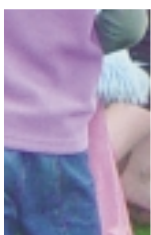
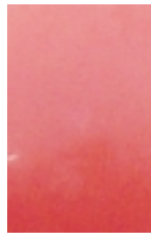
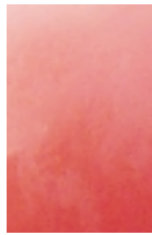
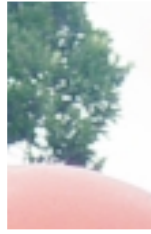
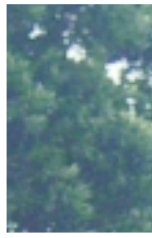
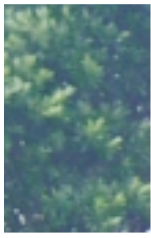


TARANAKI HEALTH NEEDS ASSESSMENT 2005

Summary Report



Taranaki District Health Board



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Introduction

This Health Needs Assessment (HNA) of the Taranaki population is the second in a triennial series undertaken for the Taranaki District Health Board (DHB) and timed to assist the DHB in its review of the District Strategic Plan. The HNA captures the most relevant health statistics currently available for the Taranaki population and provides a picture of our health status by detailing recent trends as well as comparing Taranaki's status against national information, giving us a continuing and improved understanding of our environment.

The HNA updates the demographic and health profiles of the region's population, and includes a stocktake of health and disability services currently funded. The information contained in the HNA is one important piece of work that will contribute to identifying the areas of greatest health need within Taranaki. It is an important factor in our strategic planning review in 2005 and will provide a quantitative evidence-based platform for future service planning. Undertaking the HNA also meets a statutory requirement for all DHBs under the New Zealand Public Health and Disability (NZPHD) Act 2000.

The Ministry of Health (2000) defines a "health needs assessment" as *"the assessment of the population's capacity to benefit from health care services, prioritised according to effectiveness, including cost-effectiveness, and funded within available resources"*. This definition describes a population-based approach; it does not refer to individual health care needs or individual disability support services.

In 2001-02, twelve DHBs (including Taranaki) collaborated in a joint project, managed by the Wellington School of Medicine and Health Sciences Public Health Consultancy, to produce the first HNA reports.

The 2004-05 HNA has been undertaken by the DHB, using internal staff, the Medical Officer of Health plus experienced external contractors and Central Technical Advisory Services. The team also worked in collaboration with the Midland DHBs. The experience and knowledge of our specialist clinical staff has been drawn upon in reviewing this information and report. The clinicians' feedback has been taken on board and recorded in the Technical Report.

The health sector is influenced by the overarching strategic directions within the NZ Health Strategy, NZ Disability Strategy, and He Korowai Oranga (Māori Health Strategy), as well as other government imperatives which guide the planning of health services in Taranaki. The HNA is, thus, only one of many planning influences but its information helps underpin the strategic planning and prioritisation processes Taranaki DHB will undertake, because it provides guidance on the relative importance of health and disability issues for the Taranaki population.

The most recently available and reliable data has been used throughout the HNA. Thus, most demographic data used is derived from the 2001 Census. Where possible health data has been sourced from the 2003 calendar year, and where that has not been possible because of reporting lags through the system, we have used the latest available data, or included time series data so that trends over time can be observed, particularly where the last available data may now be several years old. We have utilised hospital data as reported to national data sets. Primary level data is not yet sufficiently available and reliable to be used, and is an area we intend to improve upon in the next HNA in 2008.

Two documents comprise the Health Needs Assessment:

1. Technical report; and
2. Summary report.

The technical report describes the demographic characteristics of Taranaki's population, the trends observed and predicted over time, demographic determinants of health and health service need, ethnicity data trends where available and reliable, factors that are of health benefit or risk that operate at population levels and observed health and disability outcomes such as service use and death rates. It concentrates on the "top five" hospitalisation and mortality issues for each age group as it is neither possible nor desirable to present all available health and disability information details. The technical report also outlines the currently funded services in Taranaki.

The summary report provides an overview of the Taranaki district population's health determinants, health status and disability support needs. It presents key HNA findings and issues of particular significance for Taranaki when compared to New Zealand.

Inevitably there will be issues of significance or interest for particular readers that are not included in the summary. Because of limitations of time, resource, statistical significance, and privacy for individuals when presenting very small numbers, such issues may also have been too detailed to include in the technical report.

The combined reports are an important collation of current information that will assist the Taranaki DHB to review its strategic objectives for its District Strategic Plan, and provide baseline information on which to base future District Annual Plans and other strategic and service planning to address health and disability priorities and changing population needs.

It is most interesting to note that the findings in this updated HNA mirror the findings of the first HNA undertaken in 2001-02 which means that there is certainty about the directions towards which we would apply effort and resource to achieve changes in health outcomes.

Health Need and Determinants of Health

Health Need

"The broad environment of individual health and encompasses questions of deprivation and inequality related to the socioeconomic determinants of health." (MoH, 2000)

Determinants of Health

The factors affecting health status are complex and multi-layered. At the core of the above diagram are age, sex and hereditary factors which are key contributors to health, and remain relatively unchangeable throughout a person's life. Individual lifestyle factors such as whether a person smokes or exercises are choices made by the individual, but are also influenced by wider social, cultural, environmental and socioeconomic factors. To address "health needs" the wider determinants of health must also be addressed.

Meeting "health need" is not the exclusive responsibility of the health sector, but rather the responsibility of multiple sectors and will involve ongoing collaboration between health, education, housing, employment and welfare sectors.

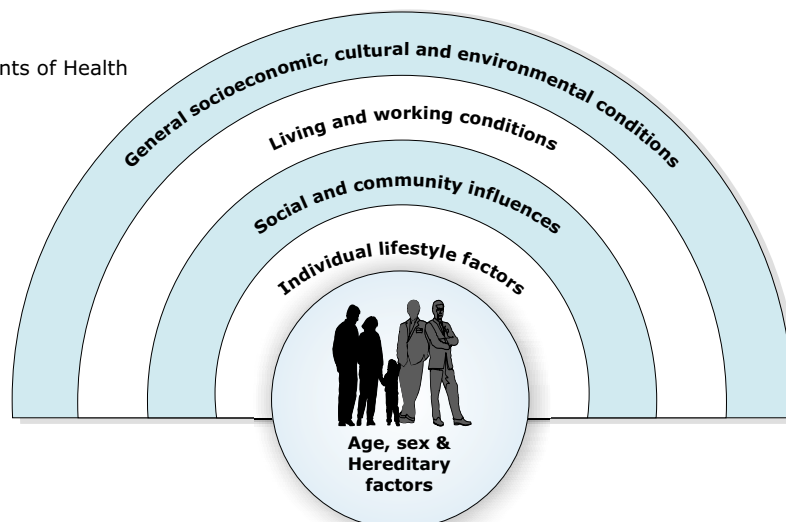
"Health Care Need"

The term "health care need" can be used to describe a population's need for the provision of particular health care services.

In an analysis of the resources necessary for the effective provision of health care, health care needs assessment not only reflects the prevalence or incidence of the condition or disease state concerned, but the number of individuals likely to benefit from treatment and for whom treatment is generally regarded as a reasonable investment for a publicly funded treatment.

Therefore there needs to be some consideration of the effectiveness, including cost effectiveness, of services in which an investment is being considered. Because available resources in all health care systems are finite, and demand will always outstrip supply, prioritisation of health service purchasing will be necessary.

Figure 1 Determinants of Health



Source: adapted from Dahlgren & Whitehead (1991)

Taranaki DHB's Population

Taranaki DHB's area of responsibility covers a total land mass of 7,273 square kilometres and comprises the territorial local authority districts of South Taranaki, Stratford and New Plymouth. There are a few densely populated centres such as New Plymouth City in northern Taranaki, Stratford in central Taranaki, and Hawera in south Taranaki. The rest of the population is scattered in and around small rural centres.

Taranaki DHB serves a population of 102,858 people (2001 Census), 2.8 percent of New Zealand's population. This represents a decrease of 3,732 people from the 1996 Census.

The three territorial local authorities in Taranaki are:

- **New Plymouth District**

The New Plymouth District covers northern Taranaki, has a population of 66,547, which is 64.7 percent of Taranaki's population (2001 Census), and is ranked fifteenth in size out of the 74 Territorial Authorities in New Zealand. The main urban centre is New Plymouth.

- **Stratford District**

Stratford District is the smallest of the three territorial local authorities in Taranaki. It administers the central Taranaki area, and has a population of 8,830, representing 8.6 percent of Taranaki's population. Stratford is the main town in this district.

- **South Taranaki District**

South Taranaki District covers southern and western Taranaki, and has a population of 27,481 (26.7 percent of the district's population). Hawera is the largest town, with Opunake, Eltham, Patea, Waverley and Manaia nearby smaller towns.

The total population of Taranaki is projected to continue to decline over the next ten years, as it has done over the past three Censuses. Taranaki has had a relatively high net outward migration, both inter-regionally and internationally. This is likely to relate to the type of employment and tertiary education opportunities that exist in the district.

In contrast, both the number and proportion of Māori in all age groups, except children and adults aged 35 to 44, are projected to increase in the next ten years. Māori have a younger population structure than non-Māori due to a higher birth rate and lower life expectancy.

A growing proportion of the population are in the over 65 years age group, because of major improvements in life expectancy over the past eighteen years.

People of European ethnicity make up approximately 80.3 percent of the usual Taranaki population, Māori approximately 14.2 percent, Asian about 1.3 percent, Pacific about 1.3 percent. Pacific peoples' numbers are increasing, but remain the smallest population group.

Birth rates for Taranaki are slightly lower than national rates, and are declining. In 1998 there were 1,538 live births in Taranaki, compared to 1,373 in 2003. Māori make up approximately 14 percent of the Taranaki population, but 23 percent of all live births.

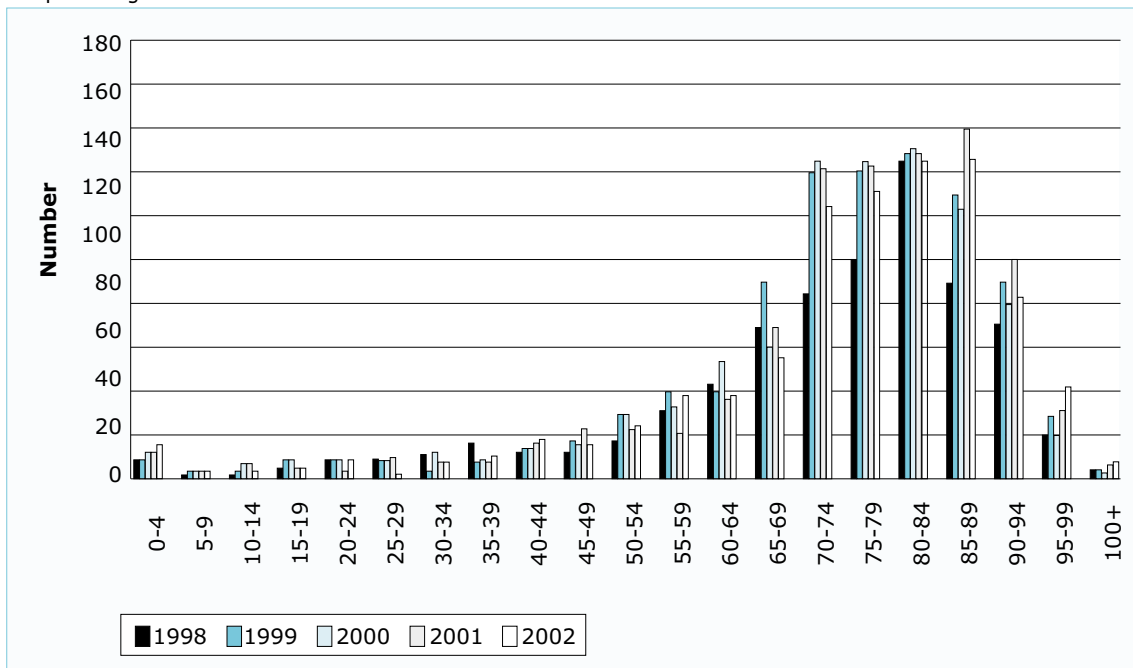
The all-cause death rate for Taranaki is significantly lower than the national rate. In 1998 the number of deaths in Taranaki was 754 (55 were Māori) compared to 890 in 2002 (92 were Māori), with an average of 867 deaths per annum across this five year period.

Health Need and Determinants of Health

Taranaki DHB's Population (cont'd)

The age at death is shown in the graph below:

Graph 1 - Age at Death for Taranaki 1998-2002



Source: NZ Statistics

People over 60 years accounted for 83 percent of deaths, with half those people being over 80 years. Māori deaths peak ten years earlier than non-Māori .

Between 1980 and 1998 mortality rates for people aged 65-74 years decreased from 35 per 1000 to 22 per 1000.

Mortality rates in older age groups have been decreasing in New Zealand, with the biggest reduction being in the 65-74 years age groups.

This represents a 37 percent reduction over the 18 year period. Mortality rates for those aged 75-84 years, and 85 years and over both decreased by 35 percent over the same time period.

Cardiovascular disease is the leading cause of death in New Zealand and in Taranaki and consequently has a large impact on health services.

Ischaemic heart disease (IHD) is the major cause of death, followed by stroke, which is the greatest cause of disability in older people.

Taranaki Socio-Economic Characteristics, 2001

- The unemployment rate in Taranaki was 7.8 percent, compared with 7.5 percent for all of New Zealand.
- Educational qualifications of Taranaki residents showed fewer people with secondary or tertiary qualifications in Taranaki compared to the national average.
- The average household size in Taranaki was 2.5 people, compared with 2.7 for all of New Zealand.
- 96.1 percent of households in Taranaki had access to a telephone, compared with 96.3 percent for all of New Zealand.
- 89.7 percent of households in Taranaki had access to a motor vehicle, compared with 89.9 percent for the whole of New Zealand.
- For dwellings that were rented, the average weekly rent paid for permanent private dwellings in Taranaki was \$124, compared with \$174 for New Zealand as a whole.
- 72.0 percent of dwellings in Taranaki were owned with or without a mortgage, compared with 67.8 percent for all of New Zealand.
- The total average annual spending for households in Taranaki was \$41,564 compared with \$43,682 for the whole of New Zealand

Population Health Benefits and Risks

New Zealand-wide data for 1997 (revised 2004) identified approximately 30 percent of deaths as attributable to the joint effect of dietary factors, including six percent to inadequate vegetable and fruit consumption. Tobacco consumption was responsible for 18 percent of all deaths (combining active and passive smoking) and insufficient physical activity for almost ten percent. These trends have endured.

Among biological risk factors, higher than optimal total blood cholesterol accounted for 17 percent of deaths. This burden of risk surpasses that of higher than optimal blood pressure (13 percent of deaths) and body mass index (11.5 percent), although the latter is continuing to rise. All three of these major biological risk factors overlap in large part with the behavioural risk factors contributing to the nation's dietary and physical activity patterns. Approximately 17 percent of all deaths are attributable to relative deprivation (an impact equivalent to those of smoking or cholesterol).

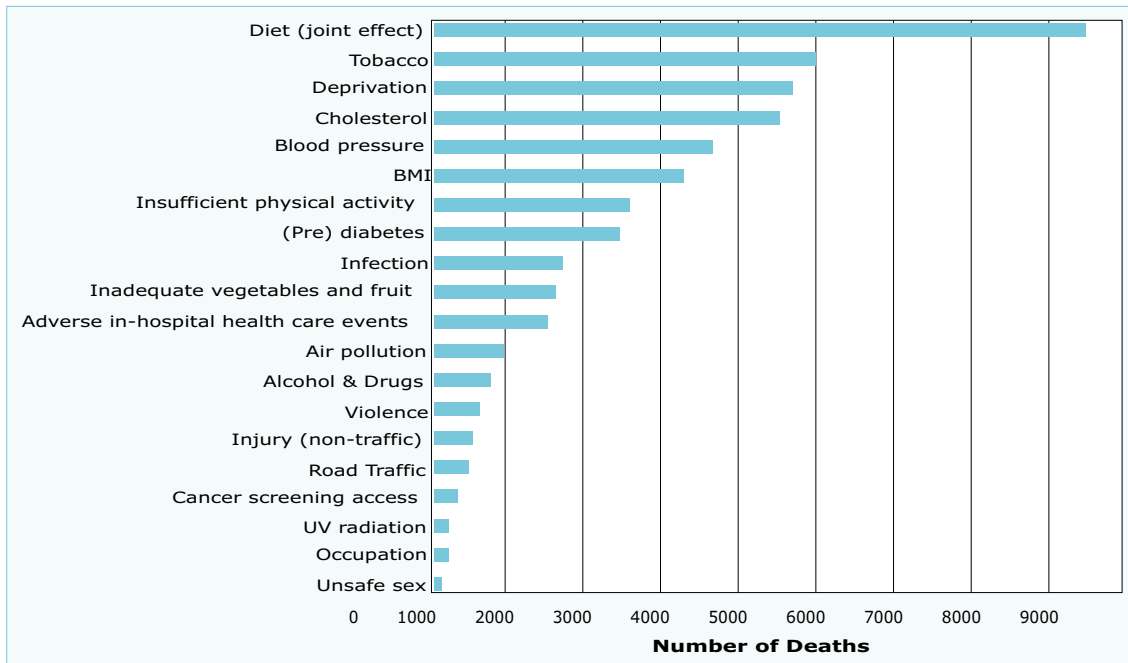
The following diagrams, provided by Public Health Intelligence, Ministry of Health, graphically depict the top twenty causes of death by risk factor in New Zealand. The information we have suggests the Taranaki picture is no different, and the total picture has not changed since 1997.

The largest proportion of hospital admissions for Taranaki DHB between 1996 and 2003 were for chronic diseases. The most common groups treated were:

- **Cardiovascular diseases (including angina, IHD and stroke.)**
- **Respiratory diseases, including asthma and chronic obstructive pulmonary disease (COPD)**

Health Need and Determinants of Health

Graph 2 - Top 20 causes of death, by risk factor, New Zealand, 1997 (updated 2004)



Source: Public Health Intelligence Occasional Bulletin Number 20, Ministry of Health, Looking Upstream: Causes of death cross-classified by risk and condition, New Zealand, 1997 (Revised edition, November 2004).

Table 1 - Causes of death, by risk factor, 1997 (ages and genders pooled)

Risk Factor Group	Risk Factor	Percentage of All Deaths
Behavioural	Diet (joint effect)	29
	Inadequate vegetable and fruit intake	6
	Insufficient physical activity.....	9.5
	Tobacco	18
	Alcohol.....	<5
	Illicit drugs	<5
	Unsafe sex	<5
	Road traffic injury.....	<5
	Injury (other unintentional)	<5
	Violence	<5
Biological	Cholesterol (total).....	17
	Blood pressure (systolic).....	13
	BMI.....	11.5
	(Pre)diabetes	8.5
Environmental	Microbes	6.5
	Radiation.....	<5
	Air pollution	<5
	Occupational.....	<5
Socio-cultural Health care	Deprivation	17
	Lack of cancer screening	<5
	Unanticipated adverse health care events (in public hospitals)	6
All	Joint effect.....	75

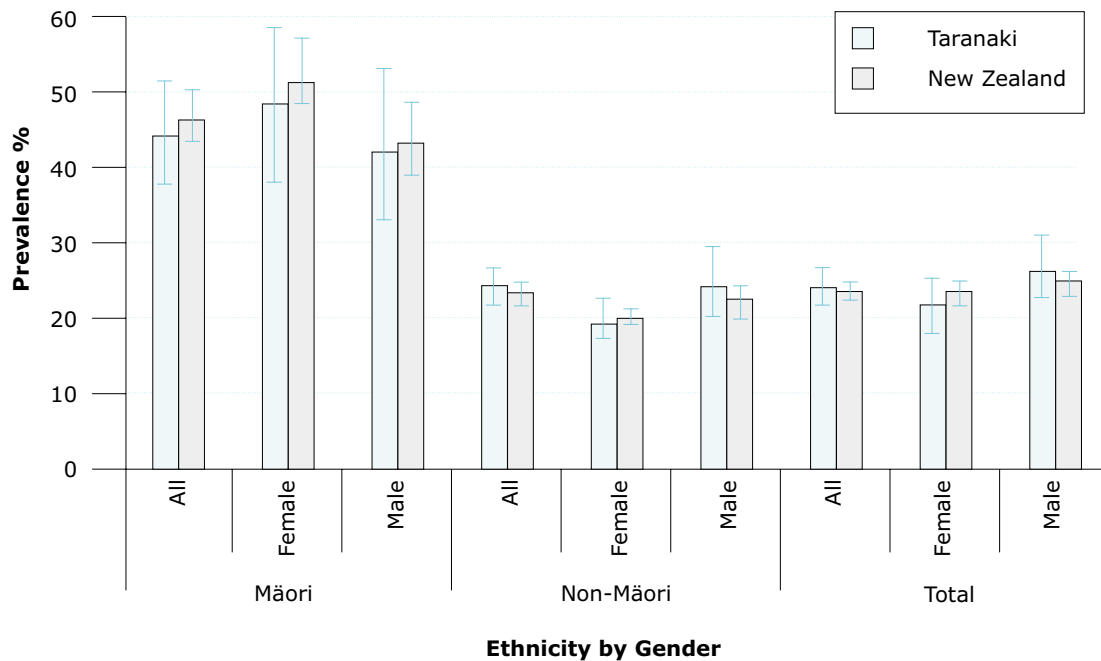
These diagrams demonstrate that most risk factors, particularly those related to good diet, adequate physical activity and avoidance of tobacco, are modifiable. This is promising for the future, if population and individual messages are accepted by the community, as these risk factors are common across a range of disease states.

Source: Public Health Intelligence Occasional Bulletin Number 20, Ministry of Health, Looking Upstream: Causes of death, cross-classified by risk and condition, New Zealand 1997 (Revised Edition, November 2004)

Key Health Risk Factors in Taranaki

- All Males (including Māori) in Taranaki have 1.5 times less adequate fruit and vegetable intake than their female counterparts.
- Māori as a whole have less intake of adequate fruit and vegetables than non-Māori.
- Māori males have the highest prevalence of adequate physical activity whereas Māori females have the lowest prevalence of adequate physical activity in Taranaki.
- As with New Zealand overall, Taranaki Māori have a considerably higher prevalence of current smokers compared to non-Māori.

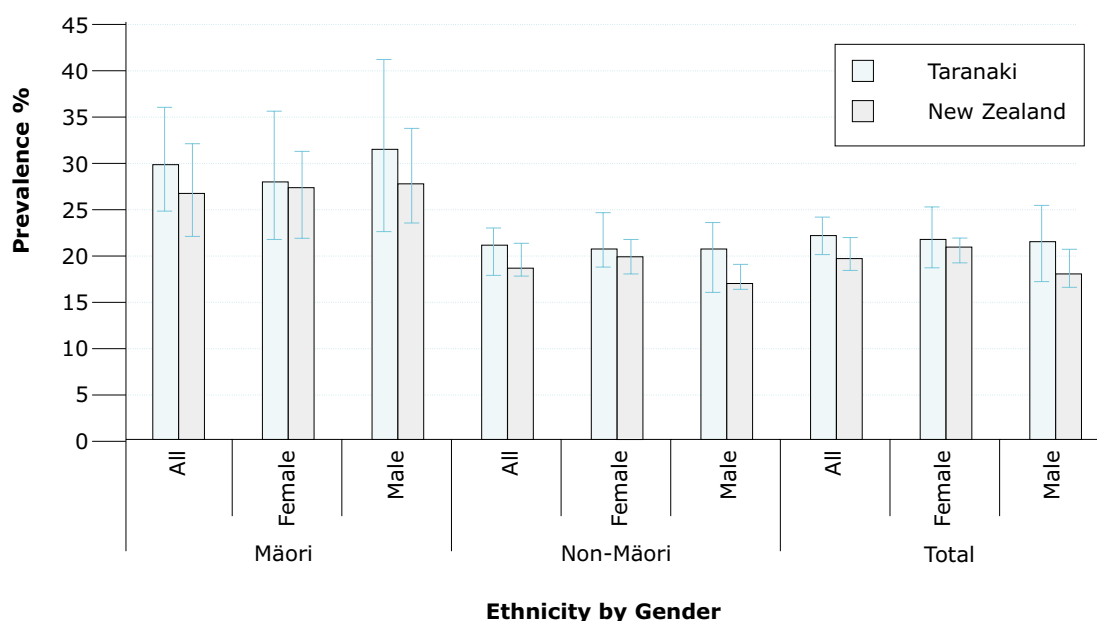
Graph 3 - Percentage Prevalence of Current Smokers by Gender and Ethnicity for Taranaki and New Zealand



Source: Central Region's Technical Advisory Services Ltd (TAS) 2004

- As with New Zealand overall, Taranaki Māori females represent a larger proportion of smokers than Māori males, whereas non-Māori female smokers are outnumbered by their male counterparts.
- Taranaki Māori and New Zealand Māori populations have a markedly higher prevalence of obesity than non-Māori.

Graph 4 - Percentage Prevalence of Obesity by Gender and Ethnicity for Taranaki and New Zealand



Source: Central Region's Technical Advisory Services Ltd (TAS) 2004

- Taranaki Māori males have a higher rate of obesity than national Māori rates, despite the prevalence of adequate physical activity (but this may be age dependent)

Taranaki has slightly higher rates of obesity compared with the New Zealand rates across both genders

Water quality

The quality of drinking water in Taranaki is similar to the water quality for New Zealand overall. The proportion of farm and rural water supplies is similar to other provincial regions; however, from the information available to the Public Health Unit, the quality of farm and small community supplies is below the national average.

This recognises however that not all farm drinking water supplies are tested and that many of the Fonterra tests are for a different supply from the drinking supply. The best information we have available suggests that, in 2003, 98 percent of the Taranaki population lived in areas that were within complying zones in terms of bacteriological compliance for water quality.

Key Findings - Taranaki HNA, 2004-05

Life Expectancy

In Taranaki, life expectancy at birth differs between Māori and non-Māori and between males and females.

Table 2 - Life expectancy by age, in Taranaki and New Zealand for Māori and non-Māori males by gender 2001

	Taranaki Māori	Taranaki non-Māori	NZ Māori	NZ non-Māori
Male	68.3	76.3	67.2	75.3
Female	72	81.1	71.6	80.6

Source: NZ Statistics 2001

Total hospitalisations, mortality, cancer registrations, and notifiable diseases have been sorted into the "Top Five" conditions for each age group in Taranaki and New Zealand. Where the numbers are sufficient for each of the conditions found they have been analysed by number, rate, ethnicity, age group, gender, and deprivation characteristics (and some combinations of these). The findings from this are presented extensively in the technical report.

Table 3-Top five mortality numbers and percentages for Taranaki and New Zealand 1988-2001 for all ages and all ethnicities

Taranaki	No.	Percent	New Zealand	No.	Percent
Ischaemic heart disease	2,005	43.6	Ischaemic heart disease	55,231	40.4
Stroke	861	18.7	Stroke	26,686	19.5
Lung cancer	611	13.3	Lung cancer	19,236	14.0
Chronic Obstructive Pulmonary Disease (COPD)	583	12.7	COPD	20,065	14.0
Colorectal cancer	534	11.6	Colorectal cancer	15,395	11.3

Source: Central Region's Technical Advisory Service Ltd (TAS) 2004

Cardiovascular disease is the leading cause of death in New Zealand and in Taranaki, thus it has a large impact on the delivery of health services. Of the cardiovascular diseases, ischaemic heart disease (IHD) is the major cause of death, followed by stroke, which is the greatest cause of disability in older people.

Table 4 - 'Top Five' Hospitalisations from 1996 to 2003 for All Age Groups and All Ethnicities

Taranaki	No.	Percent	New Zealand	No.	Percent
Angina	6,642	40.3	Angina	181,678	35.6
Respiratory infections	2,918	17.7	Respiratory infections	113,123	22.2
Ischaemic heart disease	2,691	16.3	Ischaemic heart disease	69,103	13.6
ENT infections	2,152	13.1	ENT infections	70,085	13.8
Gastroenteritis	2,077	12.6	Cellulitis	75,688	14.9

Source: Central Region's Technical Advisory Services Ltd (TAS) 2004

The largest proportion of hospital admissions for Taranaki DHB between 1996 and 2003 was for chronic diseases. The most common groups of chronic diseases treated were:

- Cardiovascular diseases (including angina, hypertensive disease (the hospitalisation rate is generally higher than the NZ rate), ischaemic heart disease and stroke).
- Respiratory diseases (including asthma and COPD)
- Ear, Nose and Throat (ENT) infections also account for large numbers of hospitalisation in Taranaki.

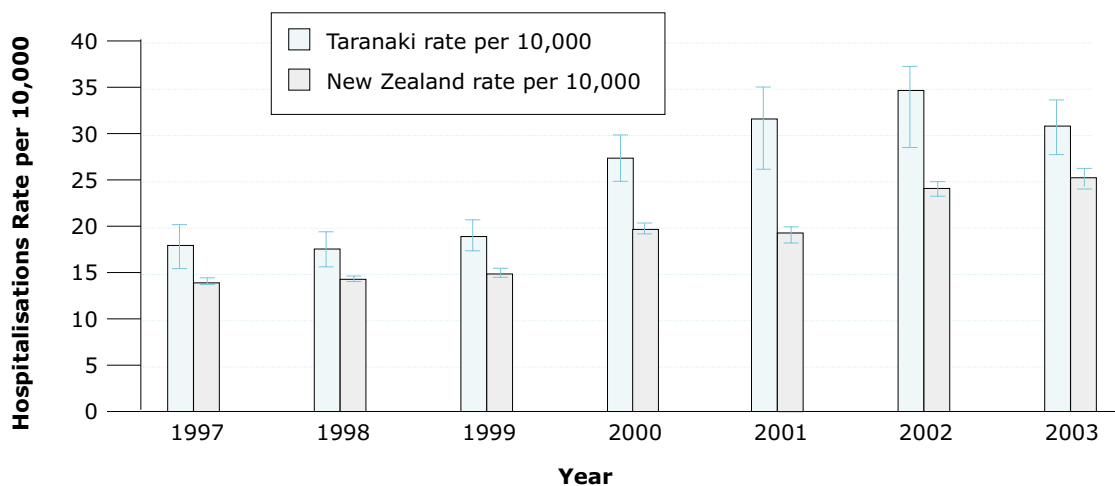
Cardiovascular Disease

The cardiovascular disease suite is an area of significance in terms of impact on the Taranaki population, and one where many of the risk factors are shared with Cancer and Diabetes and are potentially modifiable, for example nutrition, physical activity, obesity and smoking.

Ischaemic Heart Disease

During the period 1997-2003, 2,560 people were hospitalised for ischaemic heart disease (IHD) in Taranaki. In 2001 216 people died of IHD. The Taranaki rate is higher and is growing at a faster rate than the New Zealand rate. For the period covered the differences between Taranaki and New Zealand rates are statistically significant.

Graph 6 - Age Standardised Hospitalisation Rates for Ischaemic Heart Disease per 10,000 for Taranaki and New Zealand Total Population, 1997-2003



Source: Central Region's Technical Advisory Services Ltd (TAS) 2004

Stroke

During the period 1997-2003, 892 people were hospitalised for Stroke in Taranaki and 861 people died of Stroke. 96 percent were Other ethnicities and Māori accounted for the remaining four percent. The differences between Taranaki and New Zealand rates, however, are not statistically significant.

Respiratory Disease

Respiratory diseases, particularly Asthma and Chronic Obstructive Pulmonary Disease (COPD) create a significant burden of disease and cause of death for people within Taranaki. The Asthma profile is particularly significant for children and Māori, and COPD has a strong impact on older people. The risk factors are modifiable, particularly smoking which either causes or exacerbates all respiratory diseases, and effective uptake of smoking prevention and cessation messages, as well as effective primary interventions can greatly reduce hospital admissions and the severity of the disease.

Asthma

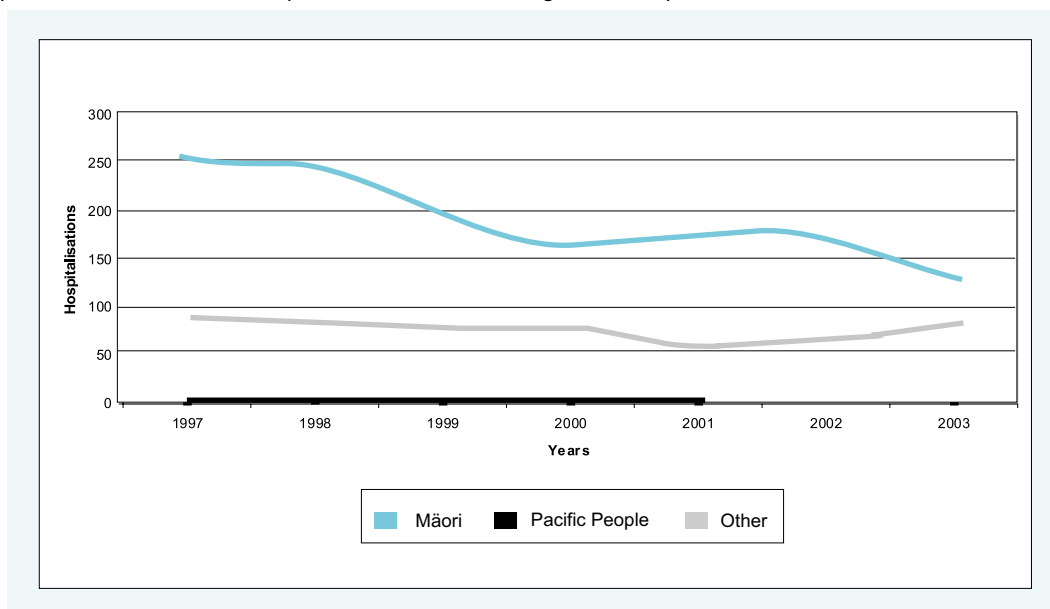
High levels of hospital admissions for asthma are a common phenomenon in developed countries and Taranaki hospitalisations also reflect this common finding.

Asthma accounts for substantial numbers of hospital admissions in Taranaki including:

- 17.8 percent of hospital admissions in the 0-14 year age groups
- 13.6 percent of hospital admissions in the 15-24 year age groups
- 13.8 percent of hospital admissions in the 25-44 year age groups

There is also a rise in hospital admissions at older ages after the age of 50, however in Māori this rise starts in the mid-thirties.

Graph 7 - Taranaki Asthma Hospital Admissions According to Ethnicity 1997-2003



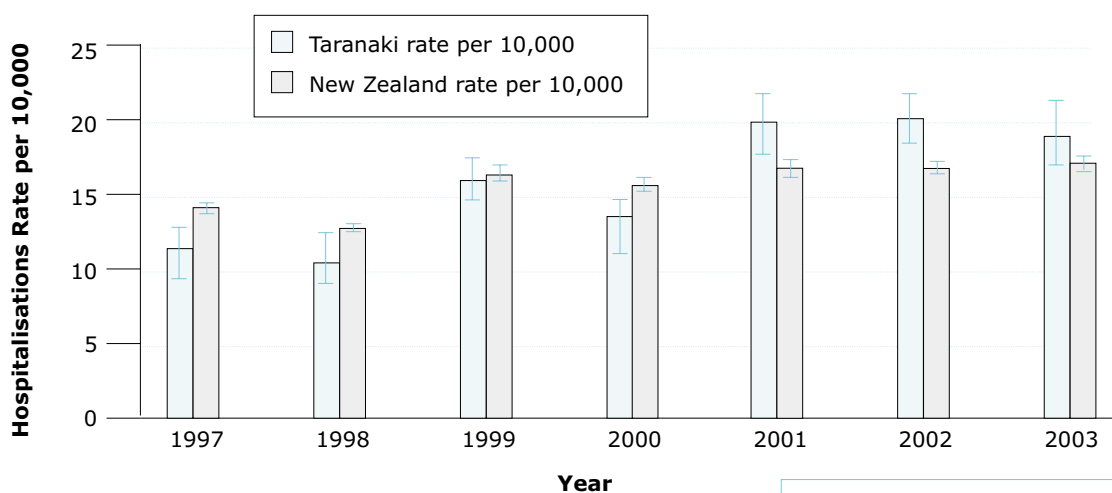
Source: Central Region Technical Advisory Services Ltd (TAS)

This graph shows that overall the numbers of hospital admissions for asthma for the Other ethnic group account for 71 percent of the total, Māori 29 percent and Pacific people one percent.

Chronic Obstructive Pulmonary Disease (COPD)

There were 1,770 hospitalisations for COPD from 1997 to 2003. Hospitalisations in the Other ethnicity group accounted for 86 percent of the COPD hospital admissions, Māori accounted for 13 percent and Pacific People made up the remaining one percent. The number of hospitalisations for COPD increased overall for all ethnicities.

Graph 8 - Age Standardised COPD Hospitalisations Rate per 10,000 - Total Ethnicity, 1997-2003 v



Source: Central Region's Technical Advisory Services Ltd (TAS) 2004

COPD is a significant cause of hospital admissions for older people in Taranaki.

Overall both Taranaki and New Zealand rates increased between 1997 and 2003. Taranaki rates were slightly higher than the national rates.

Cancer

Cancer rates will continue to rise slowly over the coming years, as our population ages. However, the risk of dying from cancer has not increased, due to improved treatment and earlier diagnosis. There were 3,231 deaths from cancer in the period between 1988 to 2001 in Taranaki. Nationally, cancer accounts for 29 percent of all deaths in New Zealand and is the second leading cause of death.

A total of 4,987 people in Taranaki developed cancer between 1991 and 2001. Māori accounted for six percent of these registrations with all other ethnicities making up the remaining 94 percent. The number of cancer registrations fluctuated over the period 1991 to 1996, with numbers increasing from 1996 to 2000.

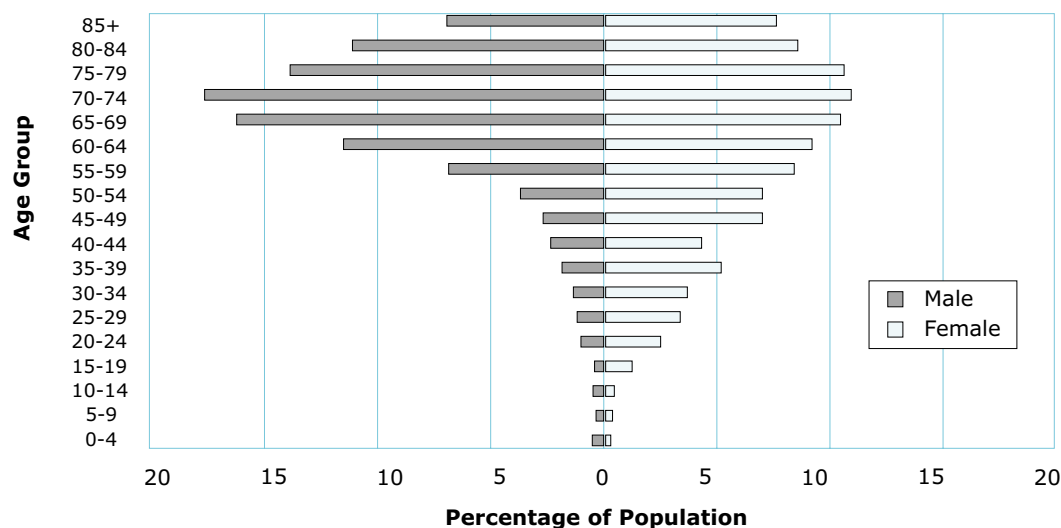
Leukaemias and lymphomas account for half of the cancer registrations for all ages in Taranaki.

Table 5 - 'Top Five' Cancer registrations from 1991 to 2000 for all ages

Taranaki	No.	%	New Zealand	Number	%
Colorectal	770	25.2%	Colorectal	23,671	23.8%
Other Cancer	712	23.3%	Prostate	20,821	20.9%
Female breast	566	18.5%	Other Cancer	20,151	20.3%
Melanoma	516	16.9%	Female breast	19,266	19.4%
Lung, trachea and bronchus	496	16.2%	Lung, trachea and bronchus	15,527	15.6%

Source: Central Region's Technical Advisory Service Ltd (TAS)

Graph 9 - Taranaki Cancer Registration, All Conditions Proportion by Age and Gender, 1991-2000



Source: Central Region's Technical Advisory Services Ltd (TAS) 2004

The age group with the highest proportion of cancer registrations for both males and females is 70-74 years. Proportionately more females than males have cancers registered between the ages of 20 to 54, with a higher proportion of male registrations at ages 55-84 years. However, in both genders the proportion of cancers is highest in the age groups over 55 years.

Diabetes

Diabetes is estimated to cause about 1,200 deaths per year in New Zealand, and diabetic complications (such as heart disease, blindness and kidney failure) are major contributors to the burden of disease experienced by people from middle age, especially in Māori and Pacific communities. Obesity, poor nutrition and smoking are key risk factors, particularly with respect to Type 2 (non-insulin dependent) diabetes.

From 1997 to 2003 in Taranaki there were 957 hospital admissions where diabetes was the principal reason for the hospital admission. Māori made up 17 percent of this total, Pacific Peoples 1 percent, with the remaining 82 percent made up of all other ethnicities. For Māori, the age groups with the highest number of hospital admissions for diabetes were 40-44 years, 55-64 years, whereas the non-Māori/non Pacific peoples grouping had the highest number of hospital admissions for diabetes in the 70-74 years age group, with high numbers for older groups.

Since 2000, and particularly since 2002, the Taranaki rate for hospital admissions for diabetes has been higher than New Zealand overall, with statistically significant differences in 2002 & 2003. This may be the outcome of an increased focus on diabetes detection and management, particularly since the advent of Diabetes Annual Reviews which have had a strong uptake in Taranaki.

Primary Health

Primary Health Organisations (PHOs) are the local provider organisations, based on general practice, through which District Health Boards (DHBs) are implementing the Primary Health Care Strategy. PHOs will aim to improve and maintain the health of their populations and restore people's health when they are unwell, through working in partnership with other providers and delivering services to all people especially those who face barriers to care.

There are three PHOs in Taranaki:

1. Pinnacle Taranaki
 2. Te Tiihi o Hauora o Taranaki
 3. Hauora Taranaki.
- Overall 97 percent of Taranaki's population are enrolled with a PHO.
 - Māori and Pacific peoples have lower enrolment rates with PHOs than other ethnicities at a total of 92 percent.
 - Some age groups specifically 45-65 years in all ethnicities, 15-25 year for non-Māori/non Pacific peoples, and 65 years and over in Māori appear to be over-enrolled. Some of this can be explained in differences in data collection methods and slightly different time periods. However there may be a small degree of duplicate enrolments and some misclassification of Māori and/or Pacific peoples within the "Other" ethnic groups.
 - Children (age group 5 to 15 years) have the lowest enrolment rates in PHOs for all ethnicities.
 - Overall Māori children have the lowest enrolment rates of all age groups and ethnicities.

Mental Health and Addiction Services

Taranaki DHB has considerably more clients accessing services on a per capita basis than any other DHB, except for Wanganui and the West Coast, and is above the Mental Health Commission's Blueprint (the development framework for implementing the National Mental Health Strategy) benchmark, which targets three percent of the adult population.

It is estimated that 2.5 percent of the total adult population (or 2,647 of Taranaki's population) have severe mental health disorders and another five percent (or 5,143 of Taranaki's population) have moderate/severe mental health disorders. An estimated total of 20 percent of the population (or 20,572 of Taranaki's population) have some kind of mental health disorder during their life.

Improving the health status of people with severe mental illness will reduce hospital utilisation of crisis and inpatient mental health service. The community overall will benefit through improved family and community relations.

Māori have high utilisation of forensic beds and forensic services (almost 60 percent) and high uptake of alcohol and drug services, particularly beds and crisis intervention. Young Māori under 20 years of age are also high users of mental health services. Overall mortality rates as a result of mental illness are low but most outstanding is the rate for Māori aged 15-19 years, which is high compared to any other age group and ethnic group.

As Pacific people represent such a small part of the population there are proportionally low numbers of contact with mental health service providers.

Bed spaces are predominantly taken up by male clients and are only higher for women between the ages 35 to 39 years. Contact time with women is highest between the ages 30 and 44 years. Women between 60 to 74 years take up more bed spaces than their male counterparts, but beyond this there is not such a disparity as women and men become older.

Disability Issues

Using information from the self-report 2001 New Zealand Disability Surveys, it is estimated that there were about 22 percent or 22,629 of Taranaki adults (people aged 15 years and over) and eleven percent or 2,681 of Taranaki children (people aged 0-14) living in households with a disability.

Older people were shown to be substantially more likely than younger people to experience disability, with an estimated nine percent of young people aged 15-24 (about 1,251 young people in Taranaki) having a disability, compared with an estimated 87 percent of people aged 85 and over (about 1,000 older people in Taranaki).

The Disability Services Directorate, Ministry of Health, provides funding to support disabled people under 65 years, as well as their families and whanau, whereas the DHB has funding for the older population over 65 years, and those that are recognised as 'close in interest', people 50 years and over with conditions associated with ageing.

Health of Older People

Most people aged 65 years or over are fit and healthy, but a minority are frail and vulnerable and require high levels of care and disability support. This is usually during the last years of their lives, or as a result of chronic illness or disability that may have been present for many years.

For the Taranaki region, 2001 Census figures indicated that people 65 years and over accounted for approximately 15 percent or 15,429 Taranaki people (compared to twelve percent nationally) of the total population of Taranaki. By the year 2021, this is expected to increase to more than 20 percent of the Taranaki population (19,080), presenting a very clear picture of an ageing population.

The median age at death for the total population in Taranaki during the December 2003 year was 78.5 years.

This compares with 75.7 years in 1993 and 73.1 years in 1983, and represents an increase of 5.4 years over the 20-year period. The rise also reflects the ageing of the population and the fact that people are living longer.

OECD data indicates that, in the developed countries, per capita health expenditure on the 65 and over age group is typically three to five times that for the 15 to 64 years age group, linking clearly an ageing population to increased demand for health services.

It is estimated that population ageing will increase the demand for health and disability services labour by between 2.5 and 4.3 times the rate of increase in the population as a whole, and increase the demand for health and disability services beyond a level that increases to funding and workforce size can meet.



Oral Health

Graph 10 - Age Standardised Dental Conditions Hospital Admissions Rate per 10,000 Total Ethnicity, 1997-2003



Source: Central Region's Technical Advisory Services Ltd (TAS) 2004

Both Taranaki and New Zealand rates for hospital admissions for dental conditions are increasing, and the Taranaki rates are statistically significantly higher than the New Zealand rates. This may reflect more open access to these services in Taranaki rather than significantly poorer oral health.

Table 6 - Taranaki Caries Free Status and Decayed, Missing and Filled Teeth Averages for 5 year-old and Year-8 Children, 2003

	Māori	Pacific People	Other
5 year old			
Number of children	382	19	1,114
Percentage Caries Free	27%	26%	52%
Average decayed, missing and filled teeth (Deciduous Teeth)	3.8	3.1	2.0
Year 8			
Number of children	365	14	1,361
Percentage Caries Free	27%	21%	36%
Average decayed, missing and filled teeth (Permanent Teeth)	2.2	3	1.7

Source: Midland Region School Dental Service Review Report, Nov 2004

Taranaki has a higher proportion of year 8 children with decayed, missing or filled teeth after treatment than New Zealand overall.

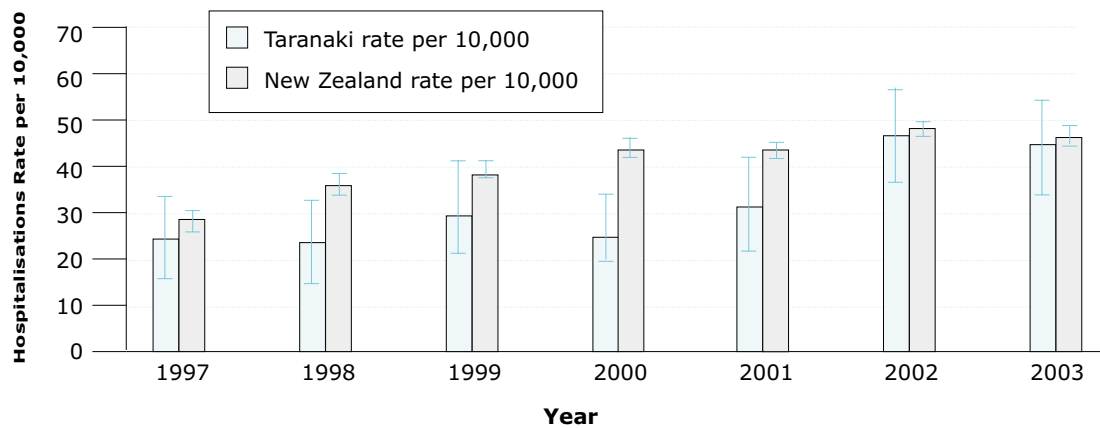
Māori and Pacific 5 year old children had nearly two times the severity of caries than other children, as shown in both:

- The caries free indicator, where percentages of caries-free Māori and Pacific 5 year-olds was nearly half that of other children.
- The Decayed, missing and filled teeth (DMFT) averages, where Māori rates were nearly twice as high as non-Māori/non-Pacific children, and Pacific rates were over 50 percent higher than non-Māori/non-Pacific children.

Cellulitis

Cellulitis is an acute non-contagious inflammation of the connective tissue of the skin (just under the outer layer), resulting from Staphylococcus, Streptococcus or other bacteria.

Graph 11 - Age Standardised Cellulitis Hospital Admissions Rate per 10,000 Māori Ethnicity, 1997-2003



Source: Central Region's Technical Advisory Services Ltd (TAS) 2004

Both Taranaki and New Zealand Māori rates for hospital admissions for Cellulitis, are increasing, although the Taranaki Māori rate is increasing at a slightly faster rate than the New Zealand Māori rate.

The Taranaki Māori rate has generally been lower than the New Zealand Māori rate.

Child, Adolescent and Youth Health

In Taranaki, children and young people (ages 0 to 24 years) make up 37 percent of the total population, 52 percent of the Māori population and 46 percent of the Pacific population.

Responding to children's health needs may differ from how we respond to adults. We want to help set the scene for lifelong good health, thus developing strategies for reducing hospital admission rates for injury, accidents and preventable illness, reducing rates of infectious diseases, morbidity and mortality rates and improving the quality of life and independence for children with special needs.

The top five causes of mortality and top five conditions for hospital admissions over the past decade for children and young people in Taranaki followed a similar trend to New Zealand overall. One exception was the level of road traffic injuries causing death or hospital admission where Taranaki had higher rates particularly in the 15-24 years age group (65 percent for Taranaki compared with 56 percent nationally over a 13 year period).

Diabetes

Type II diabetes usually develops in adulthood and is associated with obesity, however there is an increasing prevalence in teenagers and even children in Taranaki reinforcing the need to reduce obesity levels in Taranaki children and young people through good nutrition and increasing levels of physical activity.

Cellulitis

High proportions of hospital admissions for cellulitis occur in the 1-4 year age group with a significantly higher proportion for girls. Māori account for 50 percent of the admissions in this age group. Risk factors include poor housing, overcrowding, poor hygiene and poor access to primary healthcare.

Sexual Health

Based on voluntary data from sexual health, family planning and youth health clinics Taranaki has higher rates of most types of sexually transmitted infections (STIs) compared to the overall New Zealand rate.

Chlamydia is the most common STI in Taranaki and across New Zealand with more than 70 percent of cases occurring in the under 25 year age group. The difference in clinic rates could be due to several factors: differences in incidence of STIs; different recording methods; the work undertaken in Taranaki to increase the number of young people attending sexual health clinics.

Appendix 1

Overarching Strategic Directions

This section outlines the overarching strategic directions provided for the health and disability sectors by the NZ Health Strategy, NZ Disability Strategy, and He Korowai Oranga (Māori Health Strategy), as well as other government imperatives which guide the planning of health services in Taranaki.

The HNA is, thus, only one of many planning influences but its information helps underpin the strategic planning and prioritisation processes Taranaki DHB will undertake, as it provides guidance on the relative importance of health and disability issues for the Taranaki population.

New Zealand Health Strategy, 2001

The New Zealand Health Strategy is an overarching strategy that identified thirteen priority population health objectives upon which the Government has asked the Ministry of Health and District Health Board's attention to be focused over time:

1. Reducing smoking.
2. Improving nutrition.
3. Reducing obesity.
4. Increasing the level of physical activity
5. Reducing the rate of suicides and suicide attempts.
6. Minimising harm caused by alcohol and illicit and other drug use to individuals and the community.
7. Reducing the incidence and impact of cancer.
8. Reducing the incidence and impact of cardiovascular disease.
9. Reducing the incidence and impact of diabetes.
10. Improving oral health.
11. Reducing violence in interpersonal relationships, families, schools and communities.
12. Improving the health status of people with severe mental illness.

13. Ensuring access to appropriate child health care services including well child and family health care and immunisation.

The HNA confirms the importance of the majority of these areas as focus areas within Taranaki.

New Zealand Disability Strategy, 2002

Fifteen objectives were identified in the overarching NZDS and Taranaki DHB, in its planning, seeks to take these into account:

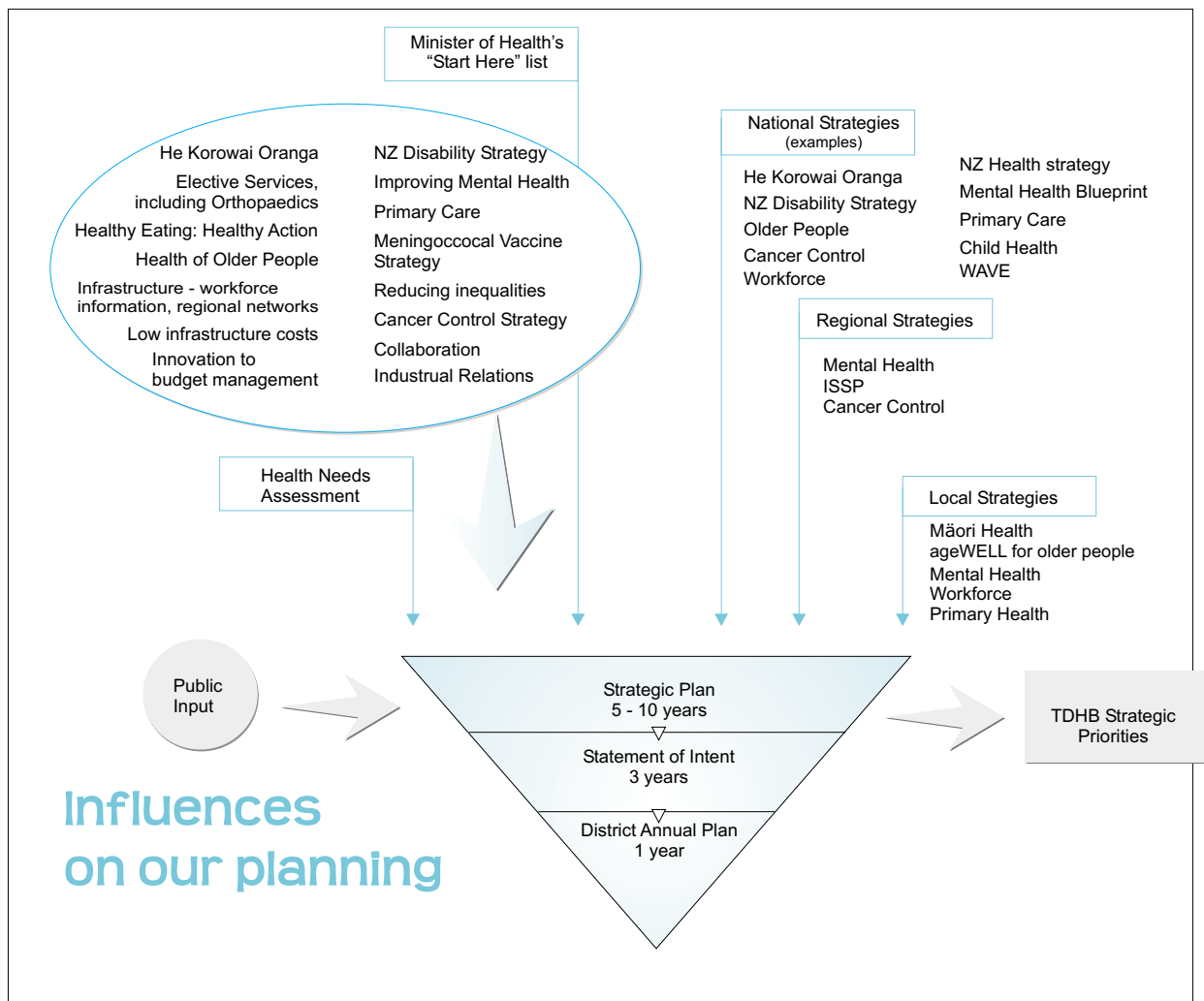
1. Encourage and educate for a non-disabling society.
2. Ensure rights for disabled people.
3. Provide the best education for disabled people.
4. Provide opportunities in employment and economic development for disabled people.
5. Foster leadership by disabled people.
6. Foster an aware and responsive public service.
7. Create long-term support systems centred on the individual.
8. Support quality living in the community for disabled people.
9. Support lifestyle choices, recreation and culture for disabled people.
10. Collect and use relevant information about disabled people and disability issues.
11. Promote participation of disabled Māori.
12. Promote participation of disabled Pacific peoples.
13. Enable disabled children and youth to lead full and active lives.
14. Promote participation of disabled women in order to improve their quality of life.
15. Value families, whanau and people providing ongoing support.

He Korowai Oranga, 2001

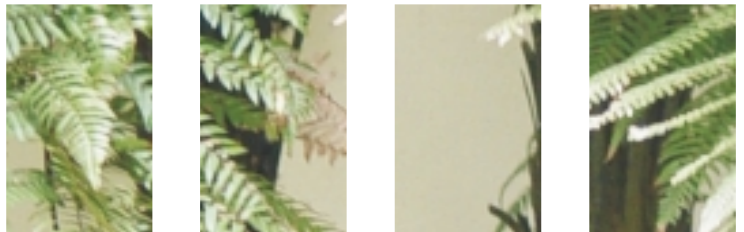
He Korowai Oranga, and its associated action plans, Whakatātaka I and II (due out in final form during 2005), provide direction for Māori health development in the health and disability sector.

He Korowai Oranga encourages agencies and organisations to work together to create a system that will achieve improved whanau health outcomes.

Figure 2 - Schematic of National, Regional & District Planning Priorities & Processes



Source: Planning & Funding, Taranaki DHB (2004)



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