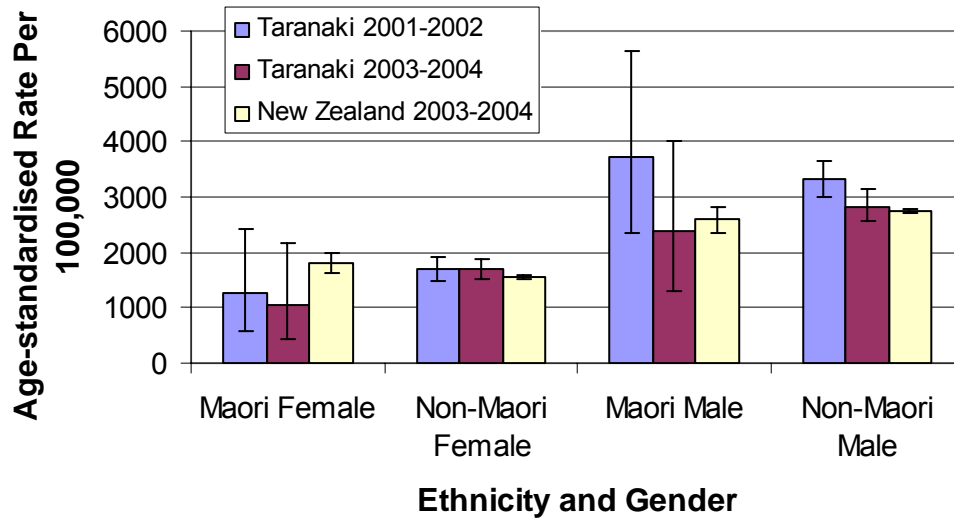


Source: New Zealand Health Information Service

Cancer Registrations

Māori females aged 65+ years had lower rates of all cancer registrations than non-Māori in Taranaki, but not statistically significantly different. Males had markedly higher rates of all cancer registrations than females, although the difference was not statistically significant for Māori in Taranaki.

Figure 25: All Cancer Registrations, 65+ Years



Source: New Zealand Health Information Service

Cardiovascular Disease

Reduce the incidence and impact of Cardiovascular Disease

Cardiovascular disease (CVD) is the leading cause of death in New Zealand and in Taranaki. It is also the leading cause of potential years of life lost by people dying early.⁴

Of the cardiovascular diseases, ischaemic heart disease is the major cause of death, followed by stroke, which is the greatest cause of disability in older people. The numbers of people in Taranaki who have cardiovascular disease is growing faster than the New Zealand average.

Cardiovascular disease is the leading cause of death for Māori people and Māori have higher rates of the disease than the general population.

Up to three quarters of all cardiovascular disease may be preventable, simply by doing things like not smoking, maintaining a healthy weight range, exercising regularly and having a healthy diet. Also important is controlling blood pressure and cholesterol levels. While prevention is a long term task, short term gains can be made in identifying and treating people at high risk, such as those with established coronary heart disease.

Our strategic aims for Cardiovascular Disease

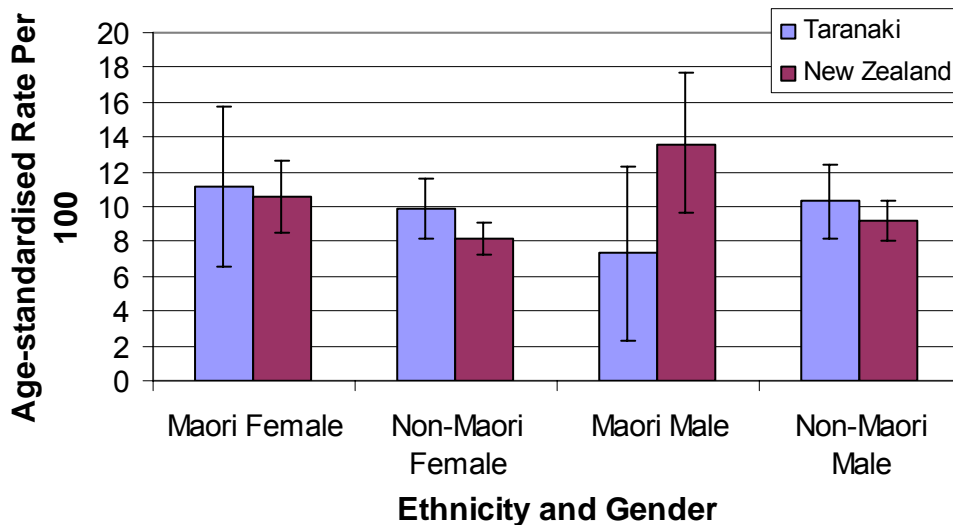
- Fewer people are developing cardiovascular disease due to healthier lifestyles
- Reduced rates of cardiovascular disease, in Māori
- Effective screening programmes
- Early detection, slowed rate of progression, and reduced incidence of avoidable complications of cardiovascular disease, due to the use of appropriate screening
- The quality of life for those with cardiovascular disease has improved due to more co-ordinated care and effective self management

⁴ In Taranaki “Years of Life Lost” before 75 years per 10000 population appear to be increasing since 1997, particularly for males, whereas NZ overall has seen a reduction.

Health Indicators

There was no significant difference in the self-reported heart disease prevalence between Māori and non-Māori in Taranaki and between Taranaki and New Zealand.

Figure 26: Heart Disease Prevalence, 15+ Years, 2003 - 04

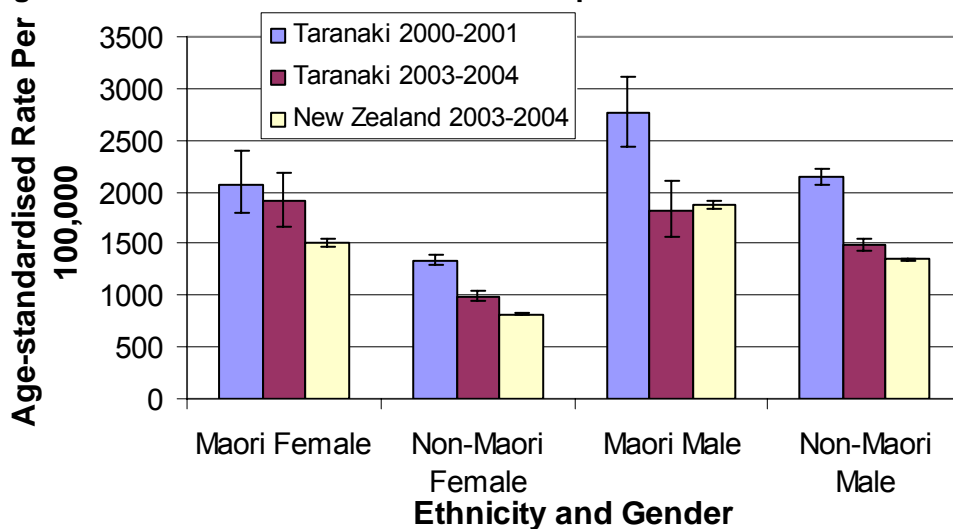


Source: New Zealand Health Survey

Māori of both sexes had significantly higher rates of all cardiovascular disease hospitalisation than their non-Māori counterparts in Taranaki. Except for Māori females these rates seem to have reduced significantly from 2000/01 to 2002/03 in Taranaki.

The hospitalisation rates among Māori females and non-Māori of both sexes in Taranaki were significantly higher than among their counterparts in New Zealand.

Figure 27: All Cardiovascular Disease Hospitalisation

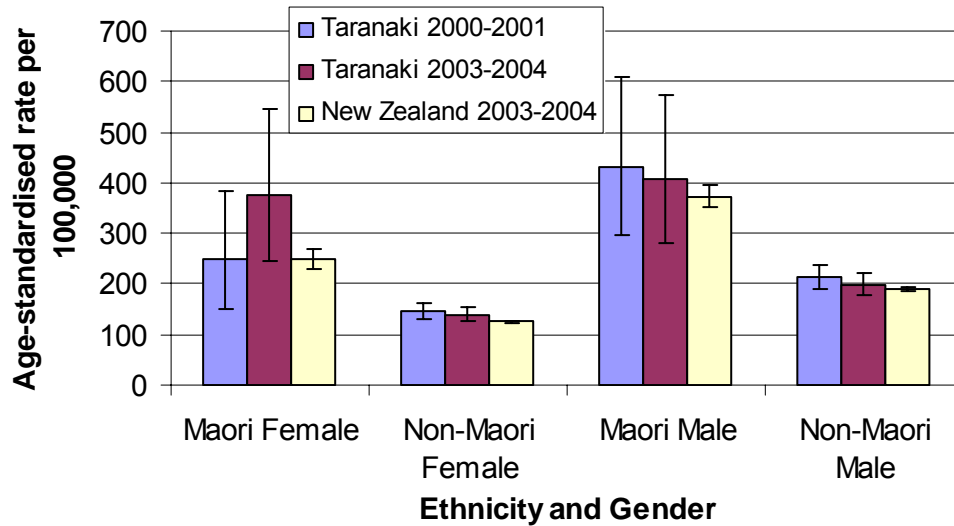


Source: New Zealand Health Information Service

All cardiovascular disease mortality rates for Māori were significantly higher than their non-Māori counterparts in 2002-2003 in Taranaki, at double the rates.

All females in Taranaki had non-significantly higher rates of all cardiovascular disease mortality than their counterparts in New Zealand.

Figure 28: All Cardiovascular Disease Mortality

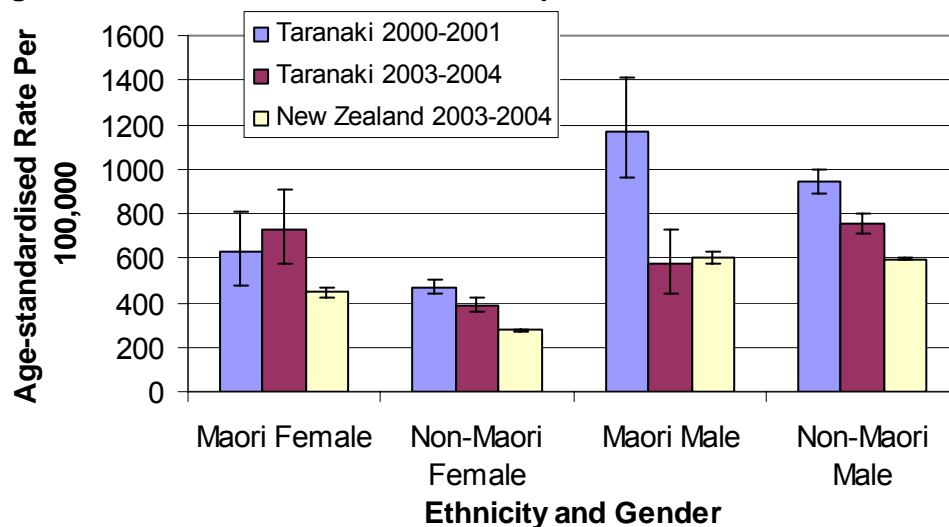


Source: New Zealand Health Information Service

In Taranaki, the rate of ischaemic heart disease hospitalisation for Māori females was significantly higher than non-Māori females in 2003-2004. However, the rate for Māori males was non-significantly lower than for non-Māori males.

With the exception of Māori males, the ischaemic heart disease hospitalisation rates in Taranaki were significantly higher than in New Zealand.

Figure 29: Ischaemic Heart Disease Hospitalisation

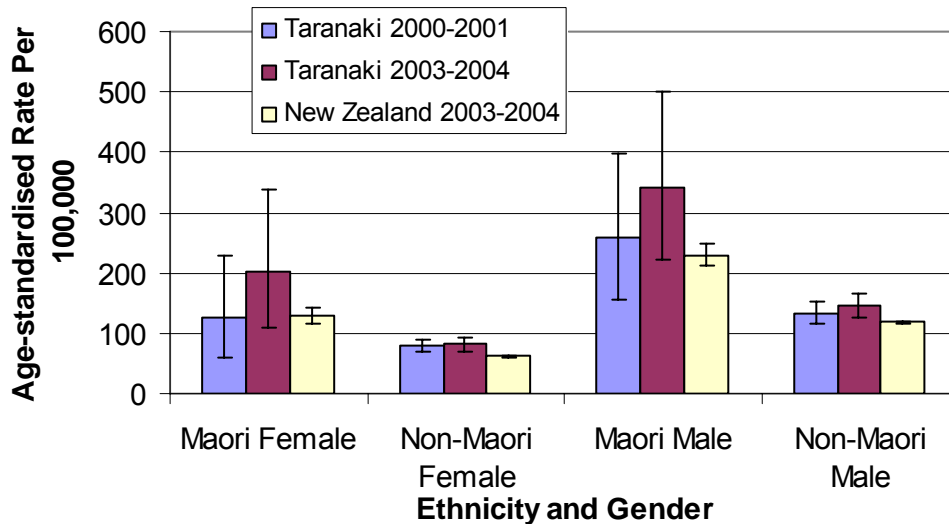


Source: New Zealand Health Information Service

The rates of ischaemic heart disease mortality were significantly higher among Māori than non-Māori in 2003-2004 in Taranaki. The rates for males were higher than females, although these differences were not statistically significant for Māori in Taranaki.

Non-Māori of both sexes and the Māori total in Taranaki had significantly higher rates of ischaemic heart disease mortality than their counterparts in New Zealand.

Figure 30: Ischaemic Heart Disease Mortality

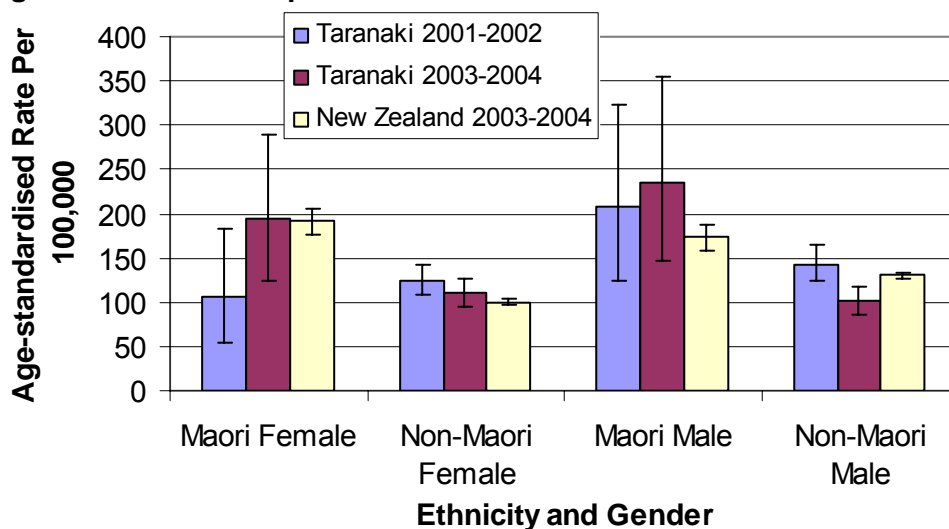


Source: New Zealand Health Information Service

The stroke hospitalisation rate was significantly higher for Māori males than their non-Māori counterparts in 2003-2004 in Taranaki.

There was a significantly lower rate of stroke hospitalisation among non-Māori males in Taranaki than those in New Zealand.

Figure 31: Stroke Hospitalisation

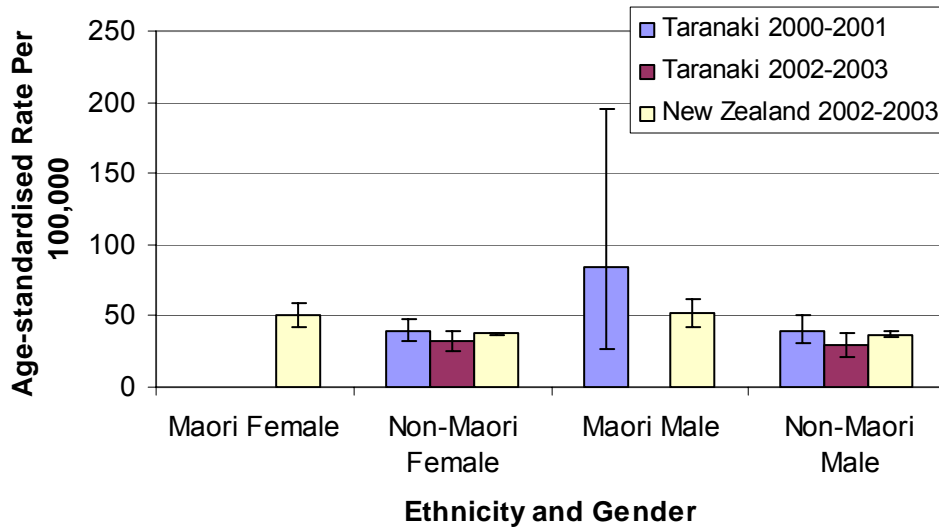


Source: New Zealand Health Information Service

The rate of stroke mortality among Māori was similar to non-Māori in 2002-2003 in Taranaki.

The total stroke mortality rate for non-Māori in Taranaki was significantly lower than their counterparts in New Zealand.

Figure 32: Stroke Mortality



Source: New Zealand Health Information Service

Cancer

Reduce the Incidence and Impact of Cancer

Cancer is the second leading cause of death (27%) and a major cause of hospital admission (7%) in New Zealand, with similar rates for Taranaki.

Cancer rates will continue to rise as the population of Taranaki gets older, because the highest rates of cancer occur in the middle and older age groups. In New Zealand, the cancer death rate is higher, and is increasing at a faster rate, than in countries that are similar to ours.

While the incidence of cancer may be increasing, the risk of dying from cancer has reduced due to improved treatment and earlier diagnosis. In addition, approximately one third of cancers are preventable.

Controlling cancer, and caring for people with cancer, can only be done through all organisations working closely together.

MidCentral DHB provides the majority of specialist, treatment and patient accommodation for cancer services for the people of Taranaki.

Our Strategic Aims For Cancer Control

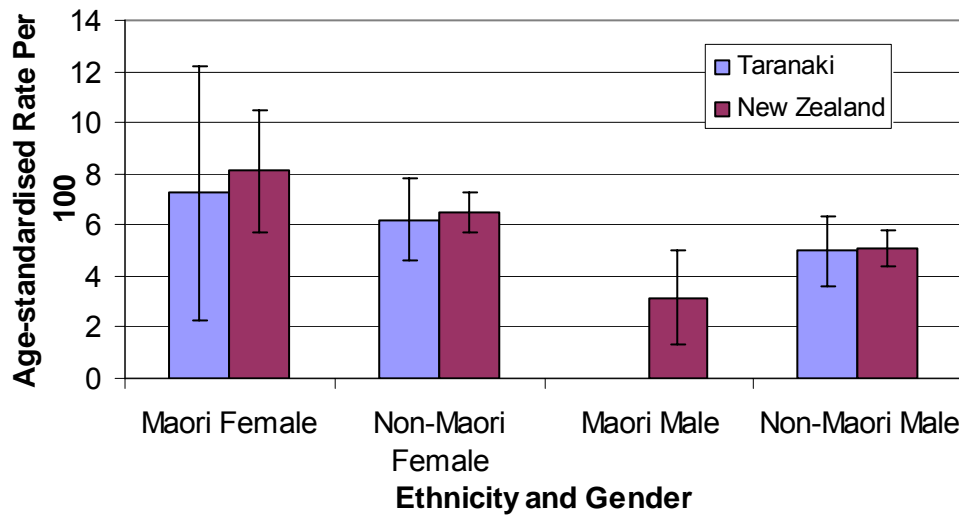
- Fewer people are developing those cancers whose risk can be minimised by healthy lifestyles
- Early detection of cancer has increased due to systematic screening
- Fewer people are dying of cancer due to effective treatment
- A co-ordinated approach to cancer is well established covering prevention, screening, early detection, diagnosis, treatment, rehabilitation and palliative care
- No group in Taranaki is affected by cancer any more than other groups

Cancer Registrations in Taranaki

A recent report for TDHB⁵ has reviewed registrations of new cases of cancer with the NZ Cancer Registry. It's findings are similar to the indicators reported below, again showing comparatively high melanoma rates in Taranaki. Readers with a particular interest in this section are also advised to consult that report.

There was no difference in the self-reported cancer prevalence between Māori and non-Māori in Taranaki and between Taranaki and New Zealand.

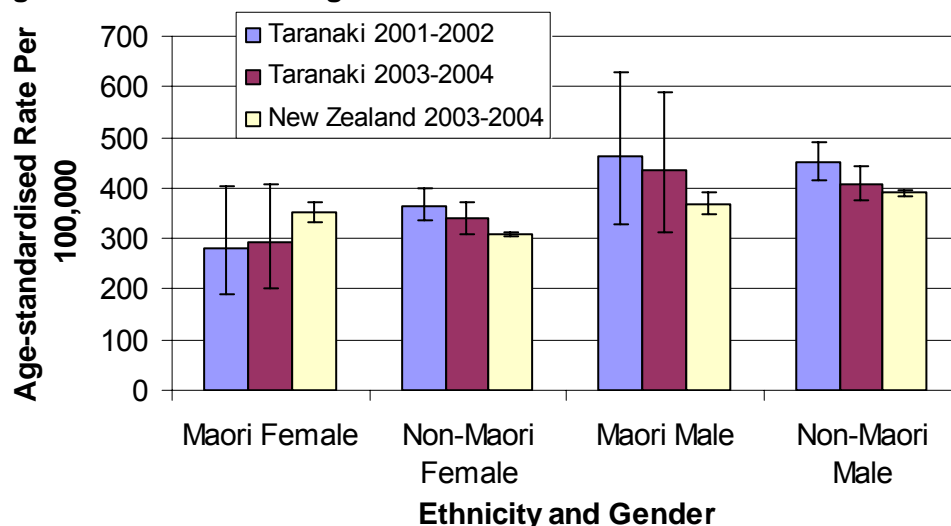
Figure 33: Cancer Prevalence, 15+ Years



Source: 2002/03 New Zealand Health Survey

Both non-Māori and Māori males had higher rates of all cancer registration than their female counterparts in Taranaki. However, the difference was only statistically significant for non-Māori in 2001-02.

Figure 34: All Cancer Registrations

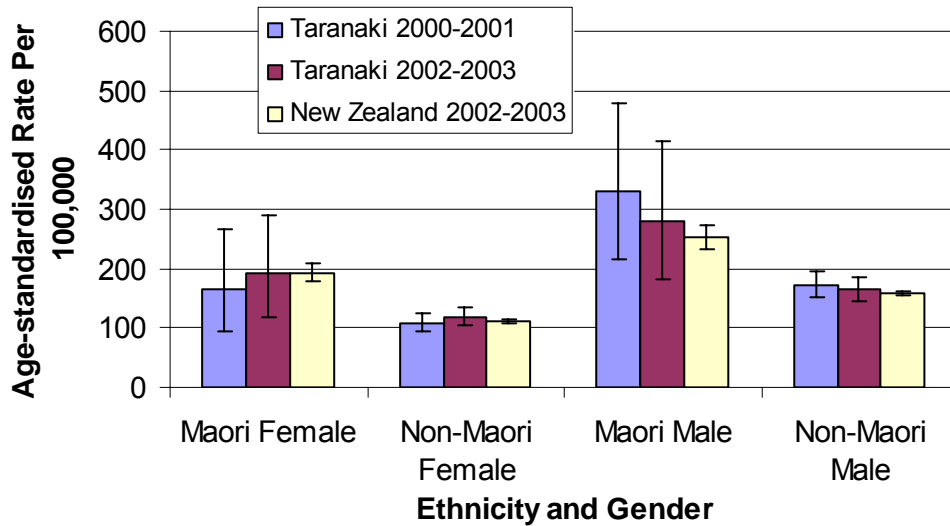


Source: New Zealand Health information Service

⁵ Cancer Registrations in Taranaki 2000-2003, Ian Hodges & Caroline Maskill, HealthSearch Ltd, May 2007

Māori had a significantly higher rate of all cancer mortality than non-Māori in 2002-2003 in Taranaki. Again, the mortality rates for both non-Māori and Māori males were higher than their female counterparts in Taranaki, but the difference was only statistically significant for non-Māori.

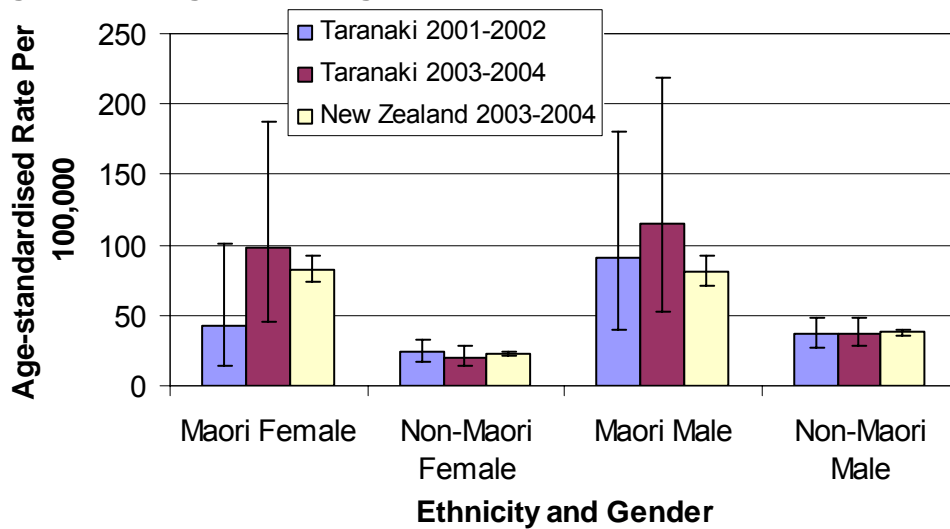
Figure 35: All Cancer Mortality



Source: New Zealand Health information Service

Māori had significantly higher rates of lung cancer registration than non-Māori in 2003-2004 in Taranaki.

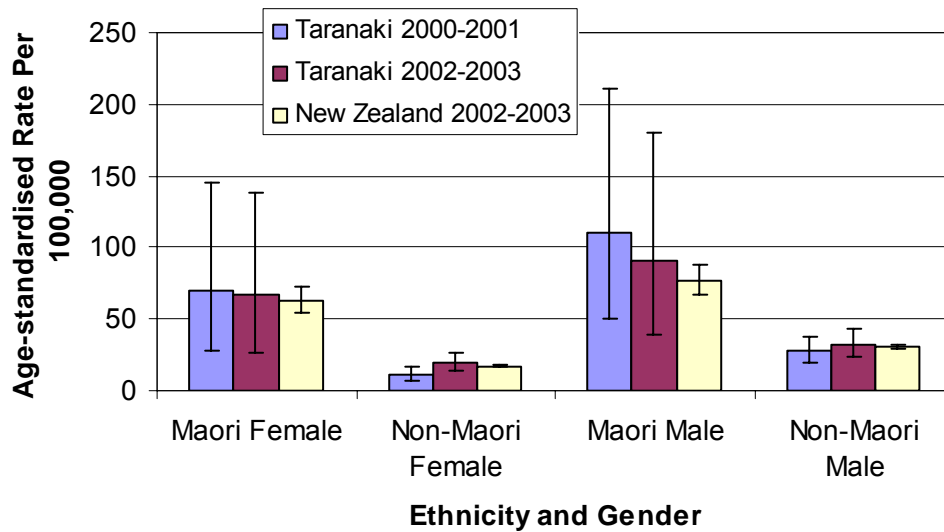
Figure 36: Lung Cancer Registration



Source: New Zealand Health information Service

Similarly, Māori males and females had statistically significant higher rates of lung cancer mortality than non-Māori in Taranaki. The rates for Māori were around 3 times higher than for their non-Māori counterparts.

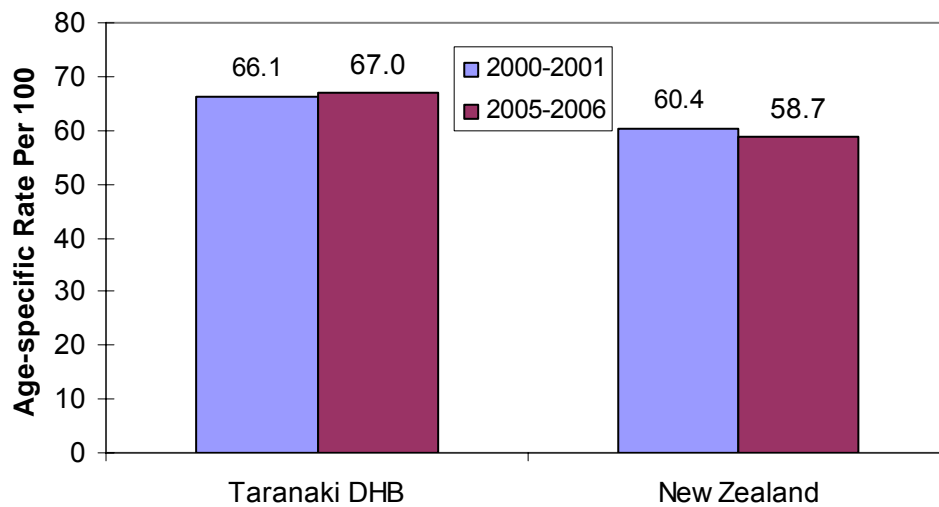
Figure 37: Lung Cancer Mortality



Source: New Zealand Health information Service

The breast screening coverage rates for women aged 50-64 years were similar between Taranaki and New Zealand.

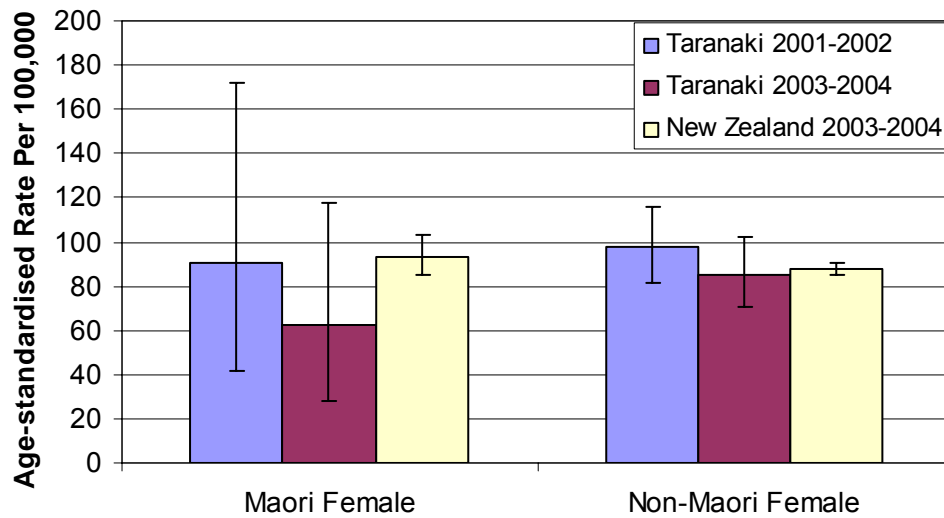
Figure 38: Breast Screening Coverage Rate, 50-64 Years



Source: National Screening Unit

There was statistically significant difference in breast cancer registration rates between non-Māori and Māori females in Taranaki.

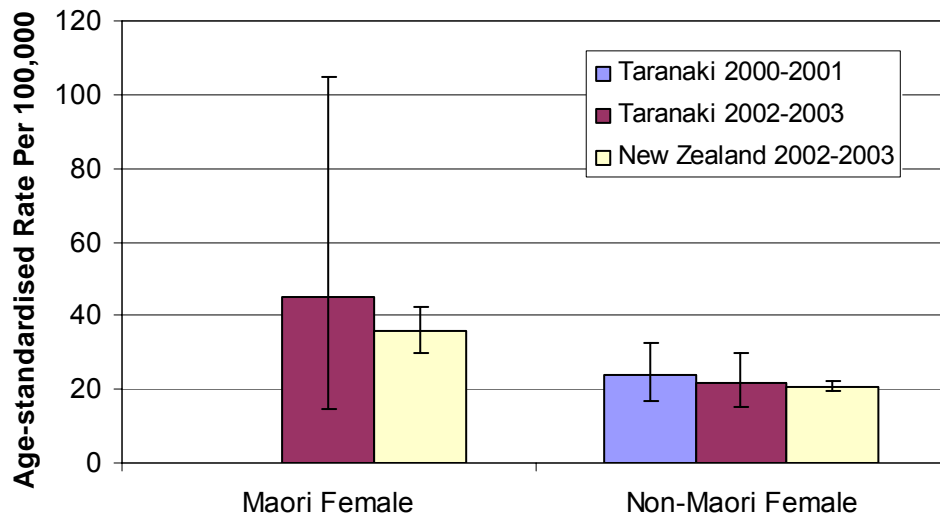
Figure 39: Breast Cancer Registrations



Source: New Zealand Health Information Service

Breast cancer was one of the top two causes of avoidable mortality, and the third highest cause of years of life lost (in people aged less than 75 years), in Taranaki females in 2003. Māori women had a higher rate of breast cancer mortality than non-Māori in 2002-2003, but this difference was not statistically significant in Taranaki.

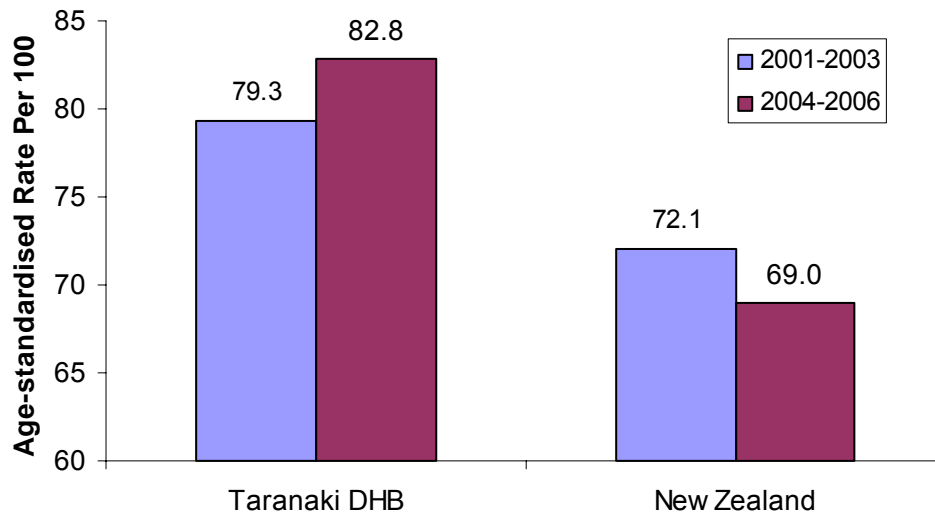
Figure 40: Breast Cancer Mortality



Source: New Zealand Health Information Service

The rates of cervical screening coverage for women aged 20-69 years were higher in Taranaki than in New Zealand overall.

Figure 41: Cervical Screening Coverage Rate, 20-69 Years



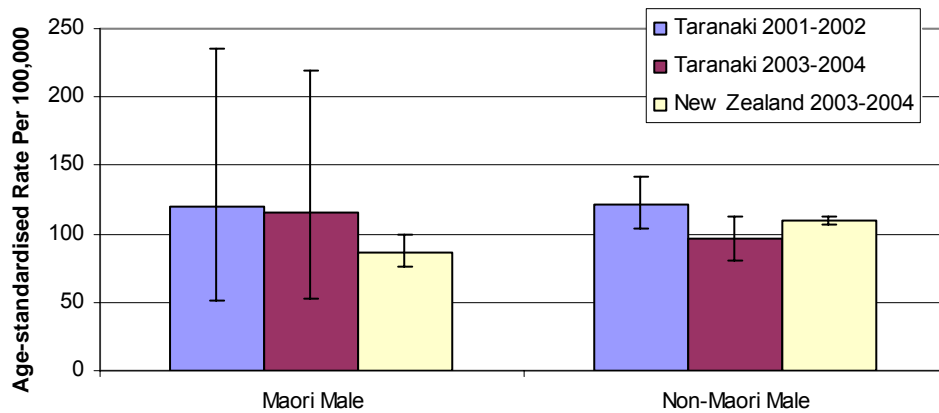
Source: National Screening Unit

As the number of cervical cancer registrations was very low in Taranaki, rates have not been presented. Three women in 2001-2002 and eight in 2003-2004 were registered with cervical cancer in Taranaki. The rates for Māori and non-Māori females in New Zealand during 2003-2004 were 11.8 (8.9-15.3) and 6.6 (5.8-7.4) per 100,000 respectively.

Again, rates have not been presented for this indicator due to the small amount of cervical cancer mortality in Taranaki. Two deaths from cervical cancer were recorded during each of two periods in 2000-2001 and 2002-2003 in the Taranaki region. The rates among Māori and non-Māori females in New Zealand during 2002-2003 were 4.7 (2.9-7.3) and 1.9 (1.6-2.3) per 100,000 respectively. (Source: New Zealand Health Information Service).

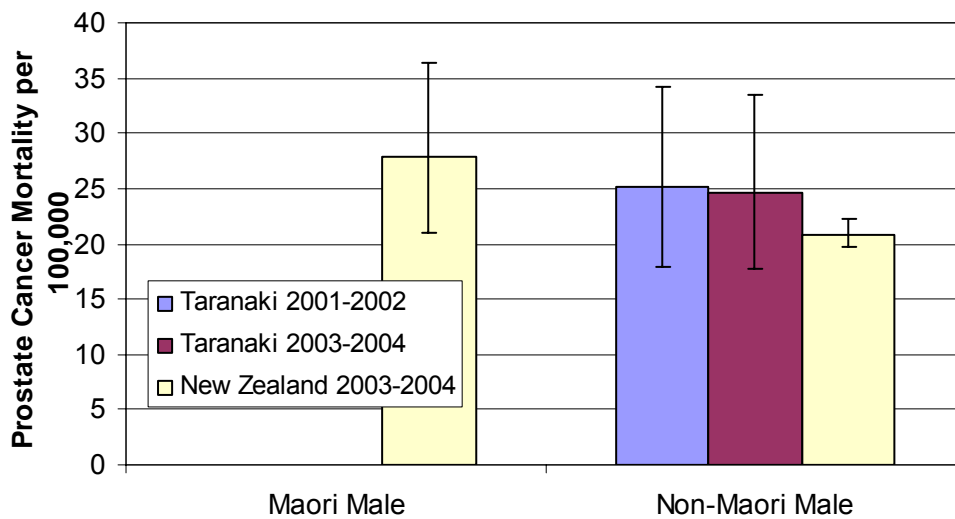
There was no significant difference in the rate of prostate cancer registration or prostate cancer mortality between Māori and non-Māori in Taranaki; neither was there any significance between Taranaki and New Zealand.

Figure 42: Prostate Cancer Registration



Source: New Zealand Health Information Service

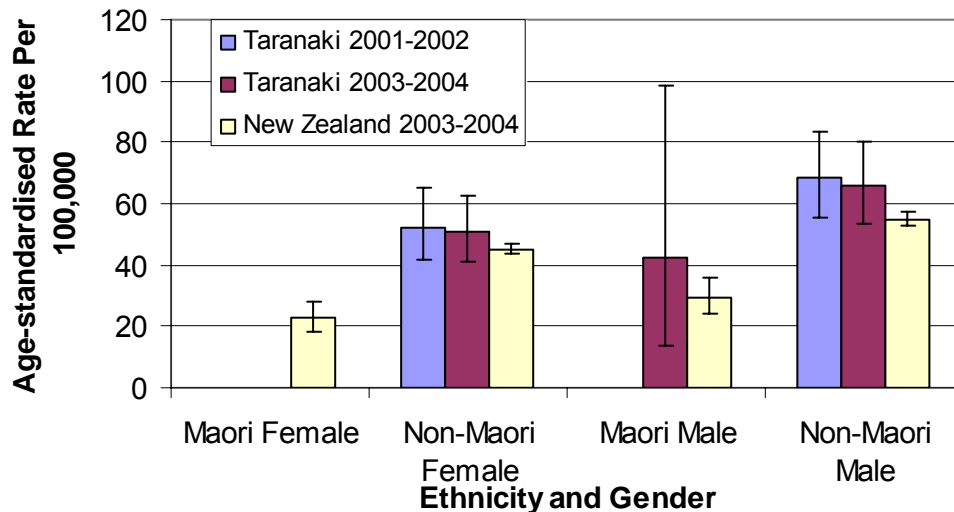
Figure 43: Prostate Cancer Mortality



Source: New Zealand Health Information Service

The rates of colorectal cancer registration were higher among non-Māori than Māori. Non-Māori males had higher rates than non-Māori females. However, none of these differences were statistically significant in Taranaki.

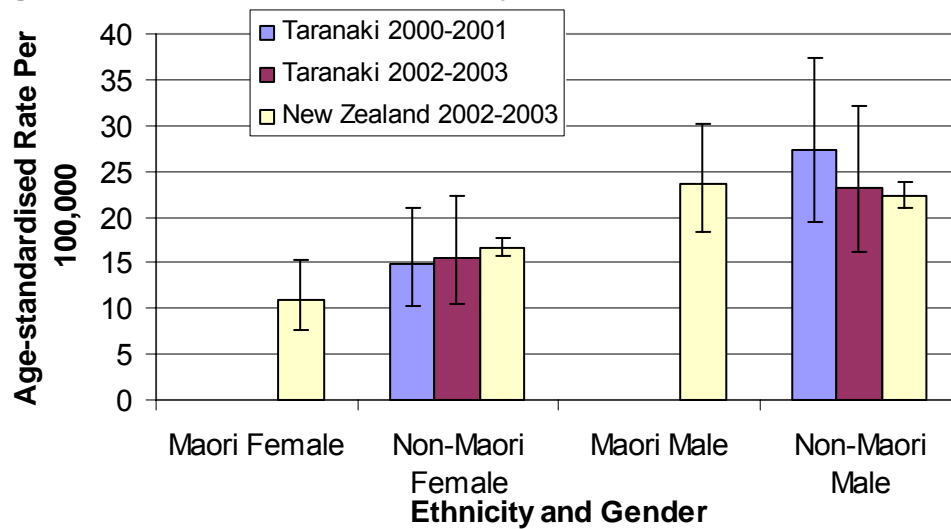
Figure 44: Colorectal Cancer Registrations



Source: New Zealand Health Information Service

Non-Māori males had higher rates of colorectal cancer mortality than non-Māori females. These differences were not statistically significant in Taranaki.

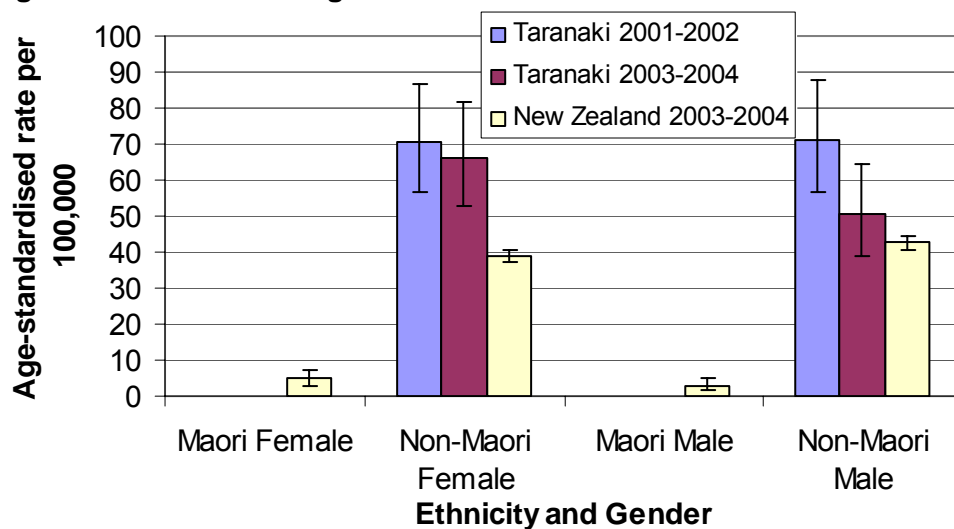
Figure 45: Colorectal Cancer Mortality



Source: New Zealand Health Information Service

In both time periods, fewer than five Māori were registered with melanoma in Taranaki. There were higher rates of melanoma registration among non-Māori in Taranaki than those in New Zealand, with most of these differences statistically significant.

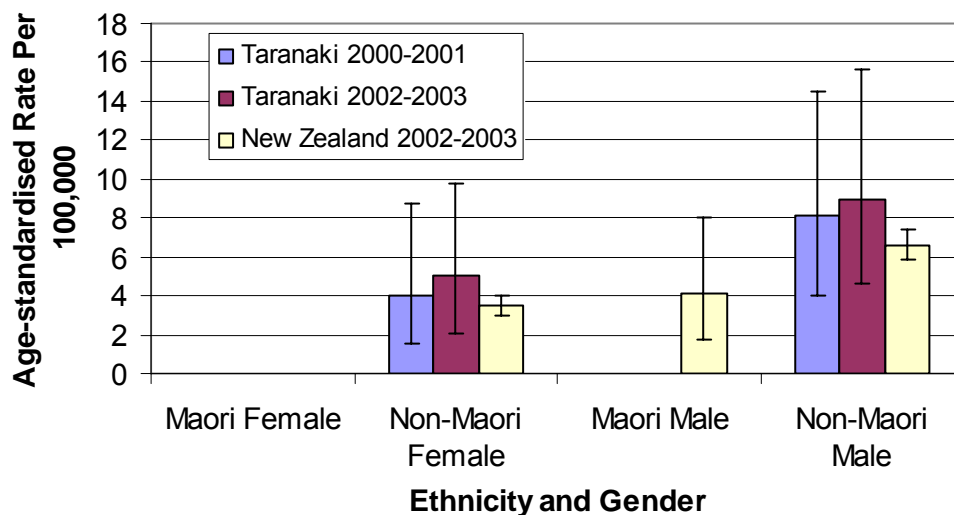
Figure 46: Melanoma Registration



Source: New Zealand Health Information Service

As for melanoma registration, fewer than five Māori died from melanoma in both periods in Taranaki.

Figure 47: Melanoma Mortality



Source: New Zealand Health Information Service

Respiratory Disease

Reduce the incidence and impact of respiratory diseases

Respiratory diseases, in particularly asthma and Chronic Obstructive Pulmonary Disease (COPD), are a significant burden of disease and cause of death for people within Taranaki. Asthma is particularly significant for children and Māori, and accounts for high numbers of admissions to hospital in Taranaki. COPD (which includes emphysema and chronic bronchitis) has a strong impact on older people.

Cigarette smoking is the most important risk factor that can cause these diseases, and is something that we can change in our communities. Other risk factors for respiratory disease include obesity, environmental pollutants and poor housing, which are also factors we can influence and change.

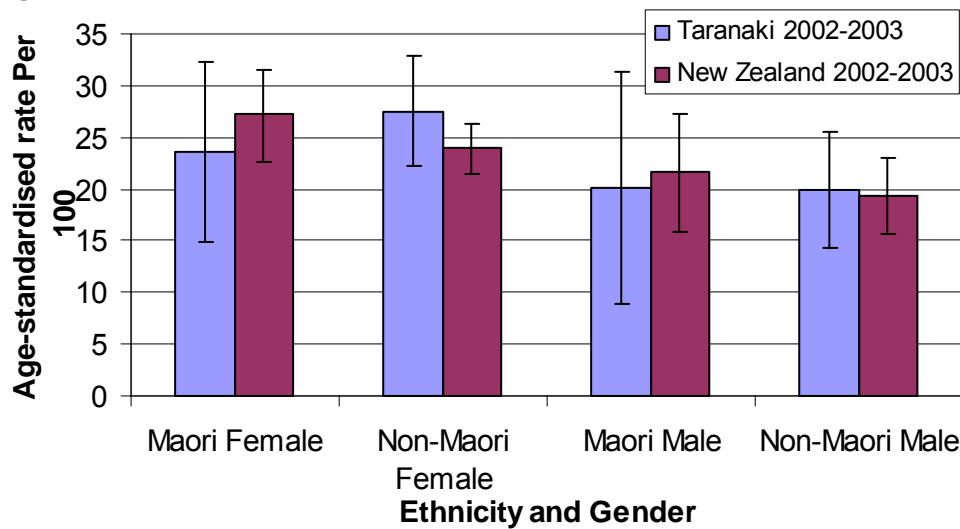
More self management and local care for respiratory disease can also reduce hospital admissions and the severity of the disease for individuals.

Our Strategic Aims For Respiratory Disease

- Less people are developing respiratory disease, especially those diseases whose main risk factor is smoking
- We have increased early detection and reduced the inequality gap
- Fewer people are dying of respiratory diseases due to effective treatment
- A co-ordinated approach to respiratory disease is well established covering prevention, screening, early detection, diagnosis, treatment
- Rehabilitation and palliative care

The self-reported asthma prevalence was similar between Māori and non-Māori in Taranaki and between Taranaki and New Zealand.

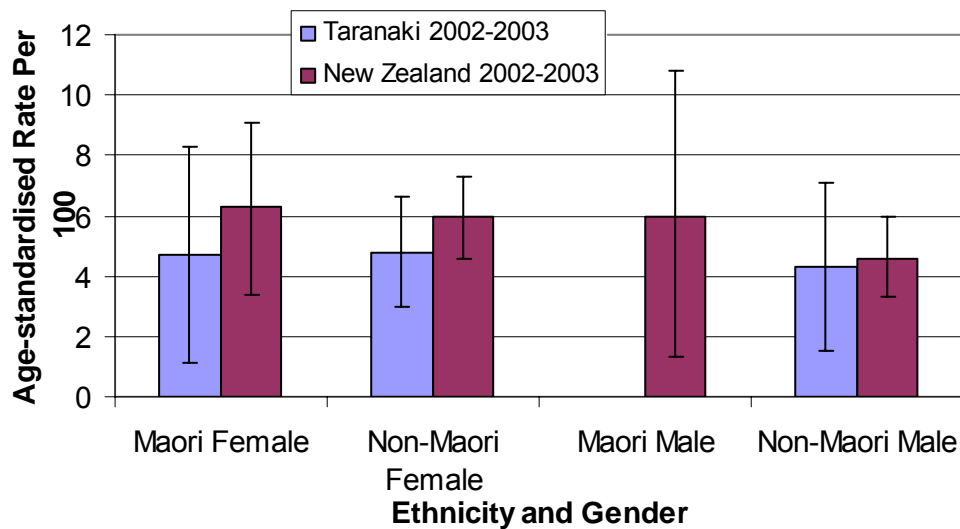
Figure 48: Asthma Prevalence, 15-45 Years



Source: 2002/03 New Zealand Health Survey

The self-reported prevalence's of chronic obstructive pulmonary disease (COPD) were similar between Māori and non-Māori in Taranaki. There was no significant difference in the rates between Taranaki and New Zealand.

Figure 49: Chronic Obstructive Pulmonary Disease (COPD) Prevalence, 45+ Years

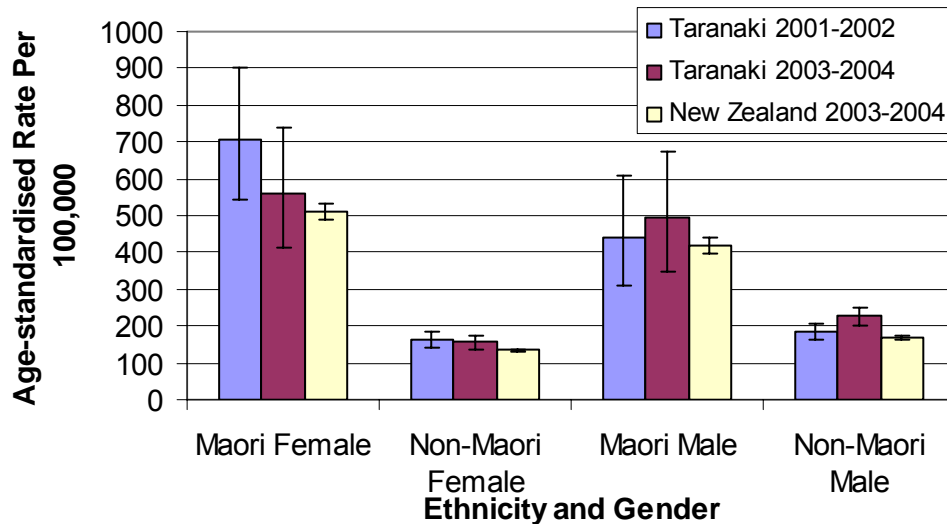


Source: 2002/03 New Zealand Health Survey

Māori had significantly higher rates of COPD hospitalisation than non-Māori in Taranaki. In 2003-2004, the rate for Māori females was 3.5 times higher and for Māori males 2 times higher than non-Māori.

The COPD hospitalisation rate was significantly higher for non-Māori males, and marginally significantly higher for non-Māori females, in Taranaki than in New Zealand.

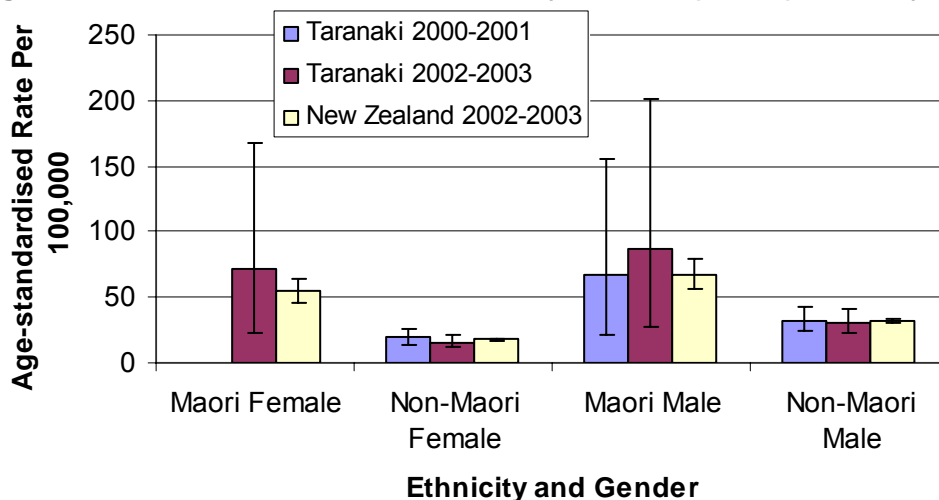
Figure 50: Chronic Obstructive Pulmonary Disease (COPD) Hospitalisation



Source: New Zealand Health Information Service

In 2002-2003 Māori had higher rates of COPD mortality than non-Māori in Taranaki, although this difference was not statistically significant for Māori males. The rate for Māori females was more than 4 times higher than non-Māori females in Taranaki.

Figure 51: Chronic Obstructive Pulmonary Disease (COPD) Mortality



Source: New Zealand Health Information Service

Diabetes

Reduce the incidence and impact of diabetes

Diabetes is estimated to cause at least 1,200 deaths in New Zealand every year. Diabetes complications (such as heart disease, stroke, blindness, kidney failure, and limb amputations) increase the burden of the disease experienced by people from middle age, especially in Māori and Pacific communities.

Obesity, poor nutrition and smoking are key risk factors, particularly for Type II (non-insulin dependent) Diabetes. However, we can do something about the risk factors that contribute to this illness, and if we detect diabetes early and manage the condition, then people's health can be significantly better.

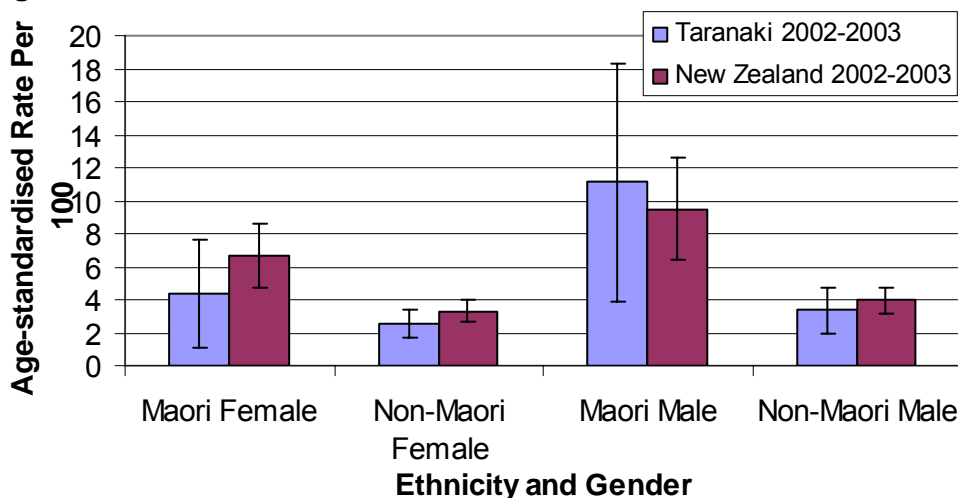
Among Māori, diabetes is estimated to cause almost 20 percent of all deaths and years of life lost. This is second only to the negative impacts of tobacco.

What Are Our Strategic Aims for Diabetes

- Fewer people are developing Type II diabetes, which is associated with lifestyle factors
- Early detection of diabetes has increased due to greater awareness of risk factors and the use of screening tools
- Fewer people require treatment and admission to hospital for complications related to diabetes due to earlier and better self management
- A co-ordinated approach to diabetes is well established that covers prevention, screening, early detection, diagnosis, treatment, rehabilitation and palliative care

Māori had higher self-reported prevalence's of diabetes than non-Māori in Taranaki, although these differences were not statistically significant. The rate for Māori males was higher than Māori females. Again this difference was not significant.

Figure 52: Diabetes Prevalence, 15+ Years

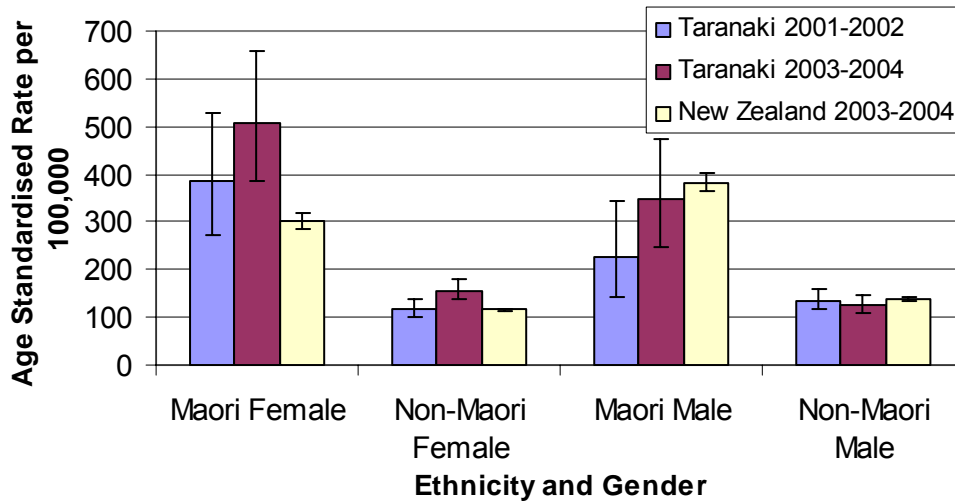


Source: 2002/03 New Zealand Health Survey

Māori diabetes hospitalisation rates were 3 times significantly higher than non-Māori in 2003-2004 in Taranaki.

Both Māori and non-Māori females in Taranaki had significantly higher rates of diabetes hospitalisation than their counterparts in New Zealand.

Figure 53: Diabetes Hospitalisation

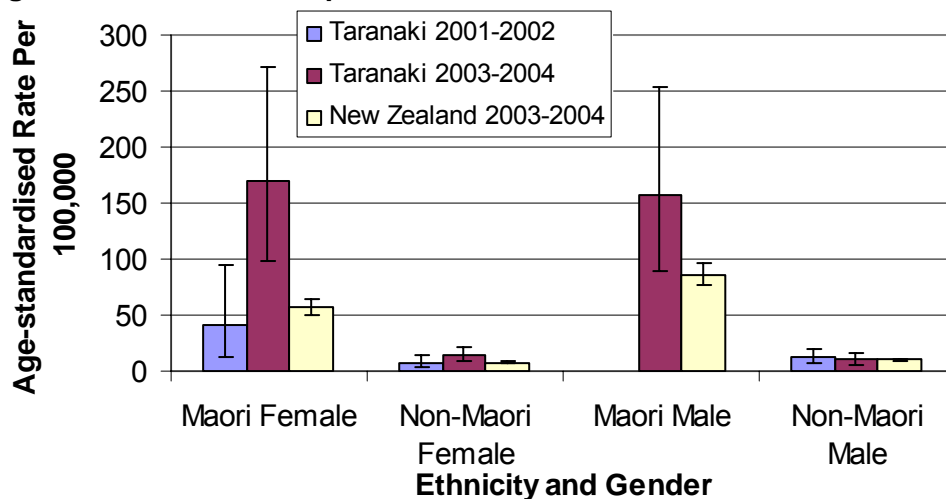


Source: New Zealand Health Information Service

Among Māori females, the rate of renal failure in people with diabetes was 11 times higher and among Māori males, the rate was 15 times higher than among their non-Māori counterparts in Taranaki.

Except for non-Māori males, the rates of renal failure complication in Taranaki were higher than in New Zealand, although these differences were only statistically significant for Māori and non-Māori females.

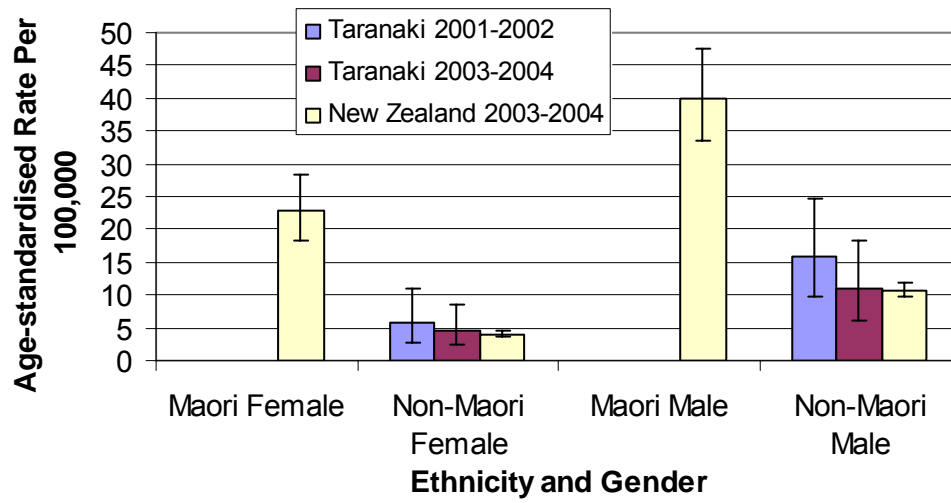
Figure 54: Diabetes Complications – Renal Failure with Concurrent Diabetes



Source: New Zealand Health Information Service

Fewer than five Māori had lower limb amputation with concurrent diabetes in both periods in Taranaki.

Figure 55: Diabetes Complications – Lower Limb Amputation with Concurrent Diabetes



Source: New Zealand Health Information Service

Mental Health & Addictions

Reduce the incidence and impact of Mental Illness and Addiction

One in five New Zealanders has experienced a mental illness and/or an addiction in the past year (representing approximately 20,500 people in Taranaki). The most recent survey of New Zealand mental health in New Zealand, Te Rau Hinengaro, has found 47 percent of the population experience mental illness over the course of their lives. Younger people have a higher prevalence as do Māori and Pacific people. People with a more serious mental health disorder are more likely to make a visit to the health care sector for mental health reasons, including for their use of alcohol and other drugs. However the proportion making a mental health visit to the health care sector is low overall with Pacific people least likely to make contact, and, to a lesser extent, Māori.

Mental health issues have a big impact on the lives of individuals and their families, on society, and on the economy. Part of that impact is that people with experience of mental illness and/or addiction issues are often subjected to discrimination, and this may affect how well or fast people recover. The government has recently broadened its interest in mental health from people severely affected by mental illness to all New Zealanders, while continuing to place an emphasis on ensuring that people with the highest needs can access specialist services.

There is a strong link between depression, anxiety disorders and substance misuse. A growing number of people have an addiction (either from alcohol and/or other drugs or from gambling) and a mental illness.

Of the top ten leading causes of disability worldwide, five out of the ten were mental health problems.

Our strategic aims for Mental Health and Addiction

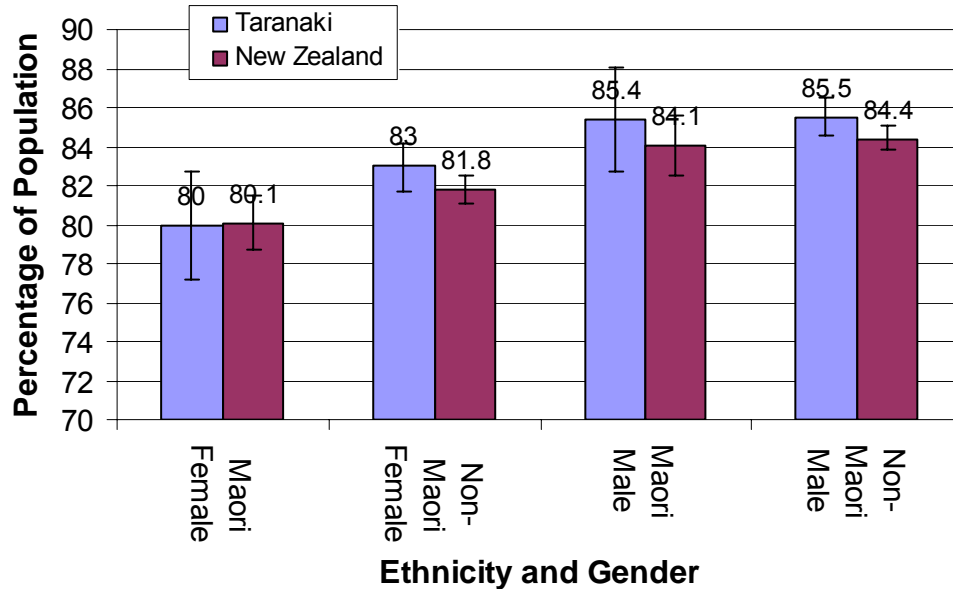
- There is a strong focus on the prevention of mental illness and addictions
- Fewer people experience acute episodes of mental illness due to early and effective intervention
- Suicide rates across all age groups are stabilised, then reduced
- More services are based in the community
- People have access to the services they need and are in control of their care
- Everyone who provides support works closely together

Indicators

There was no difference in the mean score for self-reported mental health status between Māori and non-Māori aged 15+ years in Taranaki. However, both Māori and non-Māori males had significantly higher mean scores than their female counterparts.

The mean mental health status score for non-Māori total in Taranaki was significantly higher than those for New Zealand.

Figure 56: Self-reported Mental Health Status, 15+ Years Age-standardised

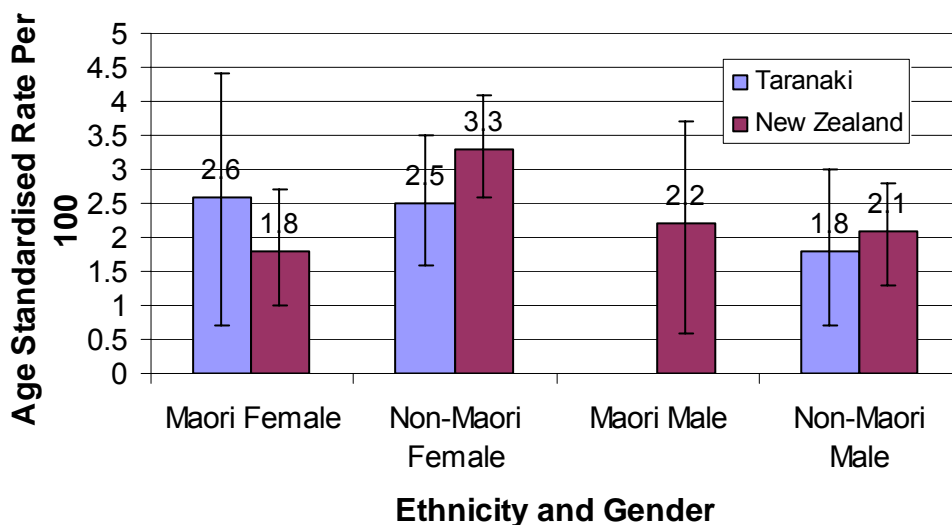


Source: 2002/03 New Zealand Health Survey

Note: SF36 is a standardised questionnaire included in the 2002/03 New Zealand Health Survey for measuring self-reported physical and mental health status.

There was no difference in the self-reported serious mental disorders prevalence between Māori and non-Māori in Taranaki and between Taranaki and New Zealand.

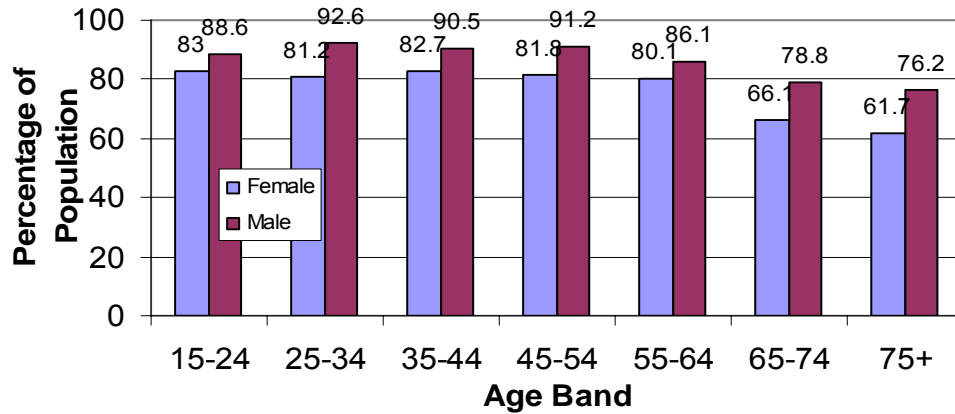
Figure 57: Serious Mental Disorder Prevalence, 15+ Years Age-Standardised Rate Per 100



Source: 2002/03 New Zealand Health Survey

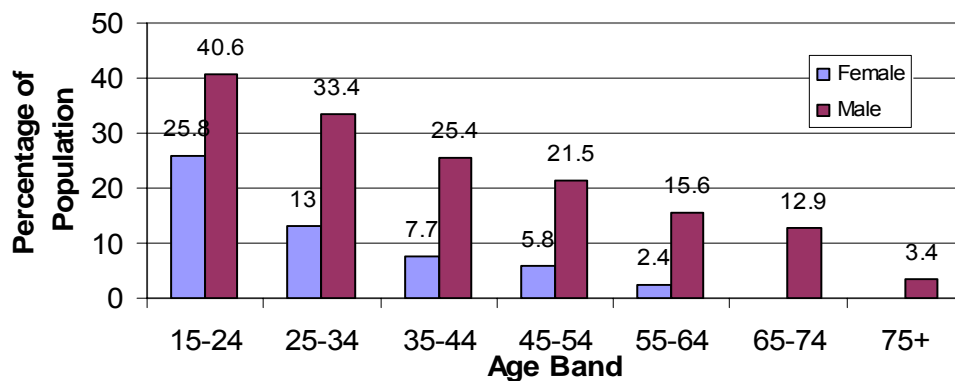
As shown in the next graph, most New Zealanders over the age of 15 consume alcohol on at least one occasion per year, with rates higher in males and decreasing slightly for older people. However, the rates of self-reported hazard drinking (following graph) are high, particularly in males and at younger ages.

Figure 58: Had Alcoholic Drink in the Last Year



Source: 2002/03 New Zealand Health Survey

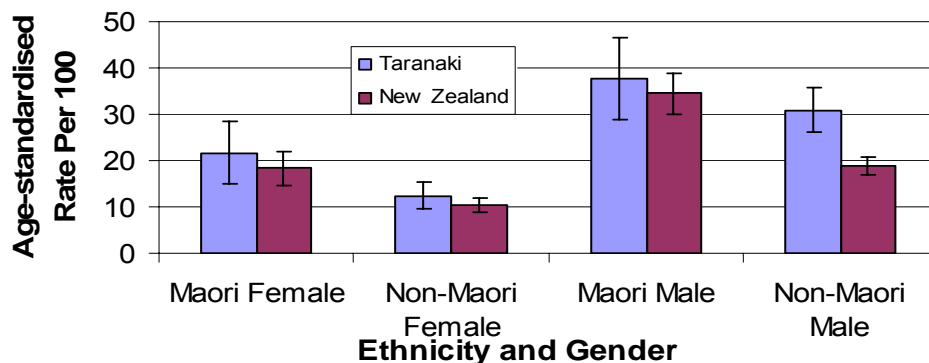
Figure 59: Hazardous Drinking



Source: 2002/03 New Zealand Health Survey

The rates of self-reported hazard drinking were higher among males than females for both Māori than non-Māori in Taranaki, with non-Māori males having statistically significant higher rates than NZ non-Māori males. Māori females and males had higher rates than non-Māori.

Figure 60: Hazardous Drinking 15+ Taranaki compared to NZ, 2002/03



Source: 2002/03 New Zealand Health Survey

Both Māori females and males aged 15+ years had higher rates of self-reported marijuana use in the past year than non-Māori in Taranaki. This difference was significant for Māori females. The rate among non-Māori males was significantly higher than non-Māori females.

Figure 61: Prevalence of Marijuana used in last 12 months, 15+ years



Source: 2002/03 New Zealand Health Survey

The prevalence of self-reported ever using marijuana was significantly higher among Māori for both sexes (though marginally for Māori females) than for non-Māori in Taranaki. The rate for both Māori and non-Māori males was higher than their female counterparts, although the difference was only statistically significant for non-Māori in Taranaki.

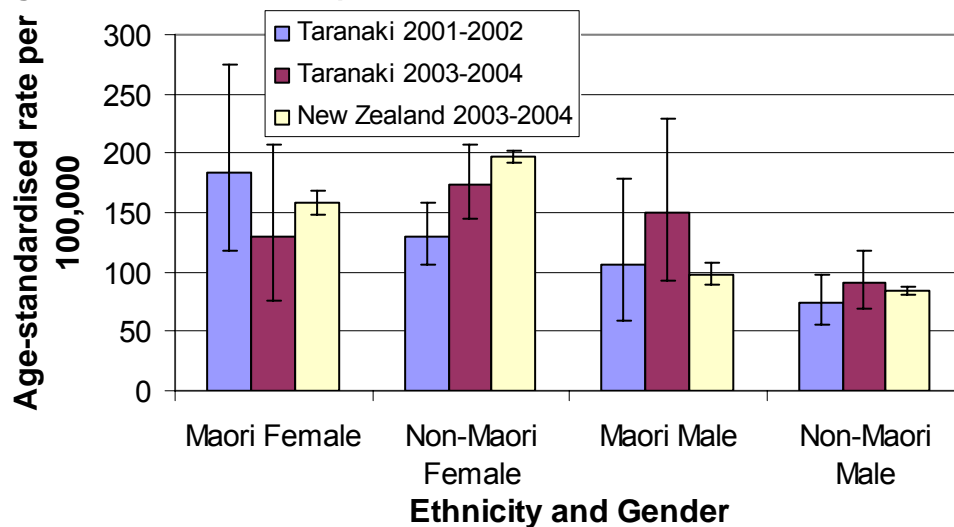
Figure 62: Prevalence of Marijuana Used ever, 15+ Years



Source: 2002/03 New Zealand Health Survey

Māori males aged 5+ years had higher rates of self-harm hospitalisation than non-Māori males in Taranaki, although not statistically significantly. The rate among non-Māori females was significantly higher than non-Māori males.

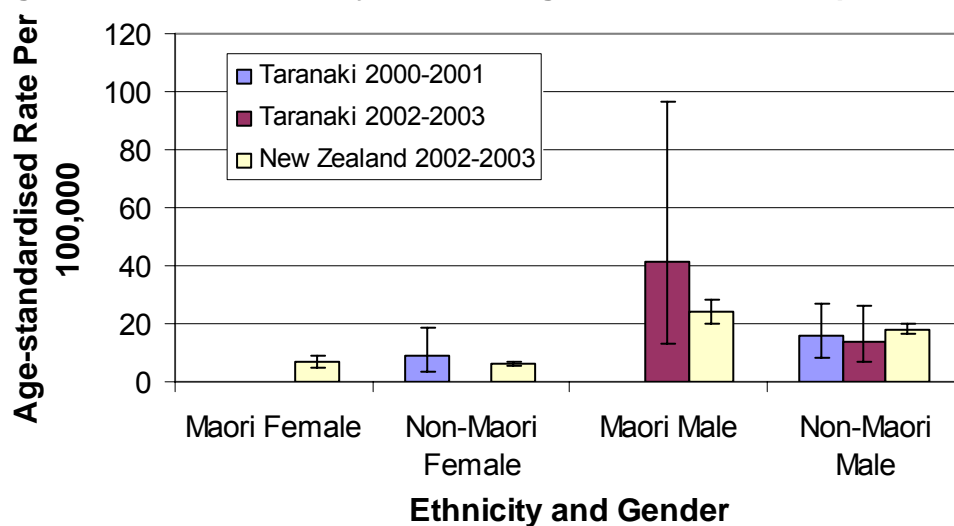
Figure 63: Self-harm Hospitalisation, 5+ Years



Source: 2002/03 New Zealand Health Survey

Māori males and the Māori total had higher rates of suicide mortality than non-Māori in Taranaki in 2002-2003. However, these differences were not statistically significant.

Figure 64: Suicide Mortality, 5+ Years Age-standardised rate per 100,000

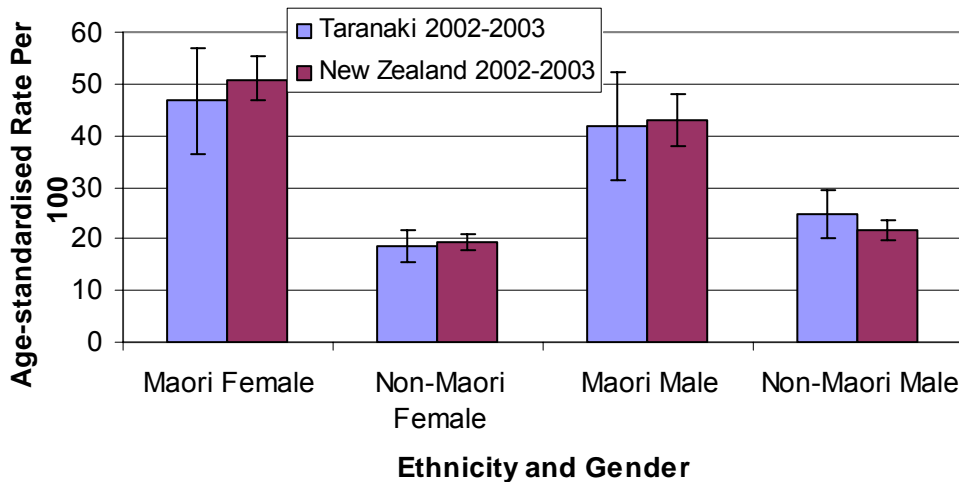


Source: 2002/03 New Zealand Health Survey

Risk & Protective Factors

The rates of current smokers (self-reported) among Māori both sexes were significantly higher than non-Māori in Taranaki. At ages 15+ years, more than two in five Māori were current smokers compared to one in five non-Māori. For a much more detailed review of tobacco use, refer to New Zealand Tobacco Use Survey 2006. Wellington: Ministry of Health (available on website).

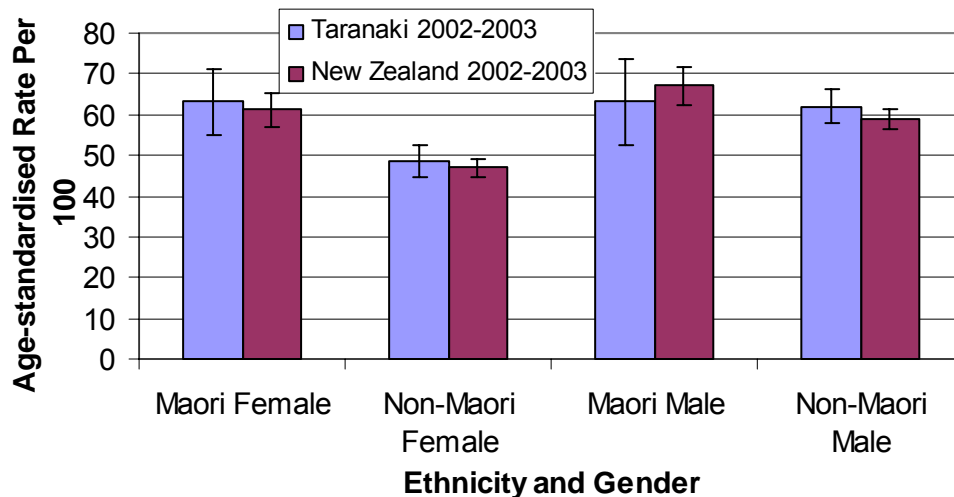
Figure 65: Current Smoker, 15+ Years



Source: 2002/03 New Zealand Health Survey

While the self-reported rate of overweight or obese was similar between Māori and non-Māori males, Māori females had a significant higher rate than non-Māori females in Taranaki. About three fifths of Māori females aged 15+ years were overweight or obese, compared to less than half of non-Māori females.

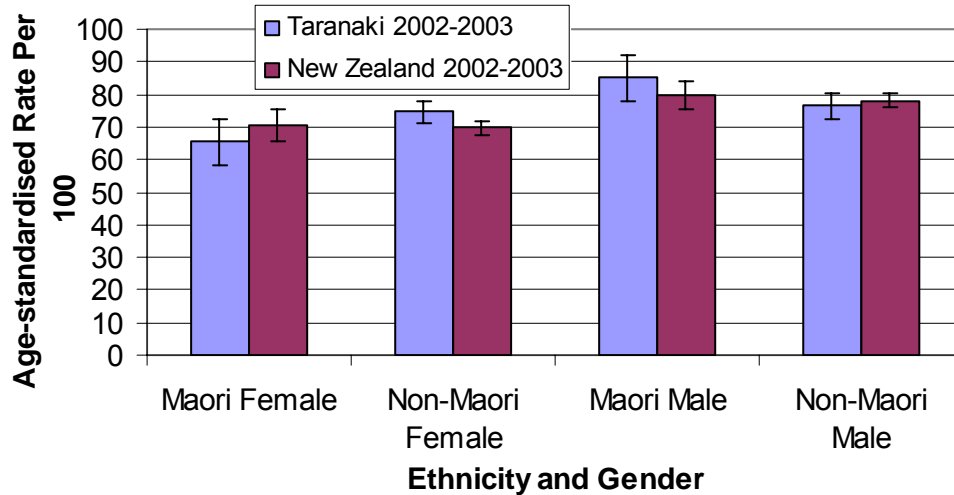
Figure 66: Overweight or Obesity, 15+ Years



Source: 2002/03 New Zealand Health Survey

Maori males were more likely to report taking part in at least 2.5 hours physical activity during the last week than non-Maori males, while Maori females were less likely to report partaking in the physical exercise than non-Maori females in Taranaki. However, these differences were not statistically significant.

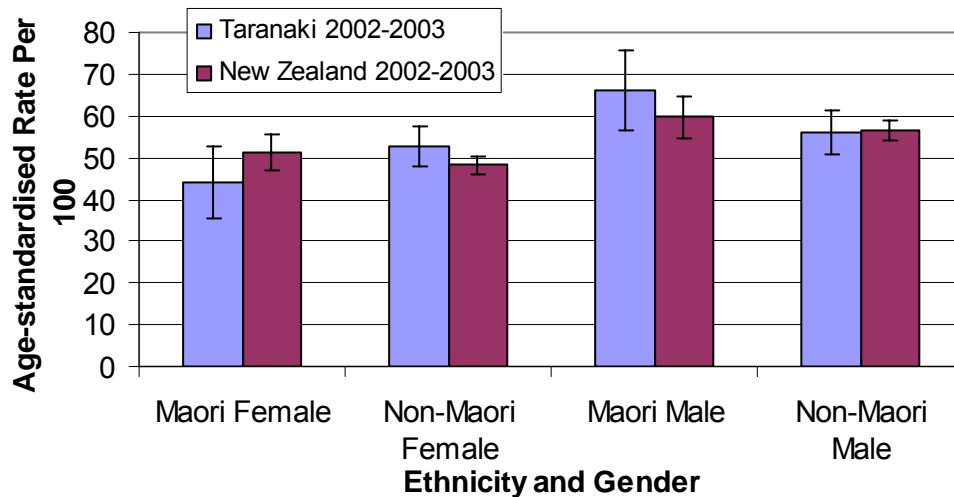
Figure 67: Physically Active, 15+ Years



Source: 2002/03 New Zealand Health Survey

As for the physically active, Māori males were more likely to report being regularly physically active than their non-Māori counterpart, the reverse was true for Māori females in Taranaki. Again, these differences were not statistically significant.

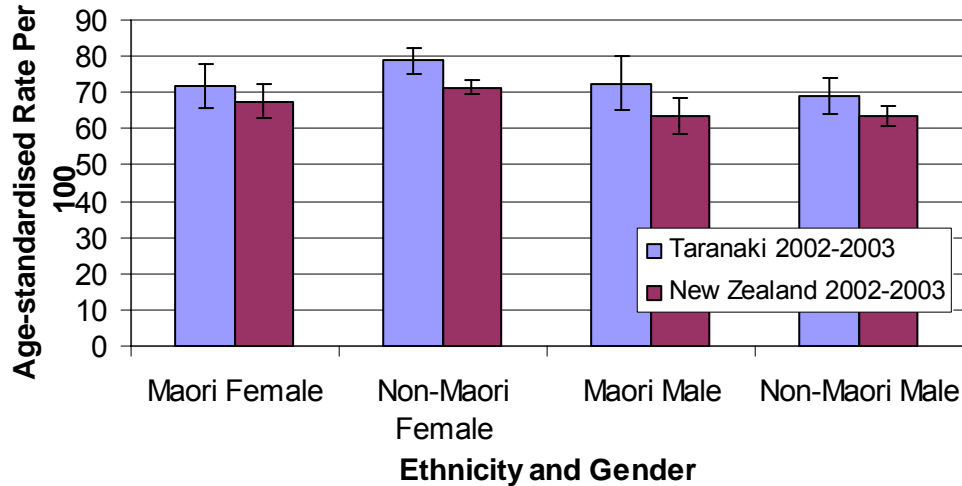
Figure 68: Regularly Physically Active, 15+ Years



Source: 2002/03 New Zealand Health Survey

A similar proportion of Māori and non-Māori aged 15+ years reported consuming the recommended 3+ servings of vegetables per day in Taranaki. There were higher prevalences of self-reported eating 3+ servings of vegetables daily among non-Māori and Māori in Taranaki than in New Zealand. However, this difference was statistically significant for non-Māori.

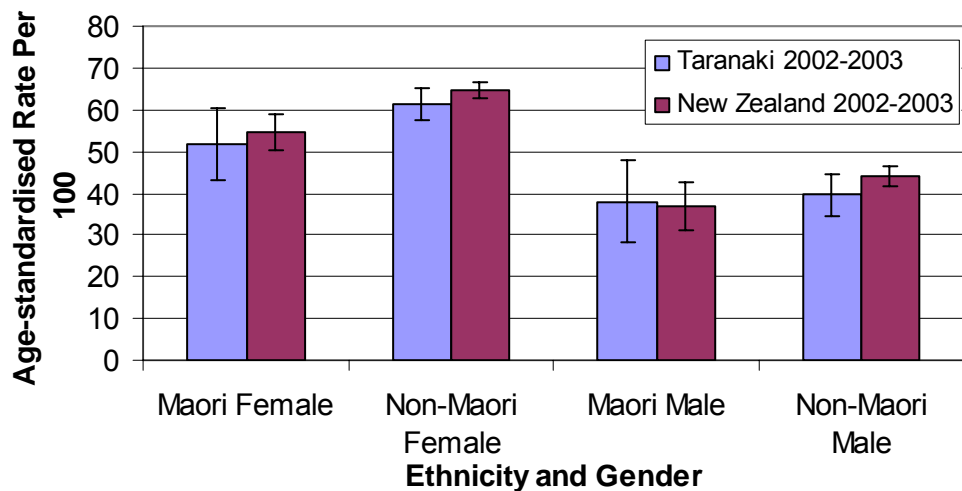
Figure 69: 3+ Servings of Vegetables Per Day, 15+ Years



Source: 2002/03 New Zealand Health Survey

Again, there was no noticeable difference in the rate of reported consuming 2+ servings of fruit daily among Māori and non-Māori in Taranaki. Only about half of both Māori and non-Māori reported consuming the recommended servings of fruit.

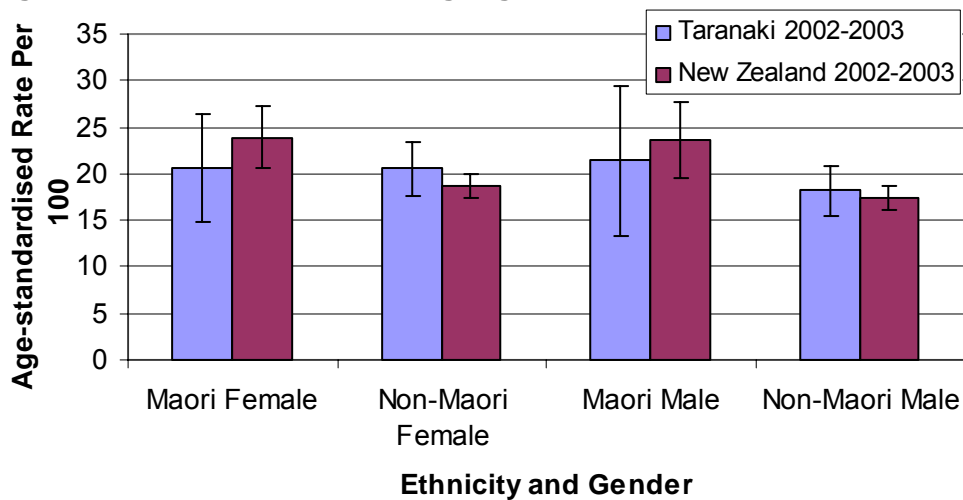
Figure 70: 2+ Servings of Fruit Per Day, 15+ Years



Source: 2002/03 New Zealand Health Survey

There was no difference in the rate of having self-reported high blood pressure between Māori and non-Māori in Taranaki and between Taranaki and New Zealand.

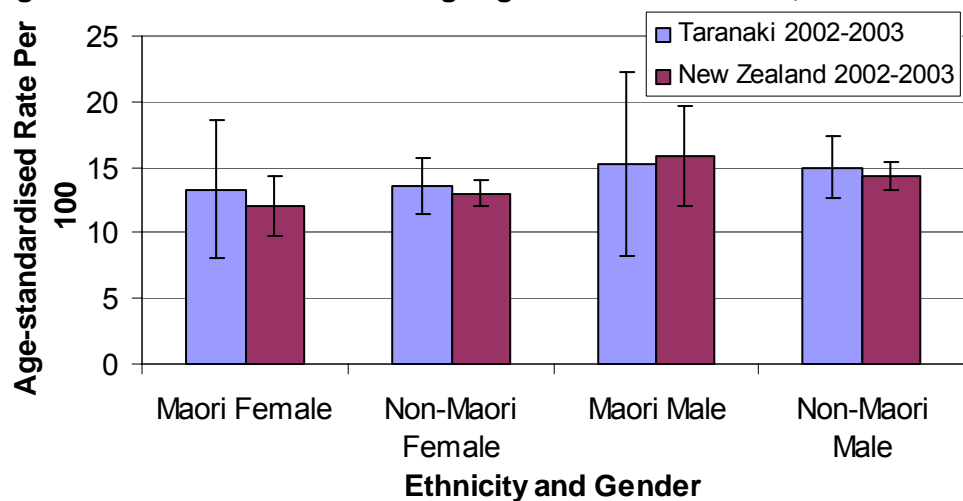
Figure 71: Ever Been Told Having High Blood Pressure, 15+ Years



Source: 2002/03 New Zealand Health Survey

Māori of both sexes had similar rates of having self-reported high blood cholesterol to their non-Māori counterparts in Taranaki. The rates in Taranaki were also similar to in New Zealand.

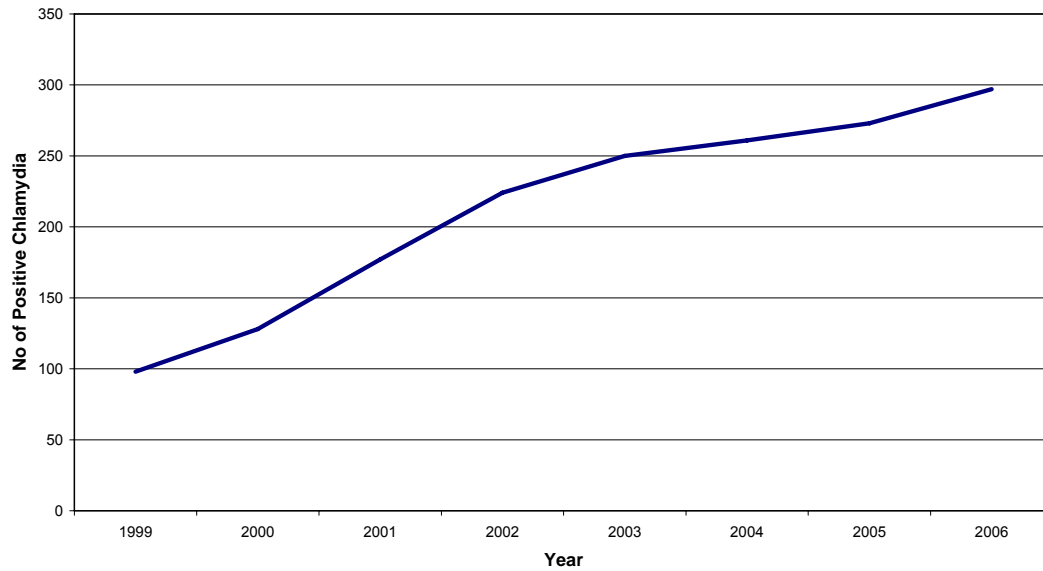
Figure 72: Ever Been Told Having High Blood Cholesterol, 15+ Years



Source: 2002/03 New Zealand Health Survey

Not all cases of sexually transmitted infections are seen in the sexual health clinic, however it is clear numbers have increased steadily in the region over the 1999 to 2006 period. This trend is also evident nationally⁶.

Figure 73: Sexual Health Clinic - Confirmed Positive Chlamydia 1999 - 2006



Source: TDHB Sexual Health Clinic

⁶ www.surv.esr.cri.nz/surveillancereports (Search for STI reports)