



**Healthy Communities, Quality Healthcare**  
*Hei Oranga Tika Mo Te Iti Me Te Rahi*



# Health Improvement Plan 2006 to 2010

**Auckland District Health Board  
District Strategic Plan to 2010**

**FEBRUARY 2006**

# Foreword

E nga mana, e nga reo, e nga karangarangatanga tangata  
Ko te Toka Tu Mai O Tamaki Makaurau tenei  
E mihi atu nei kia koutou  
Tena koutou, tena koutou, tena koutou katoa  
Ki wa tatou tini mate, kua tangihia, kua mihi kua ea  
Ratou, kia ratou, haere, haere, haere  
Ko tatou enei nga kanohi ora kia tatou  
Ko tenei te kaupapa, 'Oranga Tika,' mo te 'Te Toka Tu Mai' mo te iti me te rahi  
Hei huarahi puta hei hapai tahi mo tatou katoa  
Hei Oranga mo te Katoa  
No reira tena koutou, tena koutou, tena koutou katoa

To the authority, and the voices, of all people within the communities.

This is the message from the Auckland District Health Board.

We send greetings to you all.

We acknowledge the spirituality and wisdom of those who have crossed beyond the veil. We farewell them.

We of today who continue the aspirations of yesterday to ensure a healthy tomorrow. Greetings.

This is the Strategic Plan of the Auckland District Health Board.

Embarking on a journey through a pathway that requires your support to ensure success for all.

Greetings, greetings, greetings.

This plan outlines our future direction and priorities. 'Healthy Communities, Quality Healthcare' is our vision for Auckland DHB. It's about getting the right mix of services for the population of Auckland, and balancing the needs of the people we provide services for who live outside our area.

We receive over \$1 billion each year in funding to our organisation. Although we have a large deficit, we understand the root causes of this and have plans in place to help us live within our means. The deficit limits our ability to expand services or invest in new areas. The deficit will however not prevent us from achieving improvements in the health status of our local population and getting the health outcomes we want. It means we have to be innovative and understand what we need to prioritise now in order to get the greatest gains into the future. In short, we have to do more with the resources available to us.

In the future we will move the resources we have into the areas we know will best improve health. To do this we need to review our method of funding to make sure it is based on need and not on historical patterns that have become outdated. This means concentrating on those activities that keep us healthy as a population since we know a large proportion of our hospitalisations are avoidable.

We have matured as an organisation. Our Maori led services are setting the trend for regional integration and leadership that other services are only setting out to achieve. Just like the disability strategy, the principles of the Treaty are living policies, part of the everyday running of Auckland DHB rather than just words at the front, read but not fully used.

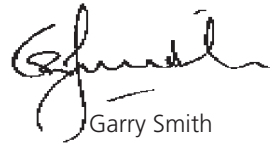
While the health of Aucklanders is our responsibility, we know it also requires close co-operation with Auckland City Council, other sectors and agencies, and real advocacy around problem areas that are unique to Auckland city. We acknowledge the work of the volunteer sector, the societies, trusts and groups who play an important role in the health sector by supporting DHB activities even though they do not receive funding from us.

This document reflects the comments made to us during the 2005 public consultation. These comments helped us get the right priorities for our area. We rely on the continued hard work of our hospital and related services staff, the primary health care sector and other health providers to help us to get the right plan for the future of our city.

Thank you for helping us with this important planning process.



Wayne Brown  
CHAIRPERSON



Garry Smith  
CHIEF EXECUTIVE

Please note.

This plan has not yet been approved by the Ministry of Health. It was released in July 2006 as a draft version so that staff and public can make use of the material for their planning purposes. Further work is underway to develop a longer term financial forecast. When the final plan is completed and approved by the Ministry of Health it will be placed on the Auckland DHB website [www.adhb.govt.nz](http://www.adhb.govt.nz). All planning documents for the Auckland DHB are available on this website or by contacting Julie Helean on 09) 638 0390 [jhelean@adhb.govt.nz](mailto:jhelean@adhb.govt.nz)

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# 1. Introducing the Strategy for Health Improvement

This plan outlines how Auckland DHB plans to improve the health of people living in Auckland city. The plan for future health outcomes incorporates feedback gathered during the 2002 and 2005 public consultations. It provides the strategic direction for more specific actions that make up our Annual Plan.

A supplementary document provides a full description of the Auckland DHB and the range of activities required of DHBs by Government. Auckland DHB also prepares an Annual Plan which details how the organisation will achieve strategic objectives over a 12-month period.

Auckland DHB planning documents are located on the website [www.adhb.govt.nz](http://www.adhb.govt.nz) or can be requested from Julie Helean 638 0390 [jhelean@adhb.govt.nz](mailto:jhelean@adhb.govt.nz).

## The Health Improvement Plan

Covers the direction for the future, the key outcomes we want to achieve and new approaches to health improvement:

- a whole system approach to health gain
- three key goals
- the vital few outcomes
- specific actions for groups of people
- specific actions to address problem areas
- how we protect rights
- how we influence areas that are not our responsibility
- financial summary to year 2007–08

## Describing Auckland DHB document

Supplementary document containing:

- demographic information on the people of Auckland city and the ethnic and age breakdowns etc
- our assessment of the main health needs in our population
- a description of the Auckland DHB governance and management structure
- description of the process used to make decisions and the decision makers
- explanation of the provider and funding arms of the organisation
- details of services provided by the Auckland DHB owned provider arm (the hospital and related services)

## 1.1 Health priorities determined by Government

The Minister of Health (Hon Pete Hodgson) determines national health priorities. This ensures a consistent response to problem areas and means there is similar entitlement and access to essential services across the country.

The Minister of Health's priorities for 2006-07 are:

- implement Healthy Eating Healthy Action (HEHA)
- implement the New Zealand Cancer Control Strategy
- increase immunisation
- oral health (re-establishment of child and adolescent services)
- additional child and youth focus
- progress the Primary Health Care Strategy
- implement the Health of Older People Strategy by 2010
- significantly progress the Health Information Strategy
- progress the Future Workforce Initiative

- cost effectiveness, efficiency and value for money
- improve elective services, including orthopaedics and cataract initiatives
- collaborate across agencies (to minimise family violence)
- Treaty of Waitangi
- measure success
- attend to service coverage and change
- accountability via the Performance Assessment and Management Framework.

Auckland DHB has to balance these national strategies with local population needs, and is responsible for providing real leadership for local health improvement.

## 1.2 How we determine local priorities

In a city of over 400,000 people, there are diverse health problems and competing demands on the \$1.2 billion available to us per year from Government. Auckland DHB prioritises on the following criteria:

i) Groups with high need	<p>Groups of people in our city who have the highest need</p> <p>Areas of inequality in health status especially between Maori and non-Maori, and Pacific and non-Pacific people</p> <p>Need and local priorities identified through community consultation</p> <p>Need and local priorities identified by other DHBs, Treaty partners and other agencies</p>
ii) Main health problems	<p>The health problems responsible for the greatest burden of disease</p>
iii) Protection of rights	<p>Maori living in the Auckland region have protected entitlement under the Treaty of Waitangi to have health needs recognised and indigenous practices supported</p> <p>People's rights are protected under the Health and Disability code and human rights legislation</p> <p>Aucklanders need to communicate their health needs and be protected from discrimination in the provision of services</p> <p>Disabled Aucklanders and others who need support require responsive support services. These assist people to live independently, to participate in community life and have quality in life</p>

### i) Groups with high need

The big differences in health status between Maori and non-Maori, and between Pacific compared to others, are unacceptable and cannot continue into the future. Redressing these inequalities requires activities specifically directed at these groups and to groups such as refugees, poor communities, and disabled people where we know there is high need and gaps in services.

We can do more to achieve better equity in health status across Auckland over the longer term. Maori and Pacific health improvements will translate into improved health for others in the community and contribute to a higher health status for the Auckland city population.

Auckland DHB continues to provide leadership, working with other sectors on activities that are based on evidence and good knowledge of the communities we work with. This approach is fully compatible with the Government's Health Strategy.

A gender analysis is also vital to future planning. Like a cultural analysis, this provides information on best approaches to health improvement; highlighting the diverse needs of women, men and transgender people.

Focusing on groups with high need means that other groups may receive less attention. Some groups in the community feel disadvantaged by this approach and tell us that they would prefer the Auckland DHB to treat everyone equally.

We are aware that while our focus on specific groups with poorer health directs resources where they are most needed, it can also create stigma. These groups tell us that the focus of attention has the potential to make people feel blamed for their health problems and for the high cost of treatment incurred.

## **ii) Main health problem areas**

Auckland DHB focuses attention on the health problems responsible for the greatest burden of disease. Information on health problems was assessed in 2005 as part of the Population Health Needs Assessment and is available in detail on the website <http://www.adhb.govt.nz/healthneeds/>

### **The most common diseases affecting people in Auckland include:**

- diabetes, cardiovascular disease (CVD), cancer, mental illness, injury, respiratory illness.

### **Areas of focus, in addition to those above, for specific groups:**

- Children: Injury prevention, violence prevention, increased physical activity, good nutrition and oral health, reduced burden of infectious diseases.
- Young people: Reduced alcohol and other drug related harm, improved sexual health.
- Refugee and migrants: Interpreter services for primary care; services for victims of torture, especially children and young people; improved sexual health.
- Older people: Management of chronic conditions; reduction of elder abuse and neglect, supports for independence and for participation in community life.
- Disabled people: Access to supports that increase independence, eliminate barriers to participation in community life.
- Women: Sexual and reproductive health.
- Men: Reduced alcohol and other drug related harm, violence prevention.

### **Findings from the 2004 survey on self assessed health status**

- 88 percent of people in Auckland have a positive quality of life.
- Only 1 percent of people in Auckland say their quality of life is poor.
- There is a direct relationship between self reported health status and age, gender, ethnicity and income.
- The lowest self ratings for health are from Pacific people, poor people, young people between 14 and 24 years old, and from people over 65 years.
- Almost all ethnic groups in Auckland rate their health higher than national rates, except for Pacific people.
- Women assess their health as higher than men except in the areas disability and mental health.

Chronic disease accounts for 70 percent of health sector costs. Reducing disease involves a major cultural shift for the Auckland DHB. The shift means we will:

- focus on improved population health status and the prevention of problems
- provide help early when people need it
- prevent health problems in specific areas where we know we can get results
- invest outside the hospital so primary health care can do more to prevent and manage diseases and problems
- establish clinical partnerships between the hospital and primary care to manage diabetes, cardiovascular disease and cancer
- develop and align more services in the community, establish partnerships with NGOs and private providers
- manage the demand for expensive treatments over the longer term through improved population health and primary health care activity
- accept that prevention and health promotion work needs a long term investment
- accept that some healthy outcomes can be achieved in a shorter timeframe through co-ordinated primary and secondary health care
- accept that in spite of our efforts at prevention, people develop serious problems and conditions which require ongoing specialist care and a compassionate, non judgemental health service
- identify and research new approaches, technologies, systems and processes to deliver the best evidence-based interventions
- communicate on an appropriate and timely basis.

### iii) Protection of basic rights

The Treaty of Waitangi is the fundamental relationship between the Crown and Iwi that provides for Maori wellbeing. Health sector Treaty principles are:

**Partnership:** Via the Memorandum of Understanding with Te Runanga O Ngati Whatua; the Auckland DHB Maori Health Advisory Committee; consultation with Maori regarding service changes; and the position of Chief Advisor Tikanga.

**Participation:** By being responsible and responsive to Maori who use our services; Manawhenua and mataawaka involvement in identifying health needs and plans to improve health and disability services; and through Maori health provider development.

**Protection:** By our commitment to He Korowai Oranga and other national policies; working towards equity in access and outcomes for all Maori; safeguarding Maori cultural concepts, values and practices, e.g. tikanga best practice; and making sure services meet the rights/rites, needs, interests and aspirations of Maori.

Other rights that relate to health include:

- the opportunity to be independent and self determining
- the right to communicate health needs with health professionals
- the right to a safe and protective environment
- freedom from discrimination, abuse, violence and oppression
- equitable access to services
- supports to participate in the community and contribute to society
- support services and access for disabled people
- ability to participate in the workforce and in the community
- gender and cultural analysis and awareness.

### 1.3 The decision makers

The Board holds final responsibility for decision-making. Of the 11 members, seven are elected by the public and four appointed by the Minister of Health. Some decisions also require specific approval from the Ministry of Health or the Minister of Health.

The NZ Health Strategy and the NZ Disability Strategy emphasise the active involvement of consumers and community in health planning and decision making. Relationships, community engagement and intersectoral links are managed through advisory committees to the Board and through project work.

The relationship with Te Runanga O Ngati Whatua is managed through a memorandum of understanding and through the operational arm of Tihi Ora MAPO.

#### **Auckland DHB Board members are:**



*Wayne Brown, Chair*

Wayne Brown (Chair)  
Ross Keenan (Deputy Chair)  
Tony Bierre\*  
Harry Burkhardt  
Chris Chambers\*  
Barry De Geest\*  
Virginia Hope\*  
Di Nash\*  
John Retimana  
Ian Scott\*

\* Elected members. October 2004.

#### **The executive team are:**



*Garry Smith, Chief Executive*

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

## 2. A Whole System Approach to Health

### 2.1 Healthy Communities, Quality Healthcare

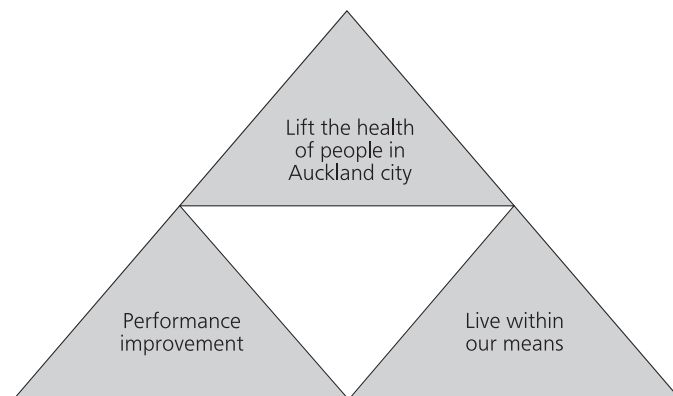
#### The vision

The vision adopted when the Board was established in 2001 has remained: *Hei Oranga Tika Mo Te Iti Me Te Rahi*, Healthy Communities, Quality Healthcare.

This vision focuses on population health, looking beyond our immediate role of providing health services to lifting the health of people living in Auckland city.

#### Three key goals

Lifting the health of people living in Auckland city is the main goal we want to achieve. Good organisational performance and managing within budget are important underpinning goals.



### 2.2 A vital few health outcomes

Auckland DHB has defined health outcomes based on priority needs in our city. Any allocation of new funding, or funding shifted from other areas of health, will be evidence-based and directed to the priorities below. Each will require a consideration of cultural, gender and age issues:

1. Reduced occurrence of diabetes, cardiovascular disease, and cancer. Reduced number and severity of complications arising from these conditions.
2. Reduced inequalities in Maori health status by implementing Treaty of Waitangi responsibilities and preserving the rights to protection and to self determination. Reduced inequalities for Pacific people, disabled people, refugee communities, and people living in poverty.
3. Better outcomes in the health of older people.
4. Better outcomes in child health.
5. Better outcomes in mental health.
6. Increased independence of disabled people, older people and others with high support needs so they participate in their communities.

## 2.3 How we achieve the outcomes we want

This plan includes the outcomes Auckland DHB will achieve in the next five years. This is the process we will use:

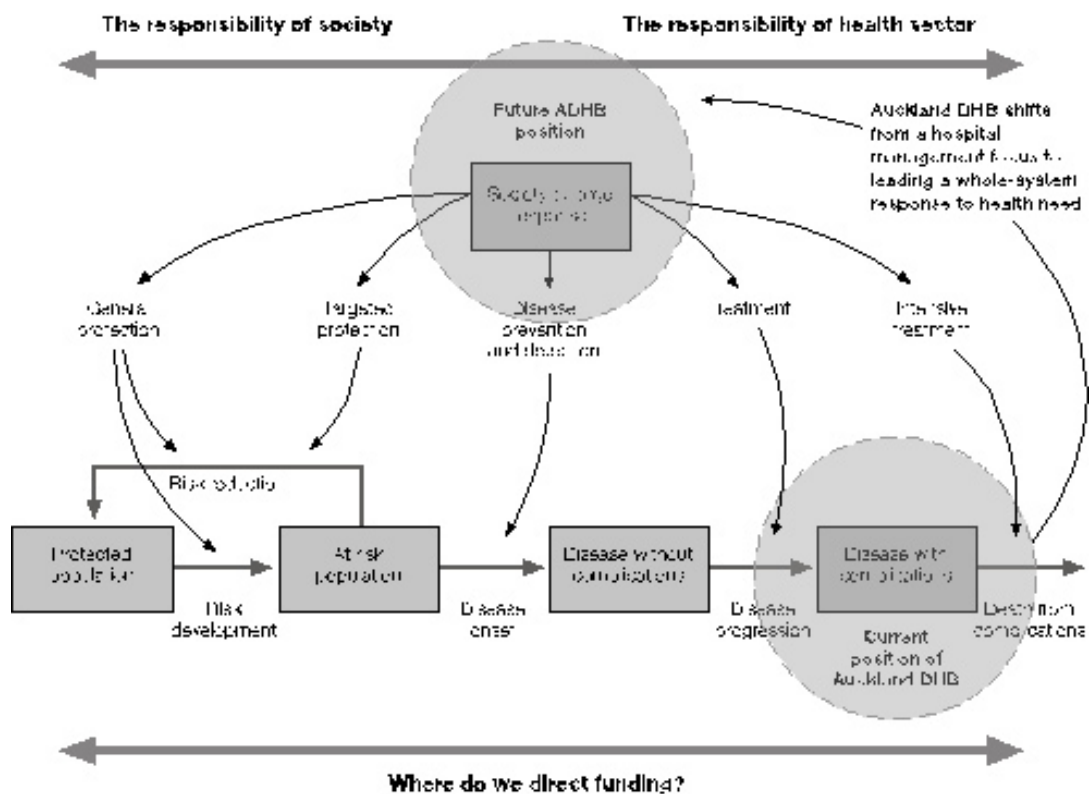
### a) The whole system will work as one

The new approach to health improvement brings all the possible health and wellbeing interventions together, from health promotion to specialist treatments, and including the support services that help people live independently. It is the correct role of a DHB to lead all the activities that make up our society's response to health need.

The diagram shows a whole system response to problems and chronic disease. It shows the progression from good health to disease, the interventions that are possible at each stage, and where we can take action to achieve the best health gain.

Research is an important part of this model because we do not fully understand what causes many illnesses we work with. We need to find out more about their origins and we need to provide excellent, compassionate care to people living with these conditions.

*The progression of chronic disease and points of intervention<sup>1</sup>*



<sup>1</sup> Adapted from Homer J, Jones A, Seville D, Essien J, Milstein B, Murphy D. *The CDC's Diabetes Systems Modeling Project: Developing a New Tool for Chronic Disease Prevention and Control.*

## **b) Specific health improvement plans**

We are developing specific Health Improvement Plans for our vital outcome areas: reduced lifestyle related diseases and complications; reduced inequalities in health status; health of older people; child health; mental health; increased independence for people with high support needs.

The Health Improvement Plans have drawn in providers and others with expertise across health and other sectors to reflect a whole system approach to health gain in that particular area. Specific actions included in each Plan will appear in the District Annual Plan. These annual objectives can be measured and monitored.

## **c) Strategic investment**

Because we have a large underlying deficit, the Board and management constantly assess where we can get better value for money. Apart from primary health care and mental health, there will be very few opportunities in the next five years to allocate new money. The Health Improvement Plans for the vital outcome areas will require funding. These plans, any new initiatives or service expansions will be funded from reallocations from other service areas.

There may be times when the Board has to reduce services in order to manage the deficit; but this will be an absolute last resort. In the longer term strategic investment outside the hospital will address some problems more effectively and may also lead to reduced demand in some hospital services.

## **d) Strategic relationships**

This plan has a strong emphasis on the primary health care sector (especially PHOs), addressing problems earlier in the community and promoting lifestyles that improve health over the longer term. PHOs, community-based services and non government organisations are key players in helping Auckland DHB achieve the population health outcomes we want.

This requires us to work more collaboratively and to pool resources and expertise. The Planning and Funding Managers at Auckland DHB are ultimately responsible for ensuring that there are opportunities for engagement and for collaboration around our priority outcome areas.

The provider arm of Auckland DHB is a key player in achieving population health gain. Hospital and community-based services understand the demand for services and where we need to develop into the future so we have the right services in the right place and aimed at the priority outcomes. Hospital-based services will take the lead in planning ahead so we are well prepared for future health demands and manage these within our budget. Over the next five years hospital-based clinicians will work more closely with other health providers in the community to better manage health problems.

The Auckland DHB is New Zealand's largest teaching and training hospital and maintains close links with the University of Auckland Medical School and with other training institutions. We will strengthen relationships with the University of Auckland and other academic institutions to foster Auckland DHB's role in medical and community research and to preserve our status as a centre of clinical excellence.

We will do more to engage with high need communities and make sure they are supported to determine their own priorities for health and lead their own health improvement initiatives. All District Health Board activities are underpinned by the core value of respect for people.

## e) Advocacy

Our consultation work with the community indicates that we need to do more for people living in Auckland city. While people understand the need to work within our budget, there are also real grievances about the level of funding available to Auckland especially in the delivery of specialist services and our role as a hospital of last resort.

Auckland DHB is responsible for the people living in Auckland city but we also have patients from all over the country who use our specialist services. These cross-boundary flows and the high cost, low volume work associated contributes to our deficit. We will continue to work closely with the Ministry of Health and other DHBs to resolve ongoing issues around pricing and funding Auckland DHB specialist health services.

Over the next three years we will develop a plan that shows how our hospital-based services will manage the flow of patients from other areas. Approximately 52 percent of Auckland DHB provider arm work is for people who live in other DHB areas. We want to preserve our reputation as a centre of excellence but we must also ensure that the costs associated with this work are fully covered.

## 2.4 The outcomes framework

The following set of indicators has been derived from Ministry of Health work. Indicators help us measure progress against our strategic goals. They allow us to demonstrate that health outcomes are being obtained from public investment in the health sector.

The link between our intended outcomes and their contribution to the health of people in Auckland city is shown in the framework below. These outcomes are all measurable and as time goes on we can draw in a wider range of indicators, including those from other sectors. Detailed indicators of DHB performance are contained in the Annual Plan and the Statement of Intent.

The vision: Healthy communities, quality healthcare	
The outcomes we want	Outcome measures
Reduced health inequalities	Life expectancy, Healthy life expectancy; Proportion of health records with NHI number; Life expectancy at birth by ethnicity and deprivation; Health expectancy by ethnicity and deprivation; Infant mortality by ethnicity and deprivation
Reduced diabetes, cardiovascular disease, cancer	Ambulatory-sensitive hospitalisations; Cardiovascular disease mortality; Cancer survival; Diabetes management; Smoking prevalence and consumption; Cancer Screening Coverage; Obesity
Increased independence	Disability requiring assistance; Self-reported unmet need for health and disability support services; Quality of life
Better outcomes in child health	Infant mortality; Primary care utilisation; Immunisation coverage (fully vaccinated two-year-olds) Obesity; Injury rates
Better outcomes in mental health	Mental health status; Rate of new admissions to general acute inpatient mental health services; Use of secondary mental health services
Better outcomes in the health of older people	Age-related residential care admissions; Treatment injury rates; Disability rate

# 3. Goal 1: Lift the Health of People in Auckland City

## 1 Focus on the health of people living in Auckland city first and foremost

- The DHB will be a role model for good health in all practices; taking a lead role across Auckland city in improved health, quality of life, and independence.
- Advocate on issues of concern to Auckland communities, i.e. stability in the health sector, additional funding to boost local services, and recognition of diversity.
- Promote good health in every possible health setting and service. Advocate for healthier public policy.
- Increase investment in health promotion, prevention and primary health care. Maximise the local expertise within NGOs, PHOs, and private providers.
- Provide high quality and cost effective secondary care and ambulatory services for people in Auckland city.

## 2 Focus on health outcomes

- Concentrate on a vital few population health outcomes for the city-based on all information about our communities, and from people who use our services.
- Set tangible health gain targets. Plan and fund services so results are delivered. Base activities on evidence of successful outcomes and on patient best interest.
- Fund dedicated whole system strategies and initiatives for diabetes, cardiovascular disease, child health, mental health, and health of older people.
- Include awareness of cultural and gender issues in plans in each of the vital outcome areas and in the services provided across Auckland DHB.
- Learn more about the public's expectations of the health system, specifically areas local people would prioritise and where they would make tradeoffs.

## 3 Take a whole system approach

- Integrate the health system to work as a whole in promoting health and wellbeing, supporting independence, preventing illness, and managing disease.
- Make the health system more responsive to people's need. Build services and funding to meet current and future population needs.
- Base services on the continuum of care model, streamline to meet people's health and support needs.
- Services are client focused, culturally appropriate and evidence based.
- Maintain a strong focus on research to learn more about the causes of illness, where to prevent disease, how to improve treatment, and how to measure our success and failures.
- Address all the organisational changes including roles, responsibilities and accountabilities needed to achieve these outcomes.

## 4 Improve the links between primary and secondary care

- Work closely with primary health care on Auckland DHB priority outcomes.
- Identify any possible areas of hospital-based health service that could be better delivered by primary health care services.

- Hospital clinicians support primary health care in partnerships that prevent disease, manage complex diseases, complications and hospital referrals.
- Investigate where primary and secondary care partnerships can reduce the cost of treatment through more appropriate referral and management.
- Tertiary Paediatric Services work with secondary and primary health care providers to develop clinical pathways, education and preventative health.
- Community and ambulatory services support primary health care to improve the efficiency and quality of care. Expand outreach and community-based services.
- Public health expand their expertise to develop partnerships with PHOs and other parts of society that impact on health, e.g. housing and local government.

## **5 Strengthen relationships and communication**

- Improve relationships and accountability with central government through the Ministry of Health via the formal systems in place.
- Reflect our Treaty of Waitangi responsibilities by maintaining the co-purchasing arrangement with our Treaty partners.
- Plan regionally with our neighbour DHBs to make sure that:
  - people in Auckland get their fair share of resources
  - changes in one DHB do not create problems for others
  - we align services across the region with expected population growth and other service requirements over the longer term
  - we learn from each other (especially other DHB successes in diabetes and cardiovascular disease prevention).
- Work with non-government organisations to increase activity in high priority areas and to reach the groups in our community with specific health needs.
- Investigate the potential use of private services in conjunction with public provision. Develop partnership arrangements around priority areas.
- Enhance consumer/community participation in service development and monitoring. Increase opportunities for the public to influence decisions.
- Advance teaching and university relationships to build up a skilled and responsive workforce.
- Work strategically and collaboratively with other sectors to address complex problems and address the broader determinants of health.

## **6 Protect basic rights**

- Protect Maori rights under the Treaty of Waitangi. Maintain relationships with Treaty partners and their representatives Tihi Ora MaPO, Maori health providers, Maori communities and other Maori stakeholders.
- Protect rights under the Code of Health and Disability Services Consumers' Rights, and the Human Rights Act 1993.
- Ensure all Aucklanders are able to communicate their health needs and have basic support services provided.
- Be an advocate for the NZ Disability Strategy, making sure that the health sector is not disabling or discriminatory.
- Protect the rights of the child by ensuring young children get the very best start in life with families, whanau supported to provide a healthy lifestyle.
- Recognise the groups that are particularly vulnerable because of their age or disability, or because they are alienated from mainstream society in some way.

## 4. Goal 2: Improve Performance

Auckland DHB building development is now completed with a new acute building on the Grafton site and ambulatory services consolidated at the Greenlane Clinical Centre. Patient care has been streamlined, making the best use of expensive new hospital resources.

### 1 Work more efficiently and effectively

- Standardise, consolidate, and integrate the services on the hospital sites.
- Streamline care across all services to ensure a client focus. Provide psychosocial and cultural supports alongside physical health services, e.g. interpreter services.
- Complete service reviews and dedicated project work to find efficiencies and resolve problems associated with the move to the new hospital.
- Work on national priorities: reduce waiting times for public hospital services, improve intervention rates for elective services; manage direct treatment costs and high cost patients; allocate funds earmarked for the Mental Health Blueprint.
- Improvement in elective services that specifically relates to Patient Flow Management, level of service and order of service.
- Benchmark Auckland DHB against comparable DHBs, identify relative performance and adopt best practice.
- Identify where hospital-based tertiary and speciality services could be provided from one location in the region for maximum efficiency and to provide a critical mass of staff and expertise.
- Provide tertiary and speciality services with the right level of secondary service to maintain clinical competence, quality standards, efficiency and service viability.
- Plan across the region to get the best use of tertiary, quaternary and specialty services, e.g. devolve certain secondary services from Auckland DHB to the other two DHBs in the region.
- Avoid timing gaps in any service changes and make sure the bed numbers required are provided. Put community outreach, follow-ups, GP contacts, etc in place to support reduced beds.
- Measure the cost effectiveness of improving disabled people's access to health and related services, to removing barriers to access, and to actions that increase independence and equality of opportunity.
- Advocate for funding that recognises Auckland DHB as a centre of excellence in some areas and as a hospital of last resort, e.g. national funding is required to preserve essential paediatric services for all New Zealanders who need these.

### 2 Continuously improve the quality of service, safeguard high standards of care

- Implement an assurance framework that has the same key indicators at clinical level, committee and board level, and that integrates measures of cost, volumes, and quality outcomes with an evidence base.
- Implement quality and risk measures (quality/clinical governance framework, emergency management/disaster and pandemic planning).
- Implement actions from the quality and risk management programme for the provider arm and establish the new systems and structure as required across the whole sector, e.g. the continued refinement of risk management.

- Use the frameworks of accreditation and certification to Health and Disability Safety Standards to achieve compliance and continue to develop good quality systems and reporting processes to underpin clinical governance.
- Use national/regional indicators to assess quality measures for the provider arm. Structures and systems to support quality improvement are in place and effective.
- Meet and exceed Ministry of Health requirements regarding health goals, regulatory requirements and quality improvement activities.
- Conduct regular audits and evaluations of health service providers and use information to mitigate or understand any concerns. Secure a high level of quality and make sure this is across the board.
- Conduct targeted research to inform practice where necessary.
- Focus on quality, accreditation and credentialing to develop a high-performing hospital sector that achieves maximum quality within the available resources.
- Involve Tihi Ora in the audit process to provide cultural audits.

### **3 Decision making is fair, consistent and transparent**

- Use the national process for prioritisation to help appropriately manage demands, expand services, fund new initiatives and adopt new treatments and technologies.
- Use the principles of Maori health gain (whanau ora), effectiveness, equity, and value for money.
- Make sure that decision makers are known and responsive to the public. Decision makers consult service users and members of the public.
- Continue to involve Te Runanga O Ngati Whatua and their operational arm (Tihi Ora MaPO) as decision makers at the highest level under the partnership arrangement.

### **4 Workforce development, teaching, and training**

- Recruit and retain the right mix of staff with the right skills.
- Value staff and support them to do high quality and culturally competent work. Ensure staff are supported to work at their very best, receive appropriate supervision and have a sense of pride and loyalty to the organisation.
- Implement the human resources plan to build a culture that supports staff to provide the best possible healthcare to the populations we serve.
- Strengthen the practical implementation of Tikanga Best Practice Guidelines and the Pacific cultural competency framework.
- Work with educational institutions and professional bodies to influence the level and quantity of placements, and quality of education provided.
- Strengthen the relationship with the Faculty of Medical and Health Sciences, recognising the faculty's role as an important partner for undergraduate medical student teaching, post graduate medical and nursing teaching, and clinical and population-based research.
- Implement retention strategies that aim to keep and strengthen intellectual capital within the organisation for the long term, e.g. succession planning attracting back the New Zealand health professionals working overseas, and retaining research developments.
- Provide flexible job opportunities and internal talent pool management for equitable access to internal career and professional development opportunities for the current workforce.

- Manage the increasing demand for health professionals when there is a workforce shortage; find new ways of using scarce human resources; and increasing the number of high quality staff.
- Maximise opportunities for medical and allied staff to work outside the hospital and to use skills in the primary health care setting to lift the health of Aucklanders.
- Encourage medical and allied staff to examine and critique current health care approaches and investigate new approaches and initiatives.

## **5 Develop a culture based on a deeper understanding of our activities**

- Build the information, research and analytical base to assist in our planning, funding and clinical work.
- Develop a profile of Auckland city including demographic characteristics, health status, availability and access of services, identification and prioritisation of local community needs and other factors linked to health status.
- Measure the health of our community, working with other agencies to measure indicators of health and wellbeing, and to monitor trends over time.
- Promote and support a research culture and infrastructure that improves cost effectiveness and outcomes of health services, and makes best use of resources.
- Strengthen relationships with the University of Auckland and other academic institutions to foster Auckland DHB's role in medical and community research and to preserve our status as a centre of clinical excellence.
- Use Auckland DHB research projects to:
  - enhance patient outcomes
  - inform health policy, priorities and effective practice
  - develop innovative treatments and approaches to improve health outcomes
  - increase local, national and international partnerships and alliances
  - achieve greater knowledge and health choices for the public
  - attract, retain and develop highly skilled and innovative professionals.
- Continue with the development of the new research governance and management structure. Work with educational facilities in relation to research.
- Use the findings from all community consultation work and from customer feedback and complaints to inform practice.
- Draw on cultural and gender analysis to support future planning. Support a greater research focus on gender issues and the inclusion of gendered concerns in the planning stages of any health initiative.
- Make sure all information collected is consistent at district, region and national levels. Share information within the sector, with other sectors and the public.
- Improve the information systems to create one source of knowledge. Implement the Regional IS Strategic Plan and the Auckland DHB IS Capital Plan.
- Continue to analyse risk and develop plans that prepare us well for future events.

## 5. Goal 3: Live Within our Means

Increases in cost have outstripped funding to create an underlying deficit of \$100 million. This deficit creates a burden for our organisation and reduces the funding available nationally for primary health care and other developments. The deficit is primarily associated with services provided to people from other DHBs and to decisions about specialist health services.

Containing the deficit within the provider arm of the DHB means the hospital is responsible for managing these costs. This allows planning and funding activities to meet local population health and service needs with some independence from provider issues.

The organisation is committed to greater efficiency and across the board cost reduction. Over the longer term Auckland DHB will prevent problems by working outside the hospital. We want to improve population health, and as a corollary, reduce the demand for specialist services and high treatment costs.

There is debate about whether improved population health translates into cost savings. Savings in the use of hospital services will be offset by the need for more and improved specialist treatments, e.g. the demand for treatment of non preventable cancers. While some health problems relate to lifestyle choices and are therefore preventable, many do not. We will continue to manage the increasing demand for secondary, tertiary and specialist services.

### 1 Emphasise productivity, clinical effectiveness and strong management

- Manage operational cost growth within the future funding track, i.e. keep infrastructure costs as low as possible, and within the funding available.
- Reframe how we see ourselves; not as one amorphous deficit-focused organisation but an organisation with local, regional and national roles, each with their own pressures and challenges.
- Separate the hospital deficit from the wider DHB responsibility for population health improvement.
- Realise all the cost saving efficiencies possible from our building development and the streamlining of services onto two sites. Implement the findings from benchmarking, reviews of services and direct treatment costs.
- Work with clinicians to better manage direct treatment costs and to explore ways of managing costs associated with the treatment of people from other districts.
- Keep areas such as mental health and public health ring fenced so these funds are not used for other purposes.
- Further analytical work to address the root causes of problems, and the impact of high cost treatments and sub-specialisation.
- Improve provider compliance to the terms of Auckland DHB contracts (including hospital services). Investigate the extent that providers are using DHB funding to subsidise other funded services (cross-subsidisation).
- Manage the demand for specialist services to contain costs in the longer term, especially improved referral of diseases across primary and secondary care.
- Funding incentives for the Auckland District-focused part of the hospital changed to incentivise a whole-system view.

## **2 Meet budget targets for the treatment of people living in Auckland city**

- Manage contracts for Auckland City Hospital as two distinct businesses: one that provides services for the Auckland DHB population and one that provides services for people from other DHBs.
- Improve the costing system and business intelligence systems, to enable monitoring, analysis and appropriate benchmarking within services.
- Set an overall deficit target for each financial year and ensure there are no variations. Expand the cost base only where there is new revenue to offset this.
- Undertake service reviews to manage expenditure across the provider arm and to ensure services operate to business plans that have specific outcomes.
- Tighter controls and transparent decision making to manage changes in clinical practice, particularly for high cost procedures.
- Maintain a high level of clinician governance within new structures to ensure that clinicians are responsible for service delivery and cost-effective care.
- Develop an implementation plan for dealing with increasing capital cost associated with the new buildings.
- Undertake further cost saving initiatives in Auckland City Hospital operations, e.g. 24-hour centre/beds.

## **3 Contain expenses related to the treatment of people from other districts within the provider arm**

- Deliver just the work that is required and paid for by other DHBs. Manage patient volumes by meeting contracted levels of service provided.
- Recover costs from referring DHBs and from organisations such as ACC. Ensure cost level and recovery from other DHBs is appropriate.
- Work with other DHBs to manage the flow of patients between areas and recover the costs for services provided to people out of area.
- Analyse interdistrict flows to understand demand for Auckland DHB services. Assess changes in future work demand from population-based funding, increased capability at other DHBs, and rationing issues.
- Manage issues associated with Auckland DHB's role as a hospital of last resort by tightly managing direct treatment costs.
- Track the funding spent, i.e. link national health index (NHI) numbers to service use so we can track service use by people in our district for planning purposes.
- Review referral protocols from private hospitals, Counties Manukau DHB and Waitemata DHB.

## **4 Manage labour costs and the clinical workforce**

- Review staff numbers against national benchmarks. Make sure that FTE levels are kept at or below budget levels with FTE costs managed tightly on a monthly basis.
- Improve management of staff numbers, payroll and annual leave.
- Review major clinical staff employee groups and use of casuals/bureau use/ temporary staff.
- Manage a reduced budget for training and course fees, consulting, travel, communication, training and professional development.
- Manage costs associated with compliance to the Health Practitioners Competence Assurance Act 2003.

## **5 Plan for what's best across the region**

- Plan for service improvements across the region, so the four Northern DHBs have a consistent approach and resolve problems co-operatively. Work with Tihi Ora and the Northern DHB Support Agency.
- Ensure tertiary services are what the region and nation want, and are in the right place, and advocate to have these paid for at efficient prices.
- Continue with interdistrict planning and development of services with other DHBs in the region, including service shifts, facility planning and capital requirements.
- Identify the level of acute demand over previous years and project expectations of how this may change over the next 5-10 years.
- Develop shared tools that support the infrastructure across the DHBs, e.g. a shared budgeting and forecasting tool, a common payroll for medical officers, common tool to track and manage medical staff leave arrangements, and a regional nursing bureau.
- Actively participate in national service planning work.

## **6 Address the problems related to the funding formula**

- Manage the population-based formula to address issues related to inter-district flows and pricing deficiencies. Support the national process to maintain the agreed national price schedule used for interdistrict flow pricing.
- Retain the volume of service to historical levels and absorb the growth in demand. Make sure that the volume of work is monitored against contract and strictly managed.
- Work with the Ministry of Health and DHBNZ on pricing issues, especially the costs associated with sub-specialisation and the introduction of new treatments.
- Work with the Ministry of Health and neighbouring DHBs to resolve funding problems, wider pricing issues and the calculation of the funding available to Auckland DHB each year from government.
- Advocate on behalf of the local population for adequate funding to cover secondary and tertiary services (e.g. more appropriate funding is required for National Paediatric Services to cover low volume, high cost tertiary services) and for the management of unpreventable problems and rare conditions.

# 6. Actions for Specific Groups

## 6.1 Treaty of Waitangi responsibilities in practice

Our Treaty relationship is with Te Runanga O Ngati Whatua through a formalised Memorandum of Understanding. This Treaty partnership is operationalised within Auckland DHB through the Maori health purchasing organisation (MaPO), Tihi Ora.

Further relationships and arrangements with other iwi groups and Maori communities residing in the Auckland DHB will be developed and strengthened.

If firm relationships with iwi and Maori communities are in place, then this provides a sound platform to lift the health status of all Maori in the Auckland DHB area.

### **Acknowledge the special relationship between Maori and the Crown**

#### **1 At the governance level**

- Work in partnership in accordance with the Memorandum of Understanding with Te Runanga O Ngati Whatua and its health operational arm Tihi Ora MaPO.
- Ensure this health partnership provides active protection of Maori interests in health planning and funding and proactively identifies joint strategies for improving the health of Maori.
- Strengthen the other mechanisms established to fulfil Treaty responsibilities: the Auckland DHB Maori Health Advisory Committee (MHAC), the Chief Advisor Tikanga and the role of He Kamaka Oranga in overseeing Maori health.

#### **2 Within planning and funding**

- Auckland DHB will involve iwi Maori in its decision making processes around planning, funding, review and monitoring of health and disability services through the Funding Management Committee and other mechanisms.
- Implement the principles of partnership, participation and protection embodied in the Treaty of Waitangi across all areas of Auckland DHB activity.
- Maori health gain is prioritised in planning and funding activities, appropriate resource allocation, through kaupapa Maori services and approaches, Maori-led initiatives, and mainstream performance.

#### **3 Within service delivery**

- Iwi Maori participation in delivering health and disability services to all, particularly to Maori.
- The Auckland DHB is responsive to the needs of Maori communities in our district and to Maori from other areas that use our services.
- Adhere to the Auckland DHB Tikanga Best Practice Policy to protect the rites of Maori, respect the tikanga of manawhenua and practically contribute to providing services that are responsive to Maori needs and interests.
- Integrate clinical with Maori models of health and wellbeing and service approaches within mainstream services.

## **He Korowai Oranga and Auckland DHB's Maori Health Plan**

He Korowai Oranga: the Maori Health Strategy, expects a reorientation of the way that Maori health and disability services are planned, funded and delivered. The aim is whanau ora: Maori families/whanau supported to achieve their maximum health and wellbeing. Whanau is central to improving Maori health and wellbeing throughout the whole spectrum, not just the clinical care intervention.

He Korowai Oranga sets the broad strategic framework for Maori health planning at a local level through Auckland DHB's Maori Health Plan.

## **6.2 The health of Maori**

According to the 2001 population census around 30,000 Maori people reside in the Auckland DHB district, comprising 8.4 percent of the total Auckland DHB population.

The Maori population has a younger age structure with over 50 percent aged 25 years and younger, therefore child and youth health issues assume much greater importance for Maori than for the overall DHB population. Fifty percent of all Maori live in the most deprived areas of Auckland.

On average, Maori whanau continue to experience poorer health outcomes than the non-Maori population with higher than average rates of child health illnesses and injuries, cancer, diabetes, heart disease and mental health problems. Evidence also indicates that Maori are exposed to greater risk, have inequitable access to mainstream health services, e.g. primary care and elective surgery, and die earlier than any other ethnic group.

In order to improve Maori health outcomes in the next five years, Auckland DHB will focus on achieving a handful of 'mission critical' health outcomes: improving child and youth health, mental health, cardiovascular and diabetes and the health of older people, reducing the percentage of avoidable hospitalisation rates in Maori, improve access to tertiary services at the same rates as other ethnic groups and proportionate to need.

The collection of Maori health information and access to Maori health service providers is an issue for Maori in the primary healthcare sector, and requires further developed systems and initiatives to improve Maori information and analysis including ethnicity data collection, utilisation and health status trends to inform Maori health needs analysis.

### **Actions for future health gain**

#### **1 Achieve better health outcomes for Maori children and youth**

- 1.1 Ensure that all Maori tamariki in Auckland DHB are enrolled with a doctor or a PHO.
- 1.2 Lead and provide input into a comprehensive Auckland DHB child health improvement plan aimed at improving Maori vaccination rates, hearing screening, reducing caries rates, injuries, asthma rates, skin sepsis and cellulitis.
- 1.3 Lead and drive with Maori rangatahi in Auckland DHB, a health wellness strategy focused on improving sexual health, reducing teenage pregnancy, minimising risky behaviours including alcohol and drug abuse.
- 1.4 Work with Maori parents to promote healthy lifestyles for whanau especially around healthy pregnancy, breastfeeding, nutrition, exercise, non-smoking and preventative care.
- 1.5 Work with other sector agencies, organisations and providers to provide a co-ordinated and co-operative approach to improving Maori child, youth and whanau health outcomes (police; health sector; whaiora).

## **2 Encourage, school and work with Maori communities to lead healthy lifestyles**

- 2.1 Use a range of appropriate health promotion strategies and information to raise awareness around the benefits of healthy lifestyle choices such as diet, regular exercise, non-smoking, non-violence, injury prevention, and reducing alcohol and drug use.
- 2.2 Promote and encourage all Maori to access screening programmes, diabetes get checked, chronic disease management and other health and disability programmes and services.
- 2.3 Actively participate in the development of a diabetes and cardiovascular health improvement plan.
- 2.4 Better co-ordinate access to and integration between primary, secondary, tertiary and ambulatory services for Maori (e.g. through the Whare Oranga initiative and Whanau Atawhai service).

## **3 Improve Maori mental health outcomes by further developing kaupapa Maori mental health services and mainstream responsiveness**

- 3.1 Develop and implement an Auckland DHB mental health strategic plan, i.e. Te Pou O te Tahuhu, ensuring clear links with local, regional and national documents.
- 3.2 Develop and implement meaningful Maori mental health outcome measures.
- 3.3 Re-develop the Whatua Kaimarie Maori Mental Health site to provide a centre of excellence for Kaupapa Maori mental health services.
- 3.4 Work with the Ministry of Health to secure early intervention initiatives funded from the mental health underspend. These will be evidence-based responses to meet the needs of local Maori with mild to moderate mental health and drug and alcohol problems.

## **4 Respond to the needs of Maori kaumatua and kuia and Maori with disabilities that may need access to health and disability support services**

- 4.1 Actively participate in the development of a strategy for older people identifying the needs and services required by kaumatua and kuia and their associated Maori communities.
- 4.2 Improve access to effective and culturally appropriate assessments and services for Maori with a disability.

## **5 Continue to build primary care to support Maori health gain**

- 5.1 Develop and implement a strategy that will ensure that all Maori in ADHB will be enrolled with a PHO.
- 5.2 Work with Maori health providers, Maori communities and other stakeholders to continue the further development of the Maori-led PHO including potential regional arrangements.
- 5.3 Develop new Maori primary health care services in the most deprived areas within Auckland DHB including Panmure, Mt Roskill and Avondale which are attuned to Maori and to the needs of our Maori communities.
- 5.4 Work with the primary care sector to further develop Maori leadership (especially clinical) and innovation at a practice level as well as Maori workforce development initiatives to recruit and retain Maori in primary care.
- 5.5 Ensure that all PHOs have a meaningful Maori Health plan that lifts the health status of their Maori enrolled patients and communities and that provides culturally effective primary care services to Maori.

## **6 Build Maori provider and workforce capacity**

- 6.1 Develop and support Maori health provider capacity and capability through the Maori Provider Development Scheme, and address the identified gaps in health and disability service provision for Maori health providers.
- 6.2 Support Maori health providers to adopt and implement an appropriate quality framework to improve the standards and performance of their health and disability services.
- 6.3 Increase the financial investment of Maori health provider health and disability services above future funding track.
- 6.4 Develop and implement an Auckland DHB Maori health workforce development strategy.
- 6.5 Ensure equitable access of Maori health professionals to clinical training agency funded programmes.

## **7 Improve the responsiveness of hospital services to Maori**

- 7.1 Develop and implement a Maori provider arm plan which focuses on improving access to secondary and tertiary services, reducing did not attend rates, quality and discharge planning.
- 7.2 Reorient services to better meet the needs of Maori and reflect an explicit focus on reducing healthcare inequalities.
- 7.3 Develop and implement a new whanau accommodation service at Auckland City Hospital site.
- 7.4 Implement the Tikanga Recommended Best Practice Policy across Auckland DHB, and other training initiatives which support the use of Te Reo and tikanga as a clinical competency and encourages the correct pronunciation of Maori.
- 7.5 Implement Maori service specifications, indicators with Maori health outcomes, and cultural competencies for inclusion in all service contracts.
- 7.6 Research, monitor and evaluate effectiveness and performance of mainstream services in contributing to Maori health gain.
- 7.7 Address key issues identified around inequitable access to elective cardiac procedures for Maori and identify and resolve other services where inequalities exist.

## **8 Maori information, analysis and outcome performance measures**

- 8.1 Auckland DHB to assist and advocate for improved Maori ethnicity data collection at all levels across Auckland DHB including PHOs. Improve analytical reports on Maori utilisation and health status.
- 8.2 Provide input into the development of a Maori needs analysis as part of a wider Auckland DHB needs assessment.
- 8.3 Develop clinical indicators, outcome, cultural and other measures that provide a more accurate picture of Maori health status in Auckland DHB.
- 8.4 Improve Maori workforce development information.

## **9 Quality**

- 9.1 Develop ongoing strategies for training and development for Auckland DHB staff on tikanga best practice.
- 9.2 Cultural audit of Auckland DHB LabPlus and mortuary services and prioritisation of two additional service audits within this period.

## 6.3 The health of Pacific people

The 43,632 Pacific people in the Auckland DHB area (2001 census) make up 12 percent of the Auckland DHB population. Over 50 percent of this group are under the age of 25.

There are significant disparities in health status for Pacific communities in our city:

- A higher number of Pacific people die before the age of 65 years compared to other ethnic groups.
- Pacific people are over-represented in mortality and morbidity statistics. The most common causes of death among Pacific people in Auckland city are cancer and cardiovascular disease.
- Abortion rates for Pacific are higher than the national average.
- Approximately 65 percent of the Pacific population live in the most deprived areas of the Auckland DHB area (deciles 8-10 measured by the NZ Deprivation Index 2001).
- Almost one-quarter of Pacific people in the Auckland DHB live in crowded households. Home ownership amongst Pacific people in Auckland is low. Living in crowded situations can contribute to poor health outcomes such as respiratory and infectious diseases, especially meningococcal disease.
- Pacific people are more likely to leave school without qualifications, more likely to live on low incomes, less likely to own their own home and more likely to rent than Europeans in the Auckland DHB area. These are all factors associated with poor health outcomes.

Many of the health problems that lead to a hospital admission are preventable and could be avoided through more effective health services working with Pacific communities.

Poverty, lack of transport and language have been identified as the three key barriers that prevent Pacific people from using available healthcare services.

There is a shortage of specialist Pacific health clinicians and specialist Pacific provider organisations.

### Actions for future health gain to reduce inequalities

#### 1 Improve and protect the health of Pacific children and young people

- 1.1 Develop and implement an immunisation strategy for Pacific children, with a focus on reducing infectious diseases and meningococcal B.
- 1.2 Participate in the development of the Auckland DHB Child Health Improvement Plan and regional services for Pacific children and young people.
- 1.3 Work with other agencies where there is evidence that a joint sector approach will gain the best results for Pacific children and young people.

#### 2 Encourage and empower the Pacific community to lead healthy lifestyles

- 2.1 Raise Pacific people's awareness of healthy lifestyle benefits, especially regular exercise, good nutrition, immunisation, not smoking, and reducing alcohol and drug use.
- 2.2 Expand the information available to Pacific communities about the health and support services available to them, e.g. public health services, sexual health, domestic violence, gambling, and pregnancy support.
- 2.3 Transition the Parish nursing service into a Pacific community development model of service delivery (Healthy Village Action Zone) which is aligned to the Lifting the Health of Aucklanders strategy and delivered within primary health care.

### **3 Primary health care delivers services to meet the needs of the Pacific community**

- 3.1 Encourage PHOs to increase their enrolment of Pacific people.
- 3.2 Encourage PHO's participation in the further development of the Parish Nursing service into a Pacific community development model within the Healthy Village Action Zone.
- 3.3 Ensure all PHOs develop and implement a Pacific health plan.
- 3.4 Develop Pacific PHOs and other local Pacific primary health care services to deliver effective and culturally responsive services for Pacific people; especially initiatives to prevent and manage diabetes, cardiovascular disease, and respiratory illness.
- 3.5 Monitor the effectiveness of health services delivered to Pacific people by the Pacific and non Pacific PHOs in Auckland DHB.
- 3.6 Work with other sectors and agencies to achieve a consistent approach to improving the health of Pacific people.

### **4 Hospital-based services deliver effective services which meet the needs of the Pacific community**

- 4.1 Support each service in the hospital to implement the regional Pacific cultural competency framework and to develop specific objectives to improve Pacific health and measure the Pacific communities' satisfaction with service delivery.
- 4.2 Improve how people leave hospital. This means good transfer of care so Pacific people get continuity of care and therefore better compliance to recommended care in the community.
- 4.3 Monitor the collection and analysis of ethnicity data in order to improve the hospital services for Pacific people and to help with future human resource planning.

### **5 Improve mental health services for Pacific people**

- 5.1 Ensure strategies to improve the mental health of Pacific peoples are reflected in the Auckland DHB Mental Health Plan.
- 5.2 Review how well mainstream mental health services are responding to Pacific people and promote models and activities that improve service provision.
- 5.3 Support the development of Lotofale (Pacific Mental Health services provided by Auckland DHB) to establish a continuum of care pathway that includes primary care and community services.
- 5.4 Support the development of a Pacific non-government organisation mental health provider as part of the continuum of care pathway.
- 5.5 Monitor the implementation of the Pacific Regional Mental Health and Addiction Plan.

### **6 Respond to the needs of Pacific people requiring older people's services, disability services and other supports**

- 6.1 Work with the Ministry of Health to provide a range of disability support services for Pacific people which are effective and culturally appropriate.
- 6.2 Improve access to effective and culturally appropriate services for older Pacific people.

### **7 Develop a competent and qualified Pacific health and disability workforce**

- 7.1 Support the training and education of Pacific people working within the health sector.

- 7.2 Develop a Pacific workforce development plan that builds the Pacific workforce and helps Auckland DHB to meet the future needs of the Pacific population.
- 7.3 Include a recruitment and retention policy for Pacific staff within the Auckland DHB Human Resource Policy and Strategy.
- 7.4 Work with the Pacific non-government organisations to develop an Auckland DHB Pacific workforce development plan which includes the needs in the non government organisation sector.
- 7.5 Continue to advance the quality and monitor the effectiveness of healthcare training courses for Pacific community health workers through partnership with the Auckland School of Population Health and Manukau Institute of Technology.

## **8 Develop Pacific health and disability information and research**

- 8.1 Support research into success factors for Pacific people's health improvement and use this evidence base in future planning, funding and service delivery.
- 8.2 Consult with Pacific communities, providers and researchers about new, effective and innovative ways of delivering services to Pacific people and evaluate new initiatives.
- 8.3 Reprioritise resources to areas of high need for Pacific people using information on the health status of Pacific people and from the Auckland DHB health needs analysis.

## **9 Increase Pacific participation in Auckland DHB governance, management and community services**

- 9.1 Assist the Auckland DHB Pacific Health Advisory Group to provide advice about health needs, approaches for Pacific people, and future service priorities.
- 9.2 Make sure Pacific communities are informed, engaged and contribute to Auckland DHBs decision-making processes.
- 9.3 Encourage the Pacific community to understand and support the Auckland DHB election process and to participate in DHB governance.

## **6.4 The health of migrants and refugees**

Migrants are people who chose to leave their country. Refugees do not choose to leave their homelands but flee in response to crisis. People from refugee-like backgrounds have come from refugee producing countries.

There is little data on migrants and refugees, a lack of data to show where these communities live, and limited knowledge of health status and current and future needs.

There is also little research available about the barriers to good health or protective and resiliency factors.

The health needs of migrants and refugees are not recognised in national policy and health strategies. The lack of long-term planning between Ministries at the policy level has led to fragmented approaches.

There are very few dedicated resources to meet projected increases in the migrant and refugee populations. Services are not well linked across Auckland between the DHBs, PHOs, public health efforts, other government agencies and non-government organisations.

Many refugees and migrants have major and multiple health issues and very high health needs. There is limited planning for long-term management of migrants with disabilities, chronic conditions and high and complex health needs. These issues particularly affect people who have had a refugee experience.

There are significant mental health issues within the refugee and migrant communities. For refugees post-traumatic stress disorder arising from pre-migration experiences is common. Both migrants and refugees have a high prevalence of depression and anxiety arising from post migration stressors including unemployment or underemployment.

Auckland DHB provides interpreters for over 155 different languages, however there is limited access to interpreter services within primary health care and the health and support services provided outside the hospital setting.

Non-English speaking migrants and refugees have limited access to, and knowledge of, primary health care services, including disability and community mental health services.

There is little information about services and how to access them written in people's own languages. There is limited access to written health promotion and prevention materials.

Health professionals have limited knowledge and skills to provide culturally relevant care for some migrant and refugee groups. The workforce doesn't reflect the diverse population groups in Auckland.

Refugees and some migrant groups have a low uptake of physical activity and may be at increasing risk of obesity, diabetes and cardiovascular disease due to changes in lifestyle. Women are especially at risk.

## **Actions for future health gain**

### **1 Expand health promotion, prevention and early intervention work**

- 1.1 Target health promotion activities to areas of priority for migrant and refugee populations: child health, sexual health, mental health and disease.
- 1.2 Work with primary health care organisations to expand health promotion work. Help providers develop a wider range of health promotion and problem prevention activities that are culturally acceptable, accessible and appropriate.
- 1.3 Prevent diabetes and other lifestyle related diseases affecting refugees and migrants by implementing the Smokefree initiative and the Healthy Eating, Healthy Action strategy.

### **2 Improvements in service delivery**

- 2.1 Work with mainstream health providers to improve the transition between secondary, tertiary services and primary services. Integrate activities with other DHBs, primary, community, secondary and tertiary health services.
- 2.2 Work with primary care providers to identify and reduce barriers to access with a special focus on the provision of interpreter services.
- 2.3 Improve the ability of NGOs, community organisations and Auckland DHB services to link to refugee and migrant communities and to engage with them.
- 2.4 Encourage all DHB services to respond to the diversity of cultures. Train more ethnic community workers in health, especially mental health and health promotion.
- 2.5 Develop primary mental health services that respond to the background and resettlement issues specific to new migrants from refugee backgrounds.
- 2.6 Expand culturally appropriate specialist mental health services (adult, child and adolescent) for refugees and migrants.

- 2.7 Ensure all refugee and migrant children access Well Child Care.
- 2.8 Improve sexual health and abuse services; developing sexual health initiatives and education for new migrants, African migrants in particular.
- 2.9 Make sure disability and support services meet the needs of new migrants and their families, and that disabled people can participate within the community.

### **3 Future priority actions for the refugee community**

- 3.1 Develop a refugee health strategy for health improvement; working with other sectors to co-ordinate responses to physical health, mental health, and social needs.
- 3.2 Investigate all options for continued interagency services for children and young people from new migrant backgrounds with high and complex needs, especially On TRACC the Transcultural Care Centre.
- 3.3 Improve research into refugee and migrant health (e.g. demographic profile of migrants, measure trends and health needs). Assist health services to analyse data and plan the service improvements required.

## **6.5 The health of Asian people**

The Asian population is expected to increase by 18.7 percent by the year 2016, primarily through immigration.

Less than 5 percent of the Asian population is older than 65 years. However older people are especially vulnerable to the effects of loneliness, isolation and alienation. These factors contribute to a higher rate of depression than the general population.

Over half of Asian people in the Auckland region are between the ages of 25 and 65 years. Working age migrant and refugees are disadvantaged through under employment. Women in this age group and the Indian community are especially at risk for diseases related to changing diets and a lack of exercise.

There is still a relative lack of research evidence about the health status of the various Asian communities.

The six top potentially avoidable deaths for Asian people in the Auckland region are ischaemic cardiovascular disease, motor vehicle crashes, stroke, lung cancer, diabetes and suicide.

The six leading causes of preventable hospitalisations for Asian people in the Auckland region are angina, respiratory infections, cellulitis, gastroenteritis, road traffic injury and asthma.

The Asian population is diverse and differs according to ethnicity, settlement history, English language proficiency and socioeconomic status.

Overall Asian communities face poorer socioeconomic status, low participation in employment, poor access to health services and poorer levels of physical activity with higher levels of diabetes than Pakeha/Europeans.

As large sections of the Asian population are recent migrants, the international experience of migrants' health decreasing with acculturation (the 'healthy migrant' effect) needs to be taken into account. This results in significantly worsened health outcomes.

There is evidence that the mental health of Asian migrants may decrease after arrival in New Zealand. Dedicated actions are required to ensure the health status of the Asian population does not worsen and that risk factors are better understood and are mitigated.

The Asian population also reports mental health problems including problems arising from isolation and racism.

The Asian student group are experiencing problems. Issues include car crashes, sexual health problems including higher presentation for abortions and sexually transmitted diseases.

### **1. Priority actions for the Asian community**

- 1.1 Advocate for a national policy and strategy for Asian people that acknowledges and prepares for the increasing size and diversity of the Asian population.
- 1.2 Involve community and Asian community organisations in the health sector, and especially in PHOs. Assist with cultural input into all stages of health service programme design and delivery.
- 1.3 Active participation in appropriate joint sector initiatives which focus on key health determinants.
- 1.4 Improve the links between Auckland DHB, PHOs, Auckland regional public health service, government, NGOs and community in health promotion programmes.
- 1.5 Improve the collection of ethnicity data for research and evaluation, especially a consistent definition of Asian ethnicity. Disaggregate data into ethnic minority groupings to acknowledge the diversity within the Asian community.
- 1.6 Establish a research programme on Asian health status and gaps in services; including research on Asian complementary and traditional medicine, and inequalities in health and socioeconomic status in Asian populations.
- 1.7 Train health providers to show a high level of cultural sensitivity and awareness around Asian issues and deliver services that are responsive, accessible and culturally appropriate for Asian people.

## **6.6 The health of children and young people**

Good child health is vital for adult health since the risk factors for many adult illnesses, and the opportunity to prevent them, occurs during childhood. In the same way good maternal health, family supports, and antenatal care is essential for healthy babies.

Inequality in the distribution of resources in society (e.g. income, education, employment and housing) is the primary cause of childhood health problems. Maori and Pacific children, as well as children from low socioeconomic families experience relatively poorer health. There is a high proportion of children and young people in the Auckland DHB area living in poverty.

A high proportion of Maori, Pacific and new migrant children have complex health and social needs. They require child-focused approaches that include and protect family/whanau health.

Increasing care and protection notifications to Child Youth and Family Services with abuse are found in around one-third of cases. Early intervention is imperative, particularly in the preschool years. Developmental delays, abuse, neglect and trauma can have permanent effects.

There is an increasing need to address the wider range of factors that contribute to child health and wellbeing and to work more with other sectors to improve child health.

Differences in access to healthcare services and differences in the type and quality of care for children receiving services also influences childhood health status and mortality.

Risk factors for chronic disease are increasing among children and young people, including prolonged and unhealthy nutrition, physical inactivity, and obesity. Children and young adults now carry the risk of obesity-related problems for more of their lifetime than previous generations have done.

The increase in childhood obesity and related conditions, especially diabetes, needs to be urgently addressed. Reducing childhood obesity will reduce the development of adult obesity, type 2 diabetes, stroke, cancer, and cardiovascular disease. Improving children's health may also reduce the future demand for adult health services.

There are increases in disease among young children (such as tuberculosis, rheumatic fever, meningitis, cellulitis and gastroenteritis) especially among Maori, Pacific peoples and people from refugee backgrounds.

Immunisation rates are low particularly amongst Maori, Pacific and new migrants. There are associated high rates of hospitalisation for respiratory disease. Auckland DHB needs to make sure the National Immunisation Register is fully implemented.

Maori and Pacific children in the district have poor oral health compared to the non-Maori, non-Pacific child population. Pacific children living in the Auckland district have the poorest oral health status of all children in the wider Auckland region. Water fluoridation is strongly linked to higher oral health status.

Smoking is an important child health risk factor, contributing to increased rates of sudden infant death syndrome (SIDS), respiratory conditions, glue ear and subsequent hearing loss. Young Maori women are more likely to smoke than other young people.

There are concerns for young people's sexual health: teenage parents, unplanned pregnancies, abortions, family and sexual violence, and a high rate of sexually transmitted infections in the 15–25 year-old age group.

Unintentional injuries are a leading cause of hospitalisation in the Auckland DHB area.

There are low levels of breastfeeding in the central Auckland district amongst all groups.

Adult health services have limited ability to respond to young people and there is a lack of dedicated health services for young people.

Tertiary specialist paediatric services provided from Starship children's health provide services for very sick children across the whole country. These services are unable to compartmentalise children by district and therefore require a more appropriate system of pricing and funding. Starship needs to be able to respond to all children who need specialist care and to provide high cost treatment to children with serious illness and rare or chronic diseases.

## **Actions for future health gain**

### **1 Promote good child and youth health and prevent problems**

- 1.1 Implement a Child Health Improvement Plan which is evidence-based, focused on achieving health outcomes and uses a population health framework.
- 1.2 Establish a Child Health Advisory Group to contribute to decision making and planning for child health outcomes across the district. Make sure the views of children and young people help to shape the development and evaluation of programmes.
- 1.3 Develop child and youth health promotion and prevention programmes that meet the needs of Maori, Pacific and other groups with high need.
- 1.4 Implement the well child national framework with a special focus on improving breastfeeding, immunisation, good nutrition, physical exercise and oral health.

- 1.5 Ensure every child in Auckland is enrolled with a primary health care organisation.
- 1.6 Work with primary health care providers to manage the need for acute services in those areas where there are high rates of preventable admissions to hospital.
- 1.7 Work with other agencies and communities to understand the wider determinants of health affecting children, young people and families. Work closely together where this will improve child health and wellbeing, and reduce health disparities.

## **2 Areas of dedicated focus**

- 2.1 Targeted efforts to reduce inequalities in access to primary health care services especially for Maori and Pacific, families, whanau living in poverty, refugees, children with disabilities and others with high need.
- 2.2 Focus on priority problem areas for children and young people: diabetes, obesity, cardiac disease, cancer, smoking; in particular programmes that focus on younger ages, sexual health, teenage pregnancy, injury, suicide, child abuse, violence, drug and alcohol abuse.
- 2.3 Make sure disability and support services are available to assist children and young disabled people to live and participate in their own communities.
- 2.4 Realise all the opportunities within the national Strengthening Families Programme for advocacy regarding issues affecting families, whanau in Auckland and to access national funding for children and young people with high needs.
- 2.5. Reduce the impact of disability and illness. Expand the range of school-based approaches to improve health and prevent problems such as the hearing and vision programmes aimed at improving learning for school children.
- 2.6 Support and evaluate initiatives that identify developmental delays, abuse, neglect, trauma and enable early intervention in the preschool years.
- 2.7 Continue to provide programmes and specialist services for children and young people with chronic conditions.

## **3 Improvements in quality, workforce development, and research**

- 3.1 Implement the National Child Health Information Strategy related to the collection, collation and analysis of data.
- 3.2 Work regionally to identify areas of unmet need, to co-ordinate the delivery of hospital services for children and young people and to target future planning and funding activities, based on this information.
- 3.3 Advocate for the expanded role of tertiary paediatric services who provide specialist services for sick children across the country and who work with primary care and other providers to expand local expertise in the knowledge and care of serious illness and chronic conditions.

## **6.7 The health of older people**

The health of older people generally focuses on people 65 years and over although Maori and Pacific people 55 years and over with similar needs are also included.

The New Zealand population is ageing, placing increasing demands on health and disability support services. Those aged 85 and over (1.3% of the population) consume 10 percent of Vote Health expenditure on health and disability support services.

As the population ages the incidence, prevalence and complexity of chronic diseases also increases. There have also been significant increases in the demand by older people for acute services over the past decade.

There is a gap in life expectancy for Maori and Pacific people compared to other New Zealanders. The life expectancy of disabled people is unknown.

Fragmented service provision across primary, secondary, tertiary, mental health and disability support sectors creates problems. Increasing interventions can create complex management problems and the risk of complications (e.g. adverse reactions resulting from poorly managed polypharmacy).

Injury, falls and elder abuse remain areas of high priority for older people.

Early detection and intervention for conditions like dementia and depression is a high priority. Older people can miss out on early detection and prevention activities because of ageism and discrimination.

Transport and mobility problems can limit the access older people have to health services.

Older adults are particularly vulnerable to social isolation and consequently lower health status. As people age they want to continue participation in community life and in paid or voluntary work and can experience barriers that limit this.

Older men and women have sexual and emotional needs that are often ignored because of their age and they want this considered as part of a healthy life.

There are difficulties in attracting people to work in services for older people and therefore concerns about the ability of the workforce to meet needs into the future.

There are problems associated with the oversupply of rest home beds in the Auckland city area and the financial problems this creates under the population-based funding model.

Changes in work/employment conditions and family/whanau lifestyles, combined with inadequate support make it difficult for family/whanau members to care for older family members at home.

Older adults may face changes in income and standard of living. Accommodation costs are often a key determinant of the overall standard of living for older people.

## **Actions for future health gain**

### **1 Prevent problems and promote good health**

- 1.1 Support health promotion programmes that encourage adults and older people to stop smoking, exercise, eat well, and get the mental and social stimulation they need.
- 1.2 Support evidence-based health promotion programmes that promote and support strategies for healthy ageing.
- 1.3 Maintain the lead role in the falls prevention programme for older people across the region, working with other organisations with expertise in this area.
- 1.4 Work with local councils, support groups and service providers to develop a 'one stop shop' where this information is readily accessible to consumers and providers.

### **2 Increase the independence of older people**

- 2.1 Expand primary and community-based health and support services to assist older people to continue living in their own homes.
- 2.2 Increase the capacity of primary health care, rehabilitation, palliative care and other community-based services to help older people live safely in their own homes (e.g. injury prevention and falls prevention programmes).
- 2.3 Integrate the needs assessment process for older people so this is firmly centred on the needs of the individual, and includes other people important to them.

- 2.4 Work with NGOs and community-based organisations to develop flexible 'packages of care' that support older people living at home.
- 2.5 Review family, whanau and carer support services (respite/day-care/short stay) for the quality of services to Maori and Pacific people and older people from other cultures.
- 2.6 Work with other agencies and NGOs to ensure that older adults have access to affordable housing.
- 2.7 Recognise the increasing number of older people continuing in paid and voluntary work by providing services to support them to remain actively involved.

### **3 Improve the quality of health services for older people**

- 3.1 Involve older people, and their family and whanau, in decisions about individual treatment plans and support needs. Whenever possible give decisions by older people precedence over those of their families/whanau.
- 3.2 Work across primary, secondary, tertiary, rehabilitation, palliative care, mental health, and disability support services to integrate all health care needs, leading to holistic health care. Focus on choice, integrated continuums of care, and on older people with multiple and complex needs.
- 3.3 Include older disabled people in all services and programmes that recognise, educate and help people who are overweight or obese.
- 3.4 Include knowledge of best practice and special health requirements of older people in skill development programmes for health professionals and support workers.
- 3.5 Engage with older people's groups and individuals in service planning, monitoring and in the research and evaluation of services.
- 3.6 Work with other DHBs to achieve consistency of access to services and a system that makes transition across various DHB boundaries easy.
- 3.7 Support research into developing an integrated approach to health care and health service delivery.
- 3.8 Work with other agencies and NGOs to ensure older adults are aware of and can access appropriate health services.

### **4 Reduce the gap in life expectancy between Maori and Pacific peoples compared to other populations**

- 4.1 Work with Maori consumers, the Maori co-purchasing organisation (MaPO) and Maori providers to strengthen adult and older people's mainstream and Maori service in the areas of health promotion, prevention, early detection, integrated treatment and the long-term management of chronic health conditions.
- 4.2 Work with Pacific consumers, planners and Pacific providers to strengthen mainstream and Pacific services in health promotion, prevention, early detection, integrated treatment and the long-term management of chronic health conditions.
- 4.3 Recognise the specific needs and views of older new migrants in planning services into the future.

### **5 Improve mental health services for older people**

- 5.1 Ensure that mental health, personal and family health, and support service providers work with consumers and families/whanau to implement the regional mental health strategy for older people.
- 5.2 Make sure all primary, secondary, mental health and disability support services are

evidence-based, co-ordinated around the needs of the older person, their family and whanau.

- 5.3 Establish training and support programmes to help primary and community-based providers identify and treat early signs of mental health conditions in older people; especially to recognise depression and address the causes.

## **6 Reduce discrimination and the abuse of older people**

- 6.1 Raise awareness with providers and in the community about the language, behaviour and attitudes that discriminate against people because of their age.
- 6.2 Ensure older adults can access good social support and that there is early detection and prevention of elder abuse within services and in the community.
- 6.3 Improve the safety, well being, freedom from abuse and neglect of older people with dementia and Alzheimer's disease.
- 6.4 Monitor services and continually improve service quality, especially protections against abuse and neglect of disabled older people.

## **6.8 Health and wellbeing for disabled people**

One in five New Zealander's is disabled (2001 Census), and 3 percent have a high degree of need. Auckland DHB provides health services as well as support services to disabled people, to people with a mental health disorder, and to older people.

### **Distinguishing between health and support services**

Auckland DHB is moving to a community-based wellbeing approach to healthcare. This emphasises the whole spectrum of services from promotion and early intervention through to treatment, rehabilitation and community-based care. Disabled and older people make use of health services as part of their overall wellbeing, so access to all services is critical for future planning.

However, many people still think of healthcare as being purely about treating illness and restoring lost function through rehabilitation. Service providers continue to confuse the health services required by the population (which includes disabled people) with the support services that disabled people and older people require to participate in the community.

Applying that approach to support services for disabled and older people is not appropriate because the support services required are not aimed at fixing anything. Care and support is focused on providing ongoing services that help people live independent and fulfilled lives in the community, and to contribute to our society and the economy. People living with a mental health disorder also require similar support services.

### **Key issues**

There is a need to distinguish more clearly between health and support services and ensure that all staff are aware of the difference.

Poorly informed social attitudes are the most common and significant barrier for those receiving support services, such as disabled, older people and people with a mental illness. Disabled people have the right to make an informed choice and give informed consent about their healthcare, to be treated with dignity and respect, and to be free from discrimination.

The autonomy of those receiving support services needs to be recognised and fostered. The prominence of their wishes over those of their families, whanau and service providers needs to be respected wherever possible.

There can be tensions between the wishes of disabled people, and those of their families, whanau and service providers.

There are issues regarding the availability, integration and co-ordination of disability support services in the local community.

The social model of disability is the preferred approach to future changes and people need help to understand this approach and how it differs to a medical approach.

Lack of research concerning disabled peoples' lives and environment. There is a lack of information on the extent of diabetes, cardiovascular disease and cancer among disabled people.

There is a need to gather evidence to support practical initiatives aimed at removing barriers and improving outcomes for people receiving support services.

### **Strategies that guide our work**

The New Zealand Disability Strategy promotes the vision of a society that highly values the lives of disabled people and continually enhances the full participation of disabled people. It provides a framework to ensure that government departments and agencies strengthen their responsiveness to disabled people to achieve that vision.

The following objectives are taken from the New Zealand Disability Strategy and guide Auckland DHB's work:

- achieve for disabled people: the best education, employment and economic development, rights, quality living in the community, lifestyle choices, recreation and culture, and long-term support systems centred on the individual
- encourage and educate for a non-disabling society
- ensure leadership by disabled people
- ensure an aware and responsive public service
- collect and use relevant information and research about disabled people and disability issues
- ensure the participation of disabled Maori, Pacific peoples and women
- ensure that disabled children and young people lead full and active lives
- value families, whanau and people providing ongoing support.

In particular, objectives 7 and 8 of the New Zealand Disability Strategy require support provided in the community and centred around each person's needs.

The New Zealand Disability Strategy is focused on all government agencies but is sometimes incorrectly viewed as a health strategy. Auckland DHB has developed a plan to implement the government's strategy in health but recognises that the best efforts will involve collaboration across all sectors.

The Government's Health of Older People Strategy and Positive Ageing Strategy guide Auckland DHB's work in funding and managing aged care services. The concept of 'ageing in place' is central to aged care.

## **Actions for future health gain**

### **1 Require service providers to demonstrate and report on their implementation of the NZ Disability Strategy**

- 1.1 Support evidence-based practical initiatives aimed at removing barriers that limit access to health services and support services by disabled people. Provide good access to culturally appropriate support services for Maori, Pacific and migrant people.
- 1.2 Integrate health care services to meet the personal health, mental health and disability support needs of older people within the Auckland DHB.
- 1.3 Include disabled people in all services and programmes that recognise, educate and reduce the lifestyle factors that contribute to diabetes, cardiovascular disease and cancer.
- 1.4 Work with the Ministry of Health to expand primary and community-based health and support services to assist people to continue living at home; in particular to improve access to equipment and aids that maintain independence.
- 1.5 Improve the collection and analysis of information about disabled people and disability issues, including research into successful initiatives that remove barriers and improve outcomes.
- 1.6 Involve disabled people in setting, updating and ensuring compliancy to service specifications and standards for service provision.

### **2 Increase engagement in planning, service delivery and quality improvements**

- 2.1 Involve disabled people in leading all activities that relate to them. Respect their wishes over those of their families, whanau and service providers if conflict arises.
- 2.2 Maintain strong networks that involve disabled people, families, whanau, and carers, disabled community organisations, iwi, Pacific peoples, disability service providers, local councils, and government agencies in planning.
- 2.3 Ensure all communication and consultation is fully accessible and culturally appropriate.
- 2.4 Work closely with organisations representing disabled people, developing their expertise in problem prevention, habilitation, rehabilitation and in the provision of support services.

### **3 Advocate on issues for disabled people within Auckland city**

- 3.1 Highlight access problems and promote greater levels of independence and participation.
- 3.2 Work with other organisations and agencies to develop a communication programme which increases disability awareness amongst the Auckland city population.
- 3.3 Work with other agencies, adopt a community development approach and support the formation of service partnerships that include people receiving support services.
- 3.4 Promote a greater understanding of the distinction between health services and support services and how this impacts on service delivery.

### **4 Disabled people are involved in and lead training for health providers**

- 4.1 Provide the orientation and training necessary to strengthen leadership by disabled and older people in governance activities within the DHB.
- 4.2 Ensure all Auckland DHB providers undertake training programmes that include disability awareness, and the needs of older people, and that this is reflected in organisational policies and practice.

- 4.3 Educate clinical staff and health workers in disability awareness including the use of equipment and aids, to improve delivery of health services and programmes.
- 4.4 Use existing accessible and culturally-appropriate awareness resources for staff, external partners, and the family/whanau of older and disabled people using services.

## 6.9 The health of women

Gender, similar to culture, influences behaviour around health and can be a risk factor for certain health conditions. Women often take up the role of primary caregiver, having responsibility for maintaining the health of the family and even the wider community. This wider social role of women was emphasised strongly in the 2002 and 2005 strategic plan consultations. Men are similarly subject to gender roles, socialisation and attitudes that influence their choice of behaviour.

Specific health issues that relate to women's role, status in society, and to biological differences include menstrual problems, contraception, pregnancy and childbirth, breastfeeding, maternal mental health, infant health and mortality, teenage pregnancy, infertility, sexual abuse, domestic violence, rape and incest, menopause, caring for the very young, the aged and those with disabilities, incontinence, and aging.

The Health Funding Authority's 1998 consultation on women's health recommended that 11 areas form the base of a women's health strategy. Auckland women have continued to advocate for a women's health strategy and support the following priority areas:

- health promotion, information and primary prevention
- long-term perspectives
- service delivery and secondary/tertiary care
- mental health
- family violence
- access to healthcare services, cost and transport
- intersectoral collaboration
- participation in decision-making
- workforce development
- disability support and care of older people
- areas of specific focus: cervical and breast cancer, sexual health and family planning.

### Actions for future health gain

#### 1 A strategic approach to women's health

- 1.1 Demonstrate a focused commitment to improvements in women's health which respond to identified priority areas and achieve improved outcomes.
- 1.2 Ensure all DHB vital outcome areas and initiatives arising from these have a gendered approach and demonstrate improved health outcomes for women.
- 1.3 Adopt a well women's approach to health, characterised by health promotion, prevention and early intervention, including screening programmes. Work across sectors to address the wider determinants of health that particularly affect women.
- 1.4 Continue to advocate for a National Women's Health Policy that ensures specific attention is paid to women's health issues across the sectors. Add support to the development of a Regional Women's Health Network.
- 1.5 Encourage the participation of women in the identification of their health needs and in policy development, planning and the implementation of services.

- 1.6 Increase the participation of women in leadership and decision-making roles in the health sector.
- 1.7 Work with NGOs and support services that are community-based, culturally appropriate and acknowledge ethnic, age, and sexual orientation differences between consumers.

## **2 Priority health outcomes for the future**

- 2.1 Provide health services to women in the primary health care setting to prevent lifestyle related problems associated with diabetes, cardiovascular disease and cancer.
- 2.2 Ensure future actions reduce inequalities between groups of women by a special focus on Maori women, Pacific women, refugee women and new migrants, and women living in poverty.
- 2.3 Improve access to services, including mental health services, particularly for women with disabilities, older women and migrant women.
- 2.4 Prioritise health outcomes related to lifestyle choices, e.g. nutrition, tobacco use, drug and alcohol use, and sexual health, suicide and unintentional injury, all forms of violence, and teenage pregnancy.
- 2.5 Work with young women to reduce the rate of unplanned pregnancy, alcohol consumption, and smoking.
- 2.6 Integrate activities across health that identify family and sexual violence early on and provide the supports necessary to reduce the incidence and impact of violence on women.
- 2.7 Make interpreter services available in primary care and in the NGO sector for women whose first language is not English.
- 2.8 Ensure that women have a choice of service providers, especially access to female providers.

## **3 Sexual health and maternity services**

- 3.1 Reduce the rate of sexually transmitted infections and improve screening to reduce the impact of untreated infections.
- 3.2 Ensure a well women focus in maternity and women's services by providing maternity services in a well women, non-medical setting.
- 3.3 Decrease the high rate of intervention and caesarean section for women giving birth.
- 3.4 Support initiatives aimed at reducing the high abortion rate among young Pacific women and Asian women.
- 3.5 Provide information and services which promote choice in the areas of contraception and sexual healthcare, abortion services, pregnancy care and birth options.
- 3.6 Support breastfeeding as a significant health determinant in both adult and child health and ensure post-natal breastfeeding care and support.
- 3.7 Promote the full implementation of the breast and cervical screening programmes and ensure continuity of care for women who are part of the screening programmes.

## 6.10 The health of men

The following issues are taken from the 1995 'The Health of Men' report developed by the Regional Health Authority (North Health).

### Key health and disability issues for men

Mortality	Hospitalisations
<ul style="list-style-type: none"> <li>• Suicide</li> <li>• Injury (especially motor vehicle crashes)</li> <li>• Cancer (especially lung, large bowel)</li> <li>• Ischaemic heart disease</li> <li>• Respiratory diseases</li> <li>• HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>• Injury</li> <li>• Ischaemic heart disease</li> <li>• Diseases of the digestive system</li> <li>• Cancer</li> <li>• Psychoses (especially schizophrenia)</li> </ul>

The following groups of men are considered to have priority health and disability needs:

- men with acute or chronic conditions (including disabilities)
- men of lower socioeconomic status
- men whose lifestyle choices place them at risk
- men who have unsafe sex with men
- Maori men, Pacific men and other groups in any of the categories above

A gender breakdown of health issues reveals male related problems in all areas of health: physical, mental and social. Some of these are extremely serious. Many are preventable.

Maori and Pacific men have a higher risk of hospitalisation in many areas of health. Other groups with high risk for some conditions include gay and bisexual men and men from low socioeconomic backgrounds or who are marginalised in some way.

Men can be reluctant to admit health problems. This reluctance is attributed to the understanding of masculinity in our cultures and how men view themselves.

Several major men's health issues are the result of wider problems in society and in many cases are interlinked, e.g. the links between drink driving, motor vehicle crash rates, alcohol abuse, physical violence and gambling.

Although the community continues to advocate for gender analysis in health planning and service development, there has been no dedicated planning or programmes aimed at improving men's health as a distinct group.

Men's health is often limited to considerations that men die younger than women. There has been little investigation of issues related to maleness and the social roles of men in society; leaving us with little understanding of health and disease as it relates to men.

### Actions for future health gain

#### 1 Planning and research as starting points

- 1.1 Develop and implement a district/regional men's health plan and advocate for a national men's health strategy.
- 1.2 Undertake research into male health problems including mental, physical and social health and the best ways to engage men in solutions.
- 1.3 Make the evidence on men's health and successful approaches available to health professionals along with assistance to select approaches and settings that have proven most successful in engaging men.

## **2 Increase men's use of primary care services**

- 2.1 Establish primary care and prevention efforts that engage men, particularly hard to reach groups, with health services.
- 2.2 Provide primary health care services in the workplace and sports settings.
- 2.3 Link boys and young men into health promotion and prevention activities while they are in school and in settings that are relevant to their age and culture.

## **3 Prevention activities aimed at men**

- 3.1 Research new ways of working with men to address men's lack of knowledge about health and disability issues and services.
- 3.2 Provide health promotion programmes that are gender and age appropriate and which support positive roles for men (e.g. fathering).
- 3.3 Use preventive messages about smoking, alcohol and drug use, poor nutrition, exercise, stress management and melanoma, to support health promotion programmes.
- 3.4 Introduce the Healthy Eating Health Action Strategy in settings most likely to reach men and engage boys in healthy choices at an early age.
- 3.5 Support community-based services by men for men that encourage men to take greater responsibility for their own wellbeing and the wellbeing of others.
- 3.6 Develop sexual health programmes with high risk populations.

## **4 Specific areas for attention**

- 4.1 Promote partnerships with community providers to minimise the harm caused by alcohol and other drugs.
- 4.2 Undertake prevention work to reduce the rate of male suicide in the community.
- 4.3 Take a special focus on men's mental health, especially male depression and breaking the isolation men experience in seeking help.
- 4.4 Agree on an approach to testicular and prostate cancer that improves outcomes for men and which ensures that over-diagnosis and unnecessary treatment is avoided.
- 4.5 Work with new migrant men to understand the barriers to health and wellbeing for them and their families.

# 7. Actions to Address Specific Problem Areas

## 7.1 Prevent problems and promote health

Public health services are those delivered to communities or population groups - as distinct from services provided to individuals - with the aim of preventing illness or injury and promoting good health.

Public health action includes the efforts of organisations, institutions and communities across society, working together to address the complex range of factors that determine our health.

Public health services are currently funded by the Ministry of Health and delivered to the region by the Auckland Regional Public Health Service and other non-government providers.

The NZ Health Strategy requires the health sector to work co-operatively towards common goals, and it promotes a population health approach to improving the health status of New Zealanders. Population health considers the health status of a whole population group which includes the health needs of individuals as well as the community in which they live. Personal and public health have complementary roles in achieving health improvements.

There are financial risks to DHBs if personal and public health planning and funding are not aligned. Effective public health action has the potential to reduce demand for some expensive acute services over time. However, the public health sector receives less than 2 percent of total health funding, and it is critical that this funding is directed exclusively to public health activities that contribute to promoting health and preventing illness.

Overall responsibility for planning and funding public health services sits with the Ministry of Health. However, DHBs are responsible for funding primary health organisations and increasingly investing in other community-based public health activities. The planning and funding of regional public health activity is aligned with DHB planning and health needs.

In the northern region (greater Auckland and Northland), the public health units governed by the Auckland and Northland DHBs provide core health protection and health promotion services. While the Auckland Regional Public Health Service is located within Auckland DHB, it also provides services for Waitemata and Counties-Manukau DHBs.

Other public health funding for the region is allocated to non-government organisations (NGOs) which undertake a range of health promotion programmes, e.g. Heart Foundation, Family Planning Association, Hapai te Hauora Tapui.

Public health activity is a significant component of the DHB's approach to each of its priority population health goals. Planning for these requires reference to relevant national strategy documents such as He Korowai Oranga Maori Health Strategy, Healthy Eating Healthy Action and the Health Equity Assessment Tool.

The public health component of each programme also aligns with the national framework for public health action, Achieving Health for All People, which identifies strategic objectives and action areas to achieve measurable progress in public health.

## **Actions for future health gain**

### **1 Lead public health action across District Health Boards, providers, local government, other sectors, and communities**

- 1.1 Work with other sectors to address negative determinants of health, and contribute to policies that can reduce these effects.
- 1.2 Work with local government to ensure sustainable development, maintain public health infrastructure, and manage future public health issues and emergencies.
- 1.3 Provide leadership for community action to address priority health issues.
- 1.4 Take a lead role in establishing healthy approaches to food, tobacco, alcohol, and other lifestyle choices to prevent diabetes, cardiovascular disease, cancer and other lifestyle diseases.
- 1.5 Strengthen the use of Maori models of health in the development of Maori public health policy and practice.
- 1.6 Undertake public health service planning that involves DHBs, Treaty partners, the Ministry of Health and providers.
- 1.7 Use evidence-based approaches to policy and practice while encouraging innovation and evaluation where there are gaps in our knowledge.
- 1.8 Establish and maintain clear roles and responsibilities in public health action.

### **2 Reduce preventable admissions to hospital**

- 2.1 Provide public health expertise to support population health activities in PHOs and in personal healthcare settings that aim to reduce diabetes, cardiovascular disease and cancer.
- 2.2 In partnership, assist personal health providers to deliver comprehensive public health programmes, e.g. immunisation, tobacco cessation, and the Like Minds, Like Mine programme.
- 2.3 Improve the collection and dissemination of information to support primary care providers' activities in the prevention of illness and promotion of wellbeing.

### **3 Promote healthy communities and healthy environments**

- 3.1 Use community action approaches within public health and the wider health sector. Promote the use of Maori models of community development.
- 3.2 Promote a social and physical environment which improves, promotes and protects public health and whanau, hapu, iwi and Maori public health.
- 3.3 Support innovation and research in the development of Maori, Pacific and other culturally appropriate models of health promotion.
- 3.4 Strengthen and maintain effective Pacific public health action.

## **7.2 Equality in health status between groups**

Significant and unacceptable health inequalities exist among different groups of people in Auckland city. These are measured by risk factors, use of services, and health outcomes. While the health of the population as a whole is improving, the health of Maori, Pacific and those on low incomes, is improving more slowly than the rest of the population, and in some cases is getting worse.

Although a wide range of people and groups have unmet needs, those living in poverty and who are poorly educated, unemployed, or living in sub-standard, uninsulated or overcrowded houses are more likely to have poorer health. These people are also more likely

to have greater exposure to health risks, poorer access to services and die at a younger age than other New Zealanders.

Groups affected include Maori, Pacific peoples, new migrants, refugees, disabled people, those with mental illnesses, the elderly, and those living in poverty and deprivation.

Children in each of these groups are particularly at risk of disadvantage.

Maori and Pacific people at all educational, occupational, and income levels have, on average, poorer health status than European/Pakeha and are more likely to live in the most deprived areas.

People living in Penrose, and Avondale-Roskill wards, are most likely to score highly on measures associated with poorer health outcomes, such as low household median income, largest household size and highest percentage of households with three or more families/whanau.

Health inequalities can be found in almost all aspects of health and disability services, including; access to care, patient perceptions of care, utilisation of care, quality of care, and some clinical conditions such as diabetes and respiratory illnesses.

Health inequalities are stubborn, persistent and difficult to change. They require long-term focused efforts in policy and all areas of practice.

Disadvantages early in life influences disadvantages and health in later life. The early years of childhood are especially important.

Reducing inequalities is heavily dependent on addressing the wider determinants of health, especially socioeconomic status, income, education, employment, housing and exposure to discrimination.

Actions to reduce inequalities in health between Maori and non-Maori need to be prioritised in order to reflect Treaty of Waitangi responsibilities to ensure that Maori health is protected and that Maori enjoy the same access to healthcare as non-Maori.

The levels of disadvantage in Auckland, and the number of groups with high needs creates competition for resources and means that efforts to reduce inequalities are poorly targeted.

The Ministry of Health has developed a framework to help DHBs address health inequalities.

## **Actions for future health gain**

### **1 Identify the groups within Auckland city with greatest disadvantage**

- 1.1 Build the base of knowledge about groups that are disadvantaged within Auckland city. Set explicit health goals and targets for reducing inequalities.
- 1.2 Set a clear agenda for future work that manages the competition for limited health resources by ensuring that processes for resource allocation are well understood and accepted by all groups with high need across Auckland.
- 1.3 Protect Maori rights under the Treaty of Waitangi so that Maori have improved access to health services and priority problem areas addressed.
- 1.4. Dedicate efforts to reduce disparities for Pacific people, new migrants and people living in poverty in the key health areas of diabetes, cancer and cardiovascular disease, mental health and child health.
- 1.5 Improve access to health services for disabled people. Take a lead role in securing the supports disabled people need to live independently and to participate in society.

- 1.6 Take a gendered approach to the collection, collation and analysis of data, and address inequalities between men's and women's health.

## **2 Focus on the underlying causes of health inequalities**

- 2.1 Implement the Treaty-based partnership with Te Runanga O Ngati Whatua and engage with other Maori communities to address the determinants of health for Maori.
- 2.2. Work with other government agencies, NGOs, councils and community groups to address problem areas in the city. Priorities include child poverty, poor housing conditions, in particular accommodation that is substandard, damp or cold, crowded households and poor educational attainment and skills.
- 2.3 Advocate for the health and wellbeing of the people of Auckland city by representing their needs at a national level and ensuring New Zealand policy considers the diverse and unique needs within Auckland city.

## **7.3 Reduce diabetes, cardiovascular disease, and cancer**

Cardiovascular disease and cancer are leading causes of death in the population and are responsible for the largest burden of disease on the local population.

The prevalence of diabetes is predicted to increase over the next 10 years and is of particular concern among Maori and Pacific peoples. About 90–95 percent of people with diabetes have type 2 diabetes.<sup>2</sup> The increase in diabetes has been linked to inactive lifestyles and obesity, and can be prevented through lifestyle changes. Those with undiagnosed diabetes have a much higher risk of developing serious medical complications.

While most diabetics in Auckland city are adults with type 2 diabetes, those adults and children with type 1 diabetes need a continuum of services to reduce the risk of chronic illnesses associated with diabetes. Auckland DHB is already working with children with diabetes. Diabetes type 2 progresses faster in young people than in adults. While type 1 is not preventable, nor high in percentages, it is a major issue for children under 16 years of age.

Chronic conditions include communicable disease (e.g. HIV/AIDS) and non-communicable diseases (e.g. diabetes, cardiovascular disease, and cancer), long-term mental disorders (e.g. depression) and ongoing physical problems (e.g. arthritis, chronic neck or back problems). These are responsible for over 80 percent of all deaths in New Zealand and account for 70 percent of health sector costs.

The management of chronic conditions is a leading cause of hospitalisation and is becoming increasingly complex. Chronic diseases are major contributors to the disparity in life expectancy between Maori and non-Maori people and between Pacific and non-Pacific people.

Many chronic conditions are preventable. The prevalence of cardiovascular disease, cancer and diabetes can be reduced by reducing smoking rates; and reducing obesity through improved nutrition and physical exercise.

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<sup>2</sup> In Type 1 diabetes, the pancreas doesn't produce insulin. In Type 2 diabetes, the pancreas usually produces it, but for some reason, the body cannot use the insulin effectively. If the glucose can't get into the cells it stays in the bloodstream and can cause a number of problems.

There are also many conditions such as motor neurone disease, leukemias, brain and other tumours for which the etiology is unknown which place a high burden on patients, their carers and services. People who are chronically ill may not be aware of the palliative care options in the community, including counselling and support for family.

While palliative care is for older people with chronic conditions, there are also people under 65 in hospice. We need to understand trends within our population and respond to these with appropriate social and multi-disciplinary supports.

## **Actions for future health gain**

### **1 Reduce rates of diabetes, cardiovascular disease, and cancer in Auckland city**

- 1.1 Prevent type 2 diabetes, cardiovascular disease and cancer in adults and young people at every possible point of intervention, from promotion, support services, primary care, secondary care and specialist services.
- 1.2 Prioritise better health outcomes for Maori. Work with Te Runanga O Ngati Whatua to prevent diabetes, cardiovascular disease and other lifestyle related problems.
- 1.3 Focus on tangible health gains for Maori. Demonstrate that health gains have reduced inequalities between Maori and non-Maori. Achieve equity of access to all levels of service for all our local population.
- 1.4 Prioritise better outcomes for Pacific people through culturally appropriate programmes that prevent type 2 diabetes, cardiovascular disease and lifestyle related problems.
- 1.5 Focus on health promotion and other initiatives that prevent and reduce lifestyle related problems in children and young people.
- 1.6 Implement the national Cancer Control Strategy with a focus on health messages that reduce the incidence of cancer, particularly smoking cessation.

### **2 Use a whole system approach to improve health over the long term**

- 2.1 Create one integrated system that promotes healthy lifestyles and encourages every person to maximise their potential for good health.
- 2.2 Invest in primary health care and public health early intervention activities that prevent health problems becoming complicated through a lack of treatment or incorrect treatment.
- 2.3 Increase the ability of primary care to improve the management of complex diabetes, heart disease, palliative care and cancer.
- 2.4 Model good health across the organisation and advocate for policy changes in other sectors that impact on the health of the population such as tobacco, alcohol consumption and housing.
- 2.5 Take a lead role in 'society's response' to health need and provide the leadership required to achieve a healthy community. Work strategically with other DHBs, sectors and organisations.

### **3 Improve the quality of life for those with cancer, their family and whanau through support, rehabilitation and palliative care**

- 3.1 Adopt proven chronic care management approaches and best practice to integrate services across all areas of health intervention so care is streamlined and client focused.

- 3.2 Place the patient, family and community at the centre of care, recognising that patient self-management is key to improving the health of people with chronic conditions.
- 3.3 Hospital and related services provide the clinical leadership needed to manage chronic care and complex conditions outside the hospital. Build clinical partnerships with primary care to increase efficiency, quality and seamless care.
- 3.4 Work with other groups with the highest need for chronic care management: Maori, Pacific, young people, and older people. Develop and evaluate dedicated approaches to working with children and young people who have chronic diseases.
- 3.5 Support screening programmes that are evidence-based and show overall benefit to the screened populations.
- 3.6 Improve palliative care services that integrate hospital and community services and which provide options for people who are chronically ill. Develop expertise at the specialist level, including adequate palliative care support for people of all ages, genders and ethnicities who are chronically ill.
- 3.7 Plan regionally to manage demand for specialist treatment services into the future.

## **7.4 Strengthen primary health care**

Primary health care can achieve population health gain and reduce hospital costs over the longer term, with some potential for short term gains. It is one of the most sustainable ways to improve health and manage the deficit but requires a long-term investment.

The combined efforts of primary health providers can address chronic disease and reduce problems associated with diabetes, cardiovascular disease and cancer. Integrating primary and secondary healthcare services helps to reduce the progression of diseases, reduces mortality, minimises the need for complex care, and achieves a healthier population.

Investing in health services outside the hospital is critical in reducing the burden of disease for our population. Hospital clinician and community leadership is a central part of successful chronic care management programmes. These programmes involve doctors and clinical nurse specialists working with primary care teams to improve the management of complex diabetes and to refer appropriately to clinics.

### **Key issues**

PHOs need to expand beyond general practice providers to include a wider range of primary health care providers: Maori and Pacific health services; child health providers; nurse services; community pharmacists; and public health providers.

There is a lack of effective co-ordination and communication between primary care and secondary care services including specialist mental health.

The range and diversity of communities within Auckland city requires primary care services to respond to many different health needs.

There are large numbers of new migrants and refugees residing in Auckland DHB area and as a result there is increasing demand for interpreter and cultural assistance for primary care consultations.

PHOs are well positioned to respond to special communities of interests and need to find ways of reaching and engaging these communities.

There are concerns about after-hours services. People find it difficult to see a doctor at night, in weekends and public holidays and find the cost associated with after-hours care is a real barrier to getting help.

Inequalities between groups in our city continue regarding access to primary health care services.

People don't always know their full entitlements when visiting a GP service or other health provider, especially in relation to payments for doctors' visits and pharmaceutical prescriptions.

There are concerns over doctor's fees structure and the need to ensure primary care subsidies are passed on to patients. Patients in areas of deprivation around the city need free or very low co-payments when they see a doctor.

There are a large number of specialist services in Auckland DHB which leads to a higher use of specialist referred services and expenses related to pharmaceuticals and laboratory services.

## **Actions for future health gain**

### **1 Increase prevention and early intervention**

- 1.1 Prevent problems using holistic and multi disciplinary approaches within general practice, accident and medical centres, community nursing services (paediatric and adult services), community health services and pharmacies.
- 1.2 Prioritise smoking prevention and cessation programmes amongst young people, particularly young Maori women.
- 1.3 Prioritise programmes for Maori and Pacific people that prevent and manage the risks of diabetes through poor nutrition, obesity and inactivity.
- 1.4 Provide more opportunity for communities of interest to identify their own health needs, to prioritise, and to generate their own locally owned solutions to problems.
- 1.5 Increase public health involvement in PHOs for health promotion and problem prevention, specifically to help people to become more physically active and to have a healthier diet.
- 1.6 Deliver primary care-based programmes that prevent coronary disease, cancer and diabetes via programmes that address poor nutrition, smoking, obesity, physical inactivity, alcohol and drug use, and hypertension.
- 1.7 Focus on prevention activities associated with screening programmes, oral health, sexual health, injury prevention, youth suicide, violence, and teenage pregnancy.
- 1.8 Develop and evaluate specific initiatives within primary health care that prevent or reduce serious ill health and acute admissions.

### **2 Integrate primary health care and hospital services**

- 2.1 Co-ordinate primary care delivery with specialist care services so there is a smooth transition between services (i.e. Well Child services, maternity, mental health, and public health).
- 2.2 Implement best practice models for integrating primary and secondary care for people with multiple and complex needs.
- 2.3 Provide clinical leadership to support primary care management of complex conditions (diabetes, cardiovascular disease), improve referrals, and reduce demand on hospital services.
- 2.4 Integrate primary and secondary service to improve health gains for children, young people and older people.
- 2.5 Improve the integration of services in the provision of mental health services and palliative care.

### **3 Equitable access to services**

- 3.1 Increase the public's knowledge about available primary health care services and improve access to primary care services for priority populations.
- 3.2 Focus on improved primary care services to under-served populations and ensure that the increased subsidies for doctor's visits and pharmaceutical prescriptions are passed on to patients.
- 3.3 Reduce cultural and gender barriers, communication, cost and transport barriers that limit access to primary care services.
- 3.4 Train and develop mainstream primary health care providers to work with Maori and Pacific communities to improve health and reduce disparities.
- 3.5 Assist primary care providers to respond effectively to Auckland's diverse communities and to achieve the community participation required for future planning.
- 3.6 Meet priority needs for refugee and migrant community, i.e. interpreters in primary care, community involvement, cater for important cultural and religious needs, and specific mental health services for children and their families.
- 3.7 Prioritise delivery of services to children in the early years, particularly children from groups identified as being disadvantaged i.e. those living in poverty, deprivation, those living with resettlement stress or living with family violence.

### **4 Specific project work**

- 4.1 Work with primary care organisations to get the right mix of skills and technologies, including pharmaceuticals and diagnostic services, to meet population needs.
- 4.2 Manage the growth in demand for acute secondary care services, and plan a well integrated approach to the management of acute and non-acute services.
- 4.3 Review community pharmacy and laboratory expenditure and other pressures in the district and region. Manage growth in expenditure for these services through the use of best practice guidelines. Improve value in the supply of both for primary care services.
- 4.4 Participate in projects to manage referred services of laboratory and pharmaceuticals. Ongoing volume management and review of dispensing patterns in the community.
- 4.5 Undertake other regional work required, e.g. implement the review of the regional laboratory project, develop a regional strategy for major purchasing.
- 4.6 Develop an integrated plan that expands emergency and after-hours primary care services and reduces the cost of these essential services.
- 4.7 Develop regional oral health and palliative care strategies which align to national strategies in conjunction with local DHBs and in consultation with key stakeholders.
- 4.8 Support nursing innovations that enable hospital-based nurses to work more closely with primary care nurses to meet community needs, e.g. well women's clinics.
- 4.9 Strengthen primary maternity care, family planning, reproductive and sexual health, and the prevention of family and sexual violence.

### **5 Provide support structures to expand PHOs**

- 5.1 Set local health goals and outcomes using demographic and epidemiological evidence, consultation, evaluation and other information about local need.
- 5.2 Develop the infrastructure to support primary health care: information systems; performance measures, referred services management, clinical performance indicators, population health outcomes; and monitoring and forecasting service use and expenditure.

- 5.3 Implement a sustainable funding model for primary care. Establish equitable budgets for primary health based on enrolled populations, review the cost-effectiveness of primary health care services, and invest in those with the most effective returns.
- 5.4 Expand primary providers to include greater participation of nurses, pharmacists, laboratories and lead maternity carers.
- 5.5 Identify future competencies required in primary health care and provide training, especially for the future role of nurse practitioners and community health workers.
- 5.6 Support a culture of quality improvement among all primary care providers by promoting the widespread use of evidence-based guidelines.
- 5.7 Realise the potential of primary care provider networks to build relationships, form partnerships, and expand the involvement of providers and community in planning.
- 5.8 Participate in the development of a nationwide service framework for primary care.

## 7.5 Stronger responses to mental health problems

Auckland DHB, along with other DHBs in the region, implements the National Mental Health Strategy which focuses on:

- more and better specialist services
- more and better services for Maori
- services responsive to needs
- mental health services in primary health care settings
- mental health promotion and prevention
- social inclusion – removing social and economic barriers to recovery
- improving the health status of people with severe mental illness.

Government mental health strategies are based on treatment and support for recovery in the community. Future funding will be based on flexible care in the community rather than on more beds.

Mental health funding is for the 3 percent of the population with serious mental health disorders and prioritises the 0.6 percent of the population who also have high support needs. Specialist mental health services are provided by District Health Boards and non-government organisations (NGOs). These provide assessment, treatment and disability support for eligible people.

Regional and local Mental Health Plans guide future planning with priorities concentrating on an increase in services for: children and young people, older people, Maori and Pacific.

Auckland DHB funding is directed to community-based specialist mental health services where the biggest gaps exist. These services address mental health problems earlier, provide effective support after hospital and ensure that services are consumer oriented and aid recovery.<sup>3</sup>

The Mental Health Commission's Blueprint details the quantity of specialist mental health services required for people with the most severe and complex needs. Services in the Auckland DHB and other DHBs in the Northern region remain well below the level specified in the Blueprint.

<sup>3</sup> Recovery is defined in the Blueprint as the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience). Each person with a mental illness needs to define what 'living well' means to them.

There are tensions between the funding supplied for mental health which is based on Blueprint targets and the funding supplied to the DHB on the population-based funding formula.

The money provided via Blueprint funding has been under-spent because some new initiatives require workforce expertise or require a long establishment phase.

The flow of patients between districts causes funding difficulties. This is especially relevant if the care to an individual is provided by several DHBs in the region.

Residential facilities funded to provide care for people with some independence (level 1 and level 2) are undergoing changes.

Mental illness accounts for 15 percent of the global burden of disease with five mental health disorders (unipolar depression, schizophrenia, alcohol use, bipolar affective disorder, obsessive compulsive disorders) causing the highest disability ratings in the world.

Depression is predicted to be the second highest cause of death and disability globally by the year 2020. Rates of depression are increasing and people are experiencing it at an earlier age.

One in five women and one in 10 men in New Zealand experience a diagnosable mental illness, including depression and alcohol and drug disorders at any one time.

About 17 percent of people in the population require mental health services that could be provided through primary care GP and counselling services. Mild to moderate mental health problems are not eligible for specialist mental health government funding.

A small number of primary mental health services are funded locally but these are insufficient to meet the needs of people with mild to moderate problems and those who have been sexually abused or exposed to trauma.

Asian, refugee and new migrant populations advocate for services that address resettlement issues and trauma.

Approximately 3 percent of the population have serious ongoing and disabling mental illness requiring treatment from specialist mental health and alcohol and drug services.

Alcohol and drug problems are covered under mental health funding with Waitemata Health providing Community Alcohol and Drug Services across the greater Auckland area. Auckland DHB is a lead DHB for a number of regional and national alcohol and drug residential rehabilitation contracts.

Alcohol and illicit drug use is increasing with concerns about the use of these substances among young people, Maori and Pacific peoples.

There is a high youth suicide rate among males, particularly young Maori men.

Family violence (including child and partner abuse, sexual violence, and psychological abuse) is recognised as a key social and health issue in society.

The following gaps in mental health service have been identified:

Adults	Young people	Older people
<ul style="list-style-type: none"> <li>• Kaupapa Maori services</li> <li>• Workforce development</li> <li>• Community services for consumer/whanau</li> <li>• Crisis respite models</li> <li>• Flexible supports for living in the community</li> <li>• Dual diagnosis services</li> <li>• Young adult services</li> <li>• Refugee and migrant services</li> <li>• Parents with a mental illness</li> </ul>	<ul style="list-style-type: none"> <li>• Youth specialty services</li> <li>• Alcohol and other drugs</li> <li>• First-episode psychosis</li> <li>• Family/whanau/peer support</li> <li>• Eating disorders</li> <li>• School liaison services</li> <li>• Culturally responsive services, e.g. Maori, Pacific, refugee and migrant</li> <li>• Respite care</li> <li>• Children of parents with a mental illness</li> </ul>	<ul style="list-style-type: none"> <li>• People with complex and serious needs</li> <li>• Family/whanau/peer support</li> <li>• People with depression and behavioural problems</li> <li>• People with a history of institutionalisation</li> </ul>

## Actions for future health gain

### 1 Service planning and funding activities

- 1.1 Continue the regional approach to managing mental health funding and implement the review completed by the Mental Health Commission and the Ministry of Health.
- 1.2 Complete the local Mental Health Plan and use this to guide future planning.
- 1.3 Help develop the regional management strategy for mental health to address the perceived vulnerability of NGOs.
- 1.4 Report local health needs regularly including the intended and actual use of mental health funding.
- 1.5 Support national initiatives to obtain prevalence rates of mental disorders among Maori and Pacific people.
- 1.6 Develop a funding approach that better aligns funding incentives with desired outcomes and ensure the method of funding different providers is equitable.
- 1.7 Ensure the services and programmes funded are evidence-based.

### 2 Improve services for adults

- 2.1 Expand services for people newly diagnosed with psychotic disorders.
- 2.2 Establish new services for people with high support needs.
- 2.3 Improve the responsiveness of services for people who are acutely unwell.
- 2.4 Develop improved approaches for people with borderline personality disorders.
- 2.5 Establish services in specific areas, e.g. maternal mental health, people with eating disorders, and people seen as high risk or involved in the criminal justice system.

### 3 Improve services for children and young people

- 3.1 Expand services for young people:
  - with drug and alcohol problems
  - with eating disorders.
  - who are experiencing a first episode of psychosis
  - refugee and migrant children, young people and their families and whanau.
- 3.2 Improve the level of family/whanau and peer support available to people using mental health services.

- 3.3 Ensure families and whanau have access to respite care.
- 3.4 Establish support services for children whose parents have a mental illness.
- 3.5 Establish school liaison services.

#### **4 Improve services for older people**

- 4.1 Improve services for older people with complex and serious needs, e.g. people with depression and behavioural problems and people with a history of institutionalisation.
- 4.2 Improve the level of family/whanau and peer support available to older people using mental health services.

#### **5 Expand primary health care**

- 5.1 Develop more initiatives in primary care that help people with mental health disorders get appropriate care for all their health needs.
- 5.2 Expand services available in primary health care to help with the early detection of problems, provide brief interventions and referrals to counselling or support services.
- 5.3 Improve integration and co-ordination between mental health service providers and primary care providers.

#### **6 Improve service quality**

- 6.1 Train the mental health workforce to develop awareness of recovery oriented service delivery and to understand the attitudes and behaviours that will improve people's access to services.
- 6.2 Evaluate mental health service compliance to National Mental Health Standards. Establish a cohesive approach to monitoring services and achieving continual improvement in service quality.
- 6.3 Ensure access to adequate training for service staff and for consumers and families, whanau.
- 6.4 Increase stakeholder participation in planning and service development through local networks and groups.

## 8. Managing Financial Resources

The following financial information is a brief summary taken from the financial section in our 2005–06 District Annual Plan. This information covers the period 2005 to 2008 although further work is underway to expand this information out to 2010. The detailed financial statements are contained in our Annual Plans which are available on [www.adhb.govt.nz](http://www.adhb.govt.nz) or by emailing [jhelean@adhb.govt.nz](mailto:jhelean@adhb.govt.nz).

### 8.1 Performance

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

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

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

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

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

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

The deficit reduction proposed is a gradual approach to the irreducible deficit explained above. In order to achieve this reduction a significant programme of savings will be required.

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

## Statement of Financial Performance

	2004-05 actual \$000	2004-05 base result \$000	2005-06 budget \$000	2006-07 budget \$000	2007-08 budget \$000
<b>Revenue</b>					
<i>Ministry of Health</i>					
Base – provider	649,812	647,187	686,176	699,486	720,410
Base – governance	2,824	2,824	2,824	2,909	2,996
Base – funder	414,837	401,461	442,558	458,526	472,282
Funding for increased depreciation and capital charge from asset revaluation	–	–	15,058	8,198	8,198
Other contracts	42,813	42,813	40,384	36,754	34,463
	1,110,286	1,094,285	1,187,000	1,205,873	1,238,349
<i>Other revenue</i>					
Inter-provider revenue	2,065	2,065	2,295	2,295	2,295
Other patient care revenue	25,139	25,139	21,465	21,888	22,348
External revenue	63,714	62,042	58,580	55,733	56,719
	90,918	89,246	82,340	79,916	81,362
<b>Total revenue</b>	<b>1,201,204</b>	<b>1,183,531</b>	<b>1,269,340</b>	<b>1,285,789</b>	<b>1,319,711</b>
<i>Operating costs</i>					
Employee costs	512,002	512,002	550,726	576,647	606,088
Treatment costs	181,221	181,221	180,227	185,593	191,778
Funder payments	424,862	431,832	440,005	460,586	474,404
Property and equipment maintenance	48,911	48,911	52,537	52,952	54,168
Administration	17,979	17,979	17,628	17,585	18,345
Additional net savings to be achieved not imbedded in budgets	–	–	(3,277)	(50,000)	(68,000)
<b>Total operating costs</b>	<b>1,184,975</b>	<b>1,191,945</b>	<b>1,237,846</b>	<b>1,243,363</b>	<b>1,276,783</b>
<b>Operating surplus/(deficit)</b>	<b>16,229</b>	<b>(8,414)</b>	<b>31,494</b>	<b>42,426</b>	<b>42,928</b>
<b>Depreciation, interest and capital charge</b>					
Depreciation	43,079	43,079	49,446	49,325	53,011
Interest	17,447	17,947	20,814	21,988	22,744
Capital charge	17,909	17,909	25,870	20,949	19,500
	78,435	78,935	96,130	92,262	95,255
<b>Underlying total deficit for the year</b>	<b>(62,206)</b>	<b>(87,349)</b>	<b>(64,636)</b>	<b>(49,836)</b>	<b>(52,327)</b>
<i>Other costs</i>					
Asbestos removal	9,895	–	–	–	–
Mental Health ringfence	(2,491)	–	7,399	–	–
	7,404	–	7,399	–	–
<i>Other contributions</i>					
Asbestos removal	11,500	–	–	–	–
Surplus on sale of assets	–	–	6,492	–	–
<b>Total deficit for the year</b>	<b>(58,110)</b>	<b>(87,349)</b>	<b>(65,543)</b>	<b>(49,836)</b>	<b>(52,327)</b>

The statement of financial performance includes several key features below:

### Operating margin

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

	2004/05 budget \$000	2004/05 actual \$000	2004/05 normalised \$000	2005/06 budget \$000
ADHB total revenue	\$1,159,000	\$1,201,000	\$1,184,000	\$1,269,000
Operating margin – surplus (deficit)	\$1,971	\$16,229	(\$8,415)	\$31,494
Operating margin as a percentage of revenue	0.1%	1.3%	(0.7)%	2.5%

The table indicates that before adjusting for 'one-off' impacts applied to the 2004–05 result, the strategic initiatives in place in 2005–06 will improve the operating performance by \$11.5 million. Normalising the 2004–05 financial year, the improvement in operating performance is more dramatic at \$39.9 million.

The unfavourable variance of \$10.4 million reflected in the normalised result for 2004–05 and the budget for 2004–05 is substantially a function of higher than budgeted treatment costs and the unfunded portion of employee Collective Agreement settlements.

### Overall performance year on year

The primary drivers for the budgeted deficit for 2005–06 of \$65 million being higher than the actual deficit for 2004–05 of \$58 million by \$7 million are:

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

## Statement of Financial Position

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

## Movement in equity

During the 2004–05 year, there was a substantial change to the equity position of the DHB. The revaluation of assets has contributed \$143 million to the total increase of \$152 million.

Equity injection for the Building Programme for the year is reflected at \$13 million with deficit support offsetting the deficit applied to owner's equity for the year. Apart from the final equity required to complete the building programme of \$5 million only equity required to support the ongoing deficit is anticipated.

## 8.2 Key assumptions

### Revenue changes year on year

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

### Operating cost changes year on year

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

The percentage increase in operating costs is lower than the increase percentage in revenue.

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

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

## 8.3 Savings targets

The performance improvement strategies are divided into two main areas:

- **Living within means** Target savings \$11 million per annum  
Historically the Auckland DHB has not managed to contain costs to the level of funding provided. Analysis has identified that the ongoing unfunded cost creep is in the region of \$11 million per annum.
- **Addressing the root causes of the deficit** Target savings \$69 million per annum  
Four main areas have been identified as contributing unfavourably to the cost structure of Auckland DHB. The savings gross targets per annum expected within each area to be achieved in full after three years is:

- pay gap \$26 million
- efficiency \$16 million
- infrastructure \$ 9 million\*
- service configuration \$18 million.

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

\* The original target for this area (\$15 million) has been eroded by the impact of applying the population-based funding formula (PBFF) to the revenue stream from the Ministry of Health designed to offset cost increases (capital charge and depreciation) arising from the asset revaluation performed at June 2005.

## 8.4 Capital budget

The Capital Plan must meet the following organisational criteria:

- living within means
- retirement of long-term debt
- self-funding.

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

- long-term depreciation releases cash flows to retire long-term debt
- short-term or routine depreciation releases cash flows to fund short and medium term capital expenditure.

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

	2006 budget \$000	2007 budget \$000	2008 budget \$000
<b>Total capital spending</b>	48,179	29,094	30,000
Routine (operational)	20,216	23,394	30,000
Building programme and non-routine	27,963	5,700	–

## 8.5 Treasury

### Borrowing covenants

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

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

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

## 8.6 Budget assumptions

In preparing the financial statements for the future years, a number of high-level assumptions have been used.

### Changes to employee costs

Salary increments projected to 2008 do not include 'salary creep' driven by movements up the salary steps within collective agreements. This has been allowed for in the following increment in each year respectively in addition to the rate increments as follows: Medical 2.6%; Nursing 1.1%; Technical 1.7%; Hotel services 0.5%; Administration 1.4%.

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

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

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

Base contracts have been reconciled to revenue advice provided by the Ministry of Health. A comparison between the 2004–05 budget and 2005–06 budget, shows a difference between the actual growth in revenue and the ministry's reported growth rate for new funding of 3.3%.

Other contracts revenue, in the 2005–06 budget, has been impacted by reduced revenue for the treatment of cancer patients in Australia, a reduction in disability support revenue reflecting a decision by the Ministry of Health to tender work to other DHBs.

Other contracts revenue, in the 2006–07 budget, has also reduced. This is a function of the timing of preparation of outer year forecasts and will require further review given the levels of income now forecast for the 2005–06 year.

### Other revenue

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

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

### Employee costs and FTE

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

Auckland DHB has taken account of the known and expected outcomes of collective agreement negotiations as outlined in the assumptions in section 8.2. This is the primary driver of the increases in overall employee cost identified. The increase in staff related expenses in the 2005–06 year relates to an unrealistic 2004–05 budget as large section of the cost is driven by agreements imbedded in collective agreements, such as continuing medical education.

Human resources advocates have endeavoured to stay within a Consumer Price Index target of 3.0 percent for the 2005–06 year. They wish to highlight the impact of the 5.0 percent campaign currently being run by the trade union movement and the flow on effects of the nursing agreement which will impact on outstanding agreements such as PACT (professional, administrative, clerical and technical employees represented by the PSA Union).

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

Auckland DHB will face significant challenges in containing employee costs given the settlement of collective agreements above budget and annual salary creep. In addition Auckland DHB has set itself a number of challenging savings targets in terms of:

- management of vacancies
- achievement of staff efficiencies imbedded in the budget
- continuing search for efficiencies.

As noted in the 2004–05 District Annual Plan, treatment costs are significantly impacted by the price, quality and technology cost increases across the health sector. These increases have run between 5 percent and 10 percent per annum in recent times.

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

- 2005–06 2.4%
- 2006–07 2.1%
- 2007–08 2.1%.

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

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

- **Pharmacy.** The Pharmac advised increase for pharmacy expenditure is 5.5 percent. In addition Auckland DHB has provided for a full year share of the Pharmacy One contract taken over from Waitemata DHB.
- **Pharmac rebates.** Pharmac rebates for the 2004–05 year reflect the inclusion of rebates due to Auckland DHB at 30 June 2005. The policy of recording rebates received in cash and due each year will continue in the 2005–06 year.
- **Laboratory.** Auckland DHB has assumed a 4.0 percent growth in underlying laboratory business. A procurement programme is currently in progress aimed at delivering system efficiencies that will provide reduced purchasing costs and process efficiencies.

- **PHOs.** As in the 2004–05 budget the cost estimates have been based on the numbers of enrolled patients for the June 2005 quarter. In addition there has been a small allowance made for growth.
- **Health of older people.** There are three elements driving the increase in this expenditure:
  - an 8.0 percent increase in home support costs
  - a 3.0 percent increase for residential rest home costs
  - the impact of the rise in the level for asset testing which has resulted in higher numbers of eligible patients.

### **Property and equipment maintenance**

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

### **Administration**

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

### **Savings included in budget**

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

### **Specific savings identified in the budget**

Analysis carried out for the purposes of compiling the 2005–06 District Annual Plan and budget highlights Auckland DHB's deficit issues as arising from a number of factors:

- staffing costs out of line with the health sector generally
- capital costs likewise out of line
- lower efficiency than other healthcare providers
- failing to constrain increases in spending to within funding increases on a year to year basis.

These factors have informed the process of identifying future initiatives to reduce the deficit. It will be clear from this list however that some of these factors are the result of decisions made over many years. The deficit reduction is required to be implemented over a more contracted timescale. Accordingly, the savings identified are large and challenging, and there is a correspondingly high risk associated with achieving them. Among the risks are the following, some of which have been partly mitigated against:

- the potential one-off costs of change, e.g. redundancy payments
- slippage in achieving such large savings
- lack of acceptance and push back by staff and unions.

**Depreciation and capital charge**

There is an impact arising from the asset revaluation on the depreciation expense and the capital charge. The Ministry of Health will fully fund the cost increase effects as a result of the revaluation in the 2006 year and partly offset the cost impacts in the outer years.

**Capital budget**

It is Auckland DHB's intention to set aside long-term depreciation for debt repayment.