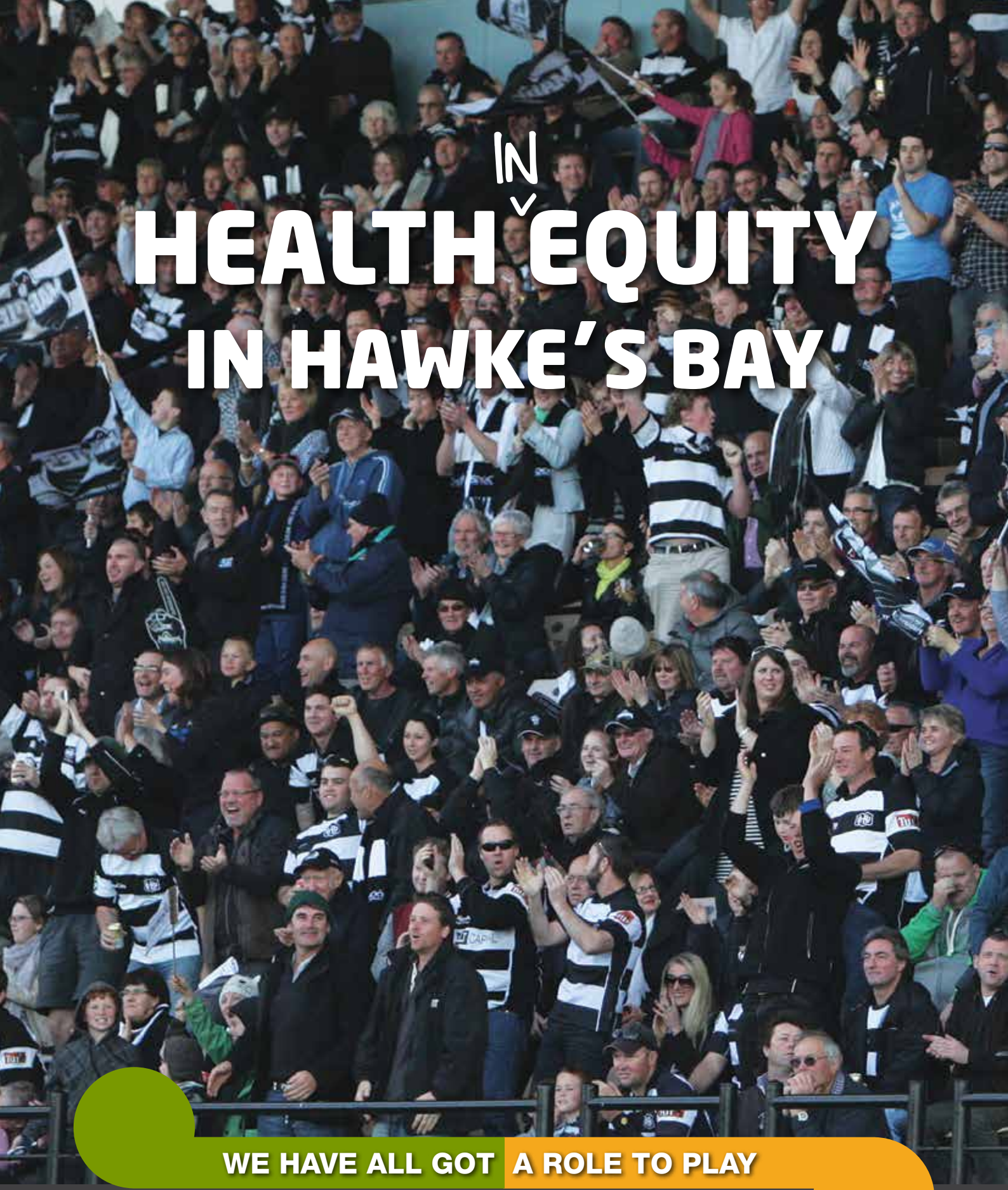

HEALTH IN EQUITY IN HAWKE'S BAY

WE HAVE ALL GOT A ROLE TO PLAY

KEY FINDINGS 2014

www.hawkesbay.health.nz

McElnay C 2014, Health Equity in Hawke's Bay, Hawke's Bay District Health Board.
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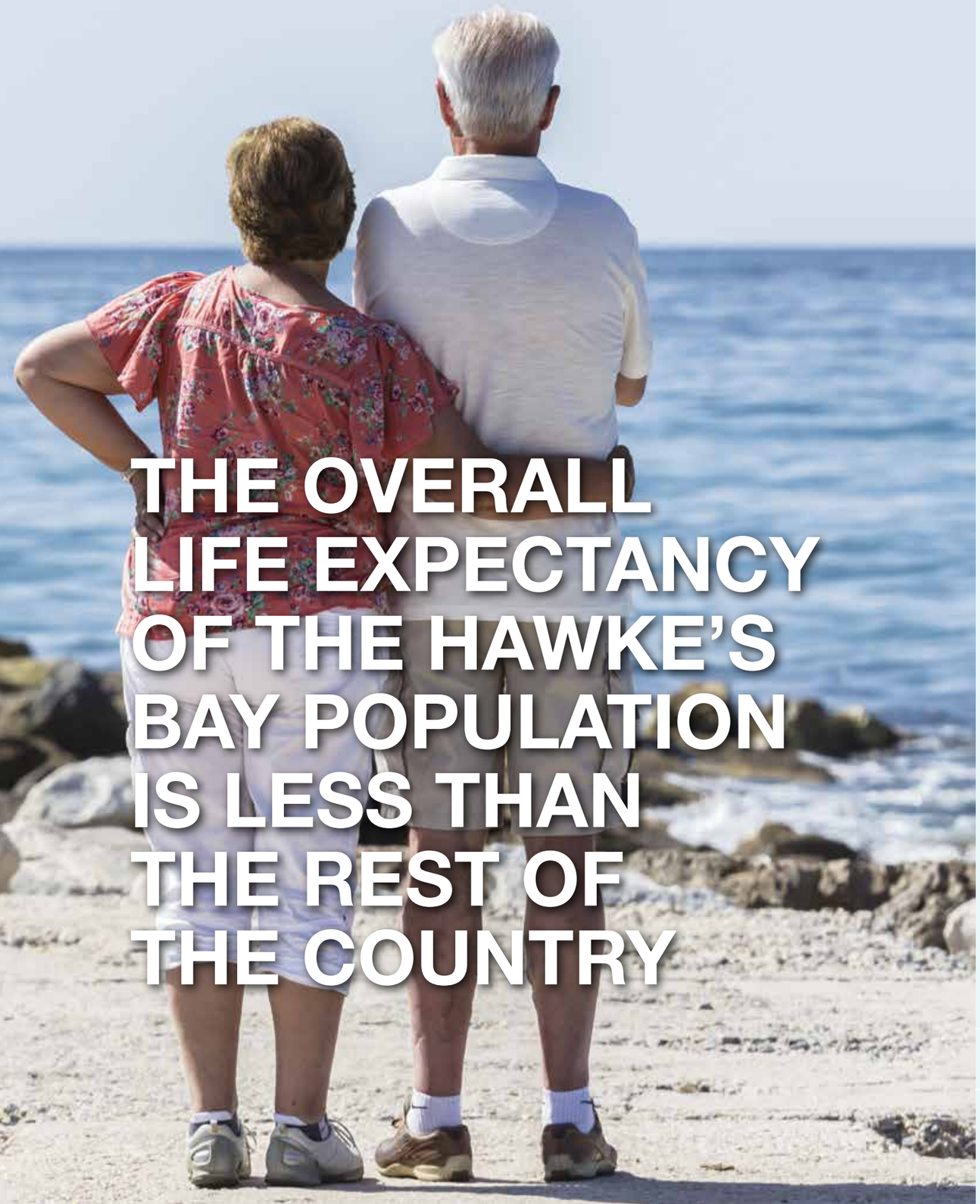


THE OVERALL LIFE EXPECTANCY OF THE HAWKE'S BAY POPULATION IS LESS THAN THE REST OF THE COUNTRY

Many things in life are unequal. Health Inequities are inequalities in health that are avoidable or preventable and therefore unfair.

This report finds many inequities in health in Hawke's Bay, particularly for Māori, Pasifica and people living in poorer areas. There are also areas where, with determined and focused effort, we have improved outcomes and reduced inequities. This demonstrates that inequities are not inevitable. We can change them if we have the courage and determination to do so.

The most unexpected finding was that people living in Hawke's Bay are less physically active than the average person who lives elsewhere in the country, despite all the region has to offer. I was so surprised at this finding I had the data revalidated.

Lack of physical activity links directly into our obesity rates. Two in three Pasifica people and one in two Māori are obese in Hawke's Bay. Obesity increases a person's risk of dying young; it increases the risk of cancer, heart disease, diabetes and a raft of other related medical conditions.

Smoking is the biggest cause of inequity in death rates in Hawke's Bay - it is the single most important cause of preventable ill health and premature mortality. The high rate of smoking amongst Māori women giving birth is a public health crisis, given the effects that this will have on the long term health of the next generation.

Inequity, however does not only relate to our Māori and Pasifica communities in Hawke's Bay.

The overall life expectancy of the Hawke's Bay population is less than the rest of the country, with an average life expectancy of 80 years compared to 80.9 years elsewhere – this may not sound like a large difference but underpinning it is a greater chance of dying younger from preventable or treatable conditions.

Our chances of getting alcohol-related cancers or alcohol-related injuries is much greater in Hawke's Bay as more of us drink dangerously than the New Zealand average. One in every four adults in Hawke's Bay is a "hazardous drinker" - this means they are likely to be harming their own health or causing harm to others through their behaviour.

More and more of our population are living in deprived areas with the standard of living dropping in areas like Tamatea and Takapau. More than half and over two thirds of our Māori and Pasifica communities live in our most deprived areas.

We have improved in some areas, for example fewer people die of ischaemic heart disease (when the heart's blood supply is blocked or interrupted by a build-up of fatty substances), with a dramatic fall in deaths since a peak in 1970. But despite this, the Māori death rate is still four times higher than for non-Māori.

Our childhood immunisation rates are high and equitable - an example of what can be achieved with systematic healthcare service improvements and targeted approaches.

Inequity is not someone else's problem. We need to recognise that everyone is affected. Reducing inequity through health promotion and healthcare initiatives will only solve some of the problems. For a difference to be made we must tackle this collectively, and take responsibility as a community.

Dr Caroline McElnay,
Health Equity Champion
Director of Population Health, October 2014

HAWKE'S BAY HAS MORE PEOPLE DRINKING HAZARDOUSLY COMPARED TO THE REST OF NEW ZEALAND

KEY FINDINGS

MORE DEATHS AT YOUNGER AGES

More Māori, more Pasifica and more people living in the most deprived parts of Hawke's Bay are dying at younger ages. The equity gap is closing but not fast enough. The top causes of preventable premature death are ischaemic heart disease, diabetes, lung cancer, road traffic injuries, suicide, breast and bowel cancers.

SOCIOECONOMIC CONDITIONS

Social inequity in Hawke's Bay is widening. Income is a powerful determinant of health in many different ways. The health impacts on children are more immediate and rates of admission to hospital for 0-14 year olds for conditions known to be strongly linked to social conditions are increasing, particularly for Pasifica and Māori children. Thirty percent of young Māori in Hawke's Bay are not in education, training or employment, affecting both their future health outcomes and their future employment opportunities.

TOBACCO USE

The leading cause of avoidable deaths amongst Māori women is now lung cancer. There are high levels of inequity in lung cancer deaths for Māori, who are six times more likely to die from lung cancer due to higher rates of smoking amongst Māori, especially Māori women. High smoking rates amongst pregnant Māori women (46%) is a significant health issue.

OBESITY

One in three adults in Hawke's Bay is obese – with one in two Māori adults and two in three Pasifica adults. Hawke's Bay men and women are less active in all age groups than their New Zealand average counterparts.

ALCOHOL USE

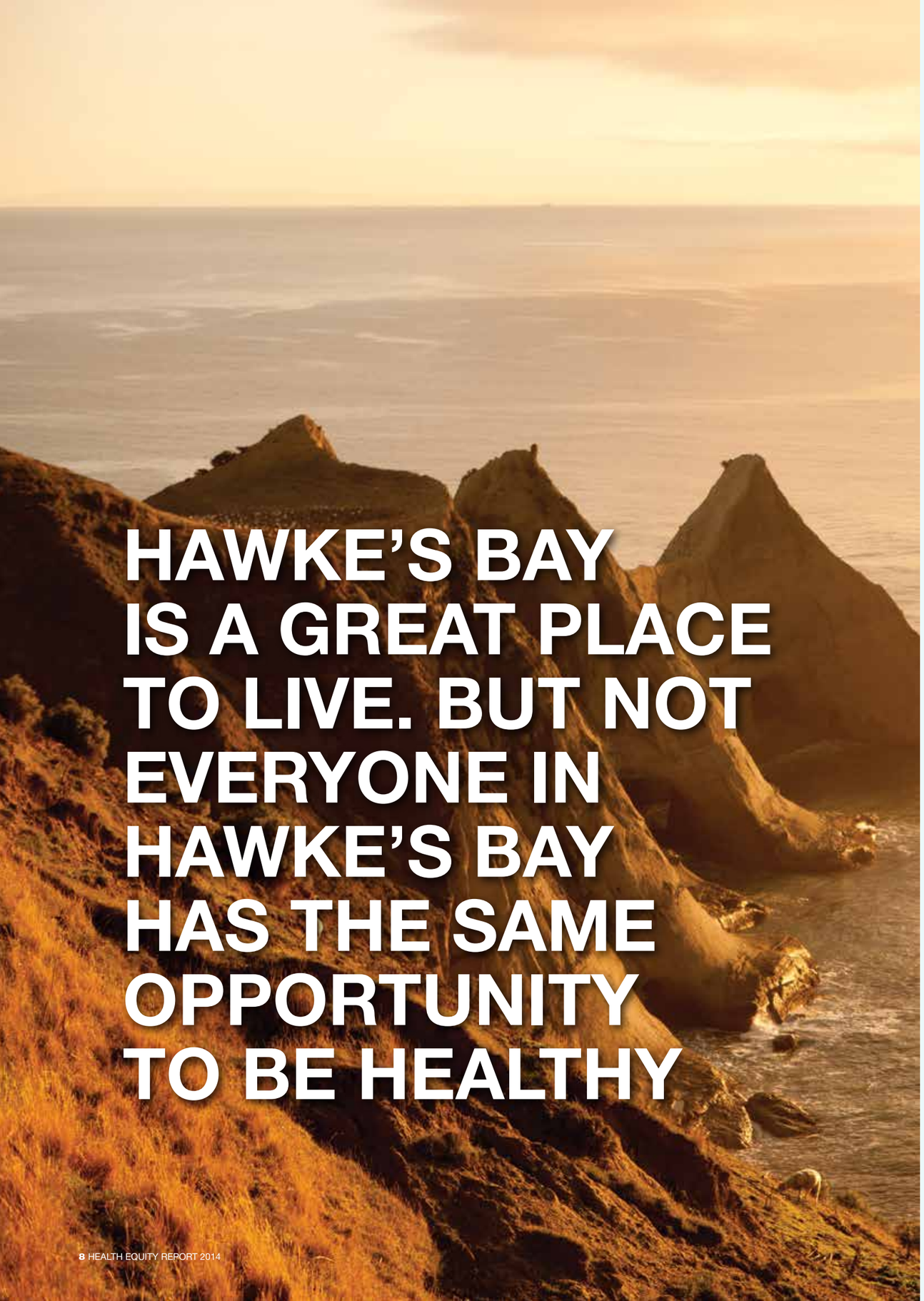
One in every four adults in Hawke's Bay is a "hazardous" drinker – this means they are likely to be harming their own health or causing harm to others through their behaviour. Māori rates are nearly twice that of non-Māori.

ACCESS TO PRIMARY CARE

High self-reported unmet need and higher rates of avoidable hospital admissions, especially amongst 45-64 year olds, show that there continue to be access issues to primary care. Cost of primary care remains one of the most common contributing reasons reported.

Of the 49 indicators examined, Hawke's Bay is worse than the New Zealand average in 15 areas. Compared to New Zealand, Hawke's Bay has:

- **more people dying at younger ages**
- **more people with poor self-rated health**
- **more people who have had a diagnosis of one of the common mental disorders**
- **more regular smokers - both adults and Year 10 students**
- **fewer people who are physically active**
- **more people drinking hazardously**
- **more teenage pregnancy**
- **more people who find it hard to get help from a GP when needed**
- **more people who see dentists only for emergency dental treatment**
- **more people living in the most deprived parts of the community**
- **more children under 5 years living in households receiving working age benefits**
- **more people, aged 15-24 years, not in education, training or employment**
- **more people who have been seriously assaulted requiring admission to hospital**



INTRODUCTION

Stark health inequities exist in some parts of our community with some groups having better health outcomes than others. For Hawke's Bay to have the brightest future possible we need to collectively eliminate these health inequities. The purpose of this report is to inform and to influence priority actions across communities and key agencies in Hawke's Bay so that we can achieve more equitable health across the region.

Health is created by more than just good medical care. Optimal health for everyone requires excellent schools, economic opportunities, a clean environment, quality housing, good transport systems, safe neighbourhoods, opportunities for being physically active and much more. There is a limit to what one agency can do by itself in providing all of this. Good health and well-being requires broad community effort and leadership from all corners of society.

Health inequities are differences in health outcomes or health measures which are avoidable or remediable. Not all differences in health are health inequities – but when avoidable differences are consistently and systematically found between groups of people (however these groups are defined) then these differences are inequitable. There are some factors influencing health that are beyond our influence – for example, if one population dies younger than another because of genetic differences there is a health inequality, but if the lower life expectancy is due to a lack of access to medication then the situation is a health inequity.

There are many factors which influence health – these are known as the determinants of health.

- Health behaviours - such as use of tobacco, diet, use of alcohol
- Health care – this includes both access to health care and receipt of high quality health care
- Social and economic factors – income and education are two of the biggest determinants of health
- Physical environment – the quality of our air, water and other environmental factors can directly affect our health and well-being

Researchers in the U.S. have estimated that health behaviours account for 30%, health care (including biology) 20%, socioeconomic factors 40% and physical environment 10% of the variability in health outcomes at a population level. Many of these determinants are not distributed equally across different population groups resulting in differences in health outcomes. Tackling areas where significant differences exist – and which are modifiable, are therefore critical if we are to achieve more equitable health outcomes for our community.

This report is the first in what will be an annual report on health equity in Hawke's Bay. It is structured around the determinants of health as outlined above and where data is available examines the differences in that determinant for Māori, Pasifica and European/ Other and by deprivation quintile of residence.

Analysis of socioeconomic position and health status for Māori has shown that there is an overlap between the two:

- The distribution of Māori in the population is sharply skewed towards the more deprived quintiles. In communities where income and living conditions are independent of ethnicity, there would be an equal distribution of Māori across the quintiles
- Health outcomes for Māori are often different from non-Māori even after controlling for deprivation

It is important to look at both dimensions of ethnicity and deprivation in order to get a much deeper understanding of the causes of the differences and to therefore intervene in the most effective way.

The indicators chosen are ones frequently used elsewhere to describe the health of a community. A total of 49 indicators were analysed and a full report on all those indicators is available on the DHB website. This report highlights the key findings of that analysis. We need to be able to identify health inequities before we can address them – but we then need to address them - together.

CHAPTER 1.0 HEALTH OUTCOMES

The measures in this section cover two types of health outcome – how long people live (length of life) and how healthy people feel while alive (quality of life or well-being). Unfortunately there are very few routinely collected measures of well-being in New Zealand.

LIFE EXPECTANCY AND PREMATURE DEATHS

Is this acceptable to us?

We are living longer but not all of us can expect to live to the current life expectancy in Hawke's Bay of 77.7 years for males and 82.3 years for females. There are still significant differences in life expectancy for both males and females between Māori and non-Māori. Life expectancy in Hawke's Bay is also shorter by nearly a year than the New Zealand average. Why is this and is it a health inequity?

This shorter life expectancy for Māori is because Māori, along with Pasifica people and people living in the least affluent parts of Hawke's Bay, are more likely to die at younger ages from conditions which are preventable or treatable. So yes, this is a health inequity.

Premature deaths are nowadays considered to be deaths occurring before the age of 75 years. Death rates under 75 years have been decreasing steadily across Hawke's Bay but Māori are still twice as likely to die before the age of 75 years as non-Māori. Pasifica rates are also higher but fluctuate due to smaller numbers in Hawke's Bay.

If we look at all deaths during the years 2006-2010 in Hawke's Bay 39% occurred under the age of 75 years, whereas for Māori 77% died before the age of 75 years. An even more marked difference is seen for deaths before age 50. ***Approximately one quarter of all deaths amongst Māori and Pasifica occur before age 50, compared to only 5% of non-Māori and non-Pasifica.***

A BABY BOY IN HAWKE'S BAY WHO IS MĀORI CAN EXPECT TO LIVE 8 FEWER YEARS THAN A BABY BOY WHO IS NOT MĀORI. HE CAN ALSO EXPECT TO LIVE FEWER YEARS IN GOOD HEALTH

LIFE EXPECTANCY IN HAWKE'S BAY BY ETHNICITY AND GENDER, 2008-2010

	HAWKE'S BAY	LIFE EXPECTANCY GAP	NEW ZEALAND	LIFE EXPECTANCY GAP
TOTAL	**80.0 years**		**80.9 years**	
Males	77.7 years	4.6 years	78.9 years	3.9 years
Females	82.3 years		82.8 years	
Māori Male	71.1 years	8.3 years	72.1 years	7.6 years
Non - Māori Male	79.4 years		79.7 years	
Māori Female	75.6 years	7.8 years	75.9 years	7.7 years
Non - Māori Female	83.4 years		83.6 years	

VARIATION IN PREMATURE DEATHS IN HAWKE'S BAY 2006-2010

% TOTAL DEATHS	MĀORI	PASIFICA	OTHER	QUNITILE 5	QUINTILE 1	HB TOTAL
Under 75 years	77.0%	52.4%	31.9%	56.5%	20.6%	38.7%
Under 50 years	26.3%	23.8%	5.1%	16.1%	4.4%	9.2%

POTENTIAL YEARS OF LIFE LOST (PYLL)

Another way of looking at premature deaths is to calculate the average years a person would have lived if he or she had not died prematurely. This method emphasises the importance of causes of death which occur at earlier ages.

Hawke's Bay rates of PYLL are statistically significantly higher than New Zealand rates. This means that more people are dying at younger ages in Hawke's Bay.

There have been reductions in Māori PYLL between 2006 and 2010 but there still remain persistent equity gaps. Māori rates are 2.3 times higher and Pasifica rates 1.75 times higher than the rest of Hawke's Bay. PYLL also increases with increasing deprivation with people living in Quintile 5 having 4.5 times the rate of potential years of life lost than people living in Quintile 1. (See page 19 for a full explanation of quintiles).

The largest inequities in PYLL, after adjusting for the different population sizes, are seen for deaths from ischaemic heart disease (Māori 4 times and Pasifica 3 times higher), road traffic injuries (Māori 4 times and Pasifica 3 times higher), lung cancer (Māori 4 times higher), diabetes (Māori and Pasifica 9 times higher) and breast cancer (Māori 2 times and Pasifica 4 times higher).

AVOIDABLE MORTALITY

Approximately three-quarters of all deaths under 75 years are avoidable either because of disease prevention or because of effective treatment and health care. The good news is that rates of avoidable deaths have been decreasing generally across Hawke's Bay and across New Zealand with Hawke's Bay rates now similar to the New Zealand average.

TOP CAUSES OF POTENTIAL YEARS OF LIFE LOST 2006-2010

CAUSE OF DEATH	PYLL MĀORI NUMBER (%)	PYLL PASIFICA NUMBER (%)	PYLL OTHER NUMBER (%)
All causes	17976 (100%)	1532 (100%)	25299 (100%)
Ischaemic heart disease	1820 (10.1%)	142 (9.3%)	2487 (9.8%)
Car occupant in transport accident	1607 (8.9%)	137 (8.9%)	923 (3.6%)
Intentional self -harm (suicide)	1178 (6.6%)	116 (7.6%)	2470 (9.8%)
Lung cancer	936 (5.2%)	-	1463 (5.8%)
Diabetes	902 (5.0%)	108 (7.0%)	-
Digestive tract cancer	748 (4.2%)	-	2298 (9.1%)
Breast cancer	516 (2.9%)	113 (7.4%)	1099 (4.3%)

But avoidable deaths are 2.6 times higher amongst Māori and 3.2 times higher amongst people living in Quintile 5 areas in Hawke's Bay.

This is a health inequity. By definition these deaths are avoidable. If current trends continue there should be a closing of the gap between Māori and Other within the next 5 years. We need to make sure this happens.

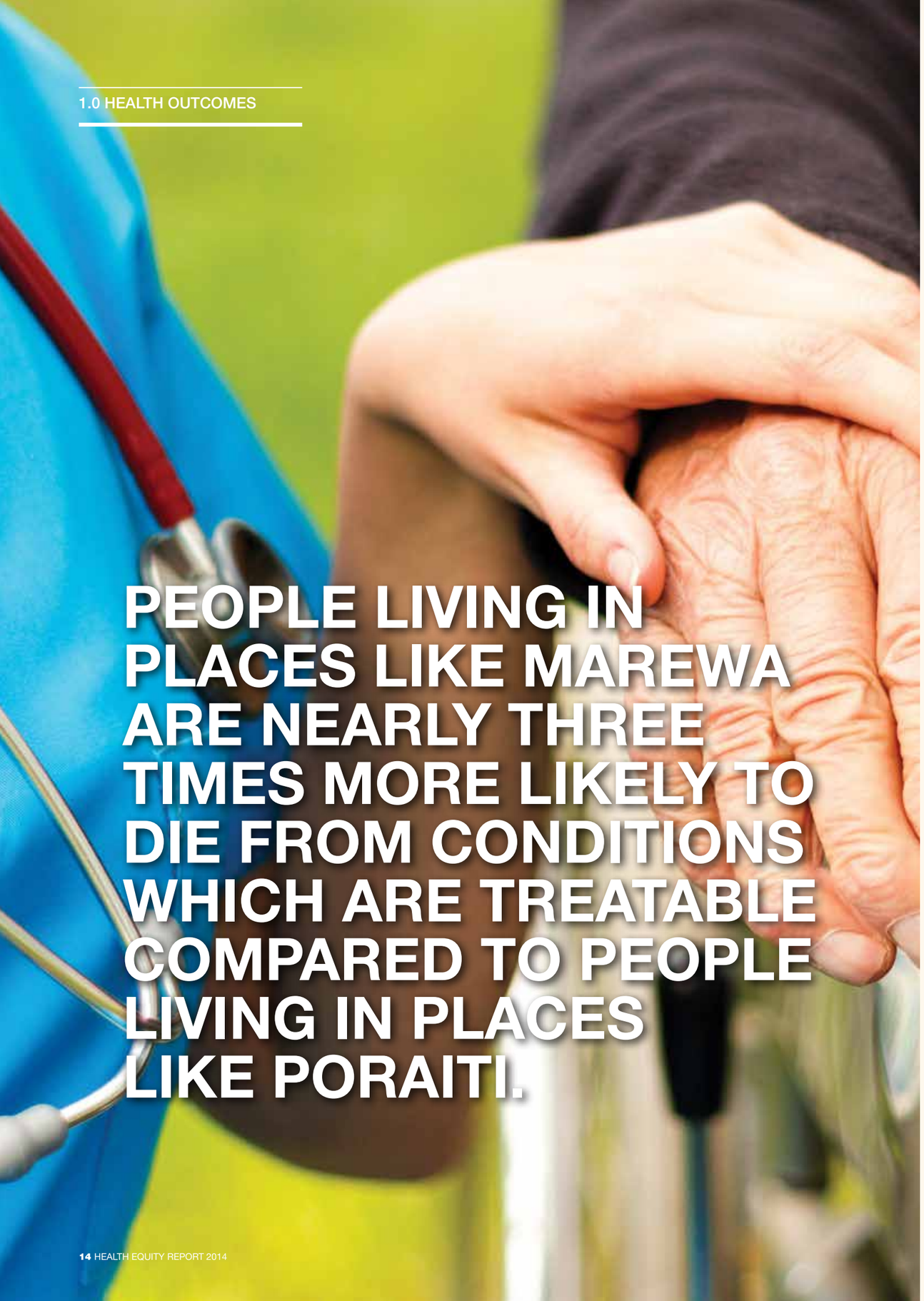
The top cause of avoidable mortality across all ethnic groups is ischaemic heart disease, accounting for about one-fifth of all avoidable deaths. Lung cancer is the second leading cause of avoidable mortality.

The top causes of avoidable mortality are generally similar by ethnicity but actual numbers and rates of deaths due to each condition vary. Of note are the higher proportion of deaths due to diabetes, and the higher proportion of deaths due to road traffic injuries amongst Māori and Pasifica. Lung cancer is also the top cause of avoidable mortality amongst Māori women, causing more deaths than breast cancer.

PEOPLE LIVING IN AREAS LIKE CAMBERLEY ARE THREE TIMES MORE LIKELY TO DIE FROM AN AVOIDABLE CAUSE OF DEATH THAN PEOPLE LIVING IN AREAS LIKE HAVELOCK NORTH CENTRAL

TOP CAUSES OF AVOIDABLE MORTALITY BY ETHNICITY AND GENDER, 2006-2010

TOP CAUSES OF AVOIDABLE DEATHS	MĀORI MALES	OTHER MALES	MĀORI FEMALES	OTHER FEMALES
Ischaemic Heart disease	29.6% (1)	27.1% (1)	16.1% (2)	11.5% (3)
Diabetes	10.6% (2)	4.3% (7)	7.0% (4)	3.8% (8)
Lung cancer	10.0% (3)	11.7% (2)	21.7% (1)	11.8% (2)
Road traffic injuries	8.6% (4)	3.2% (9)	2.2% (9 =)	1.8% (12)
Cerebrovascular disease	5.6% (5 =)	7.0% (4)	4.8% (6)	8.8% (5)
Suicide & self-inflicted injuries	5.0% (5 =)	5.2% (6)	2.2% (9 =)	2.5% (9 =)
COPD	4.0% (7)	5.4% (5)	7.0% (5)	7.5% (6)
Breast cancer	-	-	11.3% (3)	14.9% (1)
Colorectal cancer	3.0% (8)	9.2% (3)	1.7% (12 =)	10% (4)



PEOPLE LIVING IN PLACES LIKE MAREWA ARE NEARLY THREE TIMES MORE LIKELY TO DIE FROM CONDITIONS WHICH ARE TREATABLE COMPARED TO PEOPLE LIVING IN PLACES LIKE PORAITI.

AMENABLE MORTALITY

Amenable mortality are those avoidable deaths which could have been avoided through access to quality healthcare and is a very useful indicator of equity in healthcare. In New Zealand, the proportion of avoidable deaths considered to be amenable is approximately 40%. In a truly equitable healthcare system there should be no difference in amenable mortality rates by ethnicity or by place of residence.

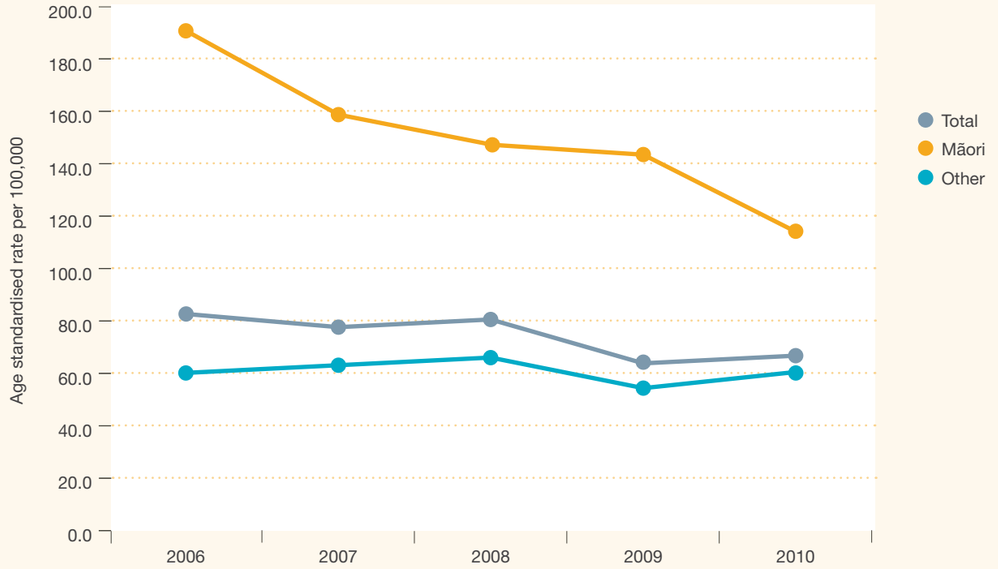
Again the good news is that rates of amenable mortality in Hawke's Bay have been generally declining over the period 2006-2010 - but there are still marked inequities in amenable mortality rate by ethnicity and by deprivation. Māori amenable mortality rates are 1.8 times higher than non-Māori/non-Pasifica. Pasifica data for Hawke's Bay are too small for any robust analysis.

People living in Quintile 5 have 2.8 times the amenable mortality rate of people living in Quintile 1.

People living in places like Marewa are nearly three times more likely to die from conditions which are treatable compared to people living in places like Poraiti.

Equity in amenable mortality can be used as a measure of inequity in terms of access to and provision of quality healthcare and our target should be no inequity by either ethnicity or place of residence.

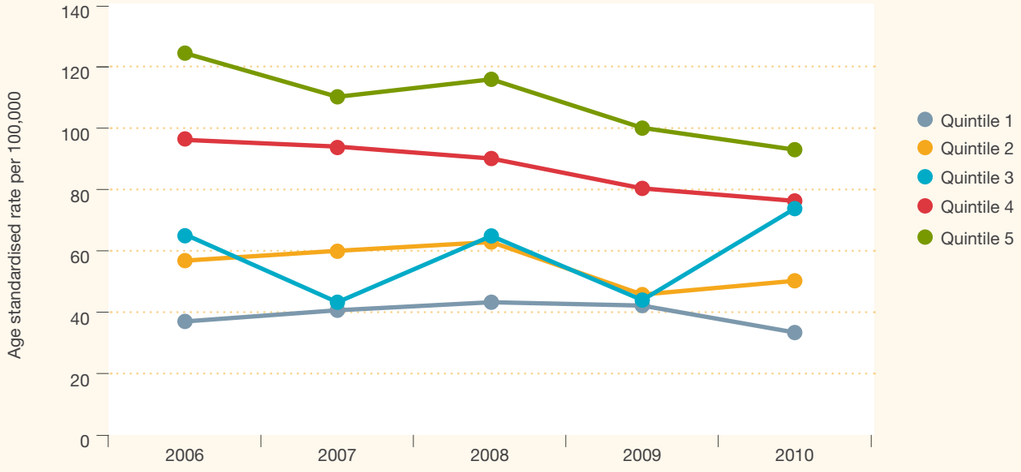
AGE STANDARDISED AMENABLE MORTALITY RATE BY ETHNICITY IN HAWKE'S BAY DHB (2006-2010)



The equity gap is closing quickly and if current trends continue this gap should have closed by 2019 – and we must make sure that this happens.

Improved access to care and better management of ischaemic heart disease, diabetes and cancers would greatly reduce amenable mortality rates.

HAWKE'S BAY DHB: AGE STANDARDISED AMENABLE MORTALITY RATE BY QUINTILE PER 100,000 POPULATION 2006-2010



TOP CAUSES OF AMENABLE MORTALITY IN HAWKE'S BAY 2006 - 2010

MĀORI	PASIFICA	OTHER
Ischaemic heart disease	Ischaemic heart disease	Ischaemic heart disease
Diabetes	Breast cancer	Colorectal cancer
Breast cancer	Diabetes	Breast cancer
Selected invasive bacterial & protozoal infections		Melanoma
Colorectal cancer = cerebrovascular disease		Cerebrovascular disease

TOP CONDITIONS CAUSING AVOIDABLE AND PREMATURE DEATHS

A significant impact on overall health equity will be achieved by focusing efforts on reducing the existing inequity and reducing the overall number of deaths for 7 key causes of death. This will require whole community approaches, not just healthcare services.

WELL-BEING

Self-Rated Health

Most adults in Hawke's Bay (86%) rated that they were in good health – this is lower than the New Zealand average of 89%. There are no differences in self-rated health between men and women.

Māori adults are less likely to rate their health as good than non-Māori with 81% of Māori in Hawke's Bay rating their health as good compared to 87% non-Māori. People living in the most deprived area were less likely to report being in good health (83%) than people living in the least deprived areas (90%).

7 TOP CAUSES OF DEATH

CAUSE OF DEATH	EQUITY ISSUES	AVOIDABILITY	TREND
Ischaemic heart disease	Māori death rates 4 times higher than non- Māori. PYLL rates 4 times higher for Māori and 3 times higher for Pasifica	Prevention and healthcare	Equity Gap closing, equity possible by 2019
Lung cancer	Māori death rates 6 times higher than non- Māori, PYLL rates 4 times higher for Māori	Prevention	Equity Gap widening, Māori rates increasing
Diabetes	Māori death rates 4 times higher than non- Māori, PYLL rates 9 times higher for both Māori and Pasifica	Prevention and healthcare	Gap closing, equity possible by 2019
Road traffic injuries	No difference in death rates. PYLL rates 4 times higher for Māori and 3 times higher for Pasifica	Prevention	Fluctuations- no obvious trend
Breast cancer	No difference in death rates. PYLL rates 2 times higher for Māori and 4 times for Pasifica	Healthcare (screening and treatment)	Similar to New Zealand (slow decline) but fluctuations seen locally
Colorectal cancer	No difference in death rates	Healthcare (screening and treatment)	Similar to New Zealand (decreasing)
Suicide	No difference in death rates	Prevention	Fluctuations, no real decline in rates

Mental Health

Good mental health is an essential part of overall good health and well-being and mental health conditions ('mental disorders') can have a large impact on a person's life.

20% of adults in Hawke's Bay reported through the NZ Health survey that they had been diagnosed with a common mental disorder in their lifetime.

This figure is higher than the New Zealand average (16%). The most commonly diagnosed mental health disorder nationally was depression with 16% adults, followed by anxiety disorders (6%) and bipolar disease (1%). Women are more likely to be diagnosed with a common mental disorder in their lifetime (25.4%) than men (14.8%). More people in 2011/12 reported being diagnosed with a common mental disorder than in 2006/2007. This increase was seen for men and women and for Māori and non-Māori.

Māori rates are lower than non-Māori rates (14.4% compared with 29.5%). The rates of diagnosed mental disorders were similar across the deprivation quintiles.

CHAPTER 2.0 SOCIAL AND ECONOMIC FACTORS

This section looks at some social and economic factors which can influence health and where possible looks at the distribution of those across the community. Measures of deprivation, income, education, employment and community safety have been used.

DEPRIVATION

35% of our total population (57% of Māori and 70% of Pasifica) live in the most deprived quintile areas compared to the New Zealand baseline of 20%. Nearly half of our children under 5 live in our most deprived areas.

The NZDep2013 is an updated version of the NZ index of socioeconomic deprivation and combines nine variables from the 2013 census reflecting eight dimensions of deprivation (income, employment, qualifications, home ownership, support, living space, transport and communication access). It provides a deprivation score (1-10) for defined geographical units in New Zealand whereby New Zealand is divided into tenths - a value of 10 indicates that the area is in the most deprived 10% of areas in New Zealand according to the NZDep2013 scores, a value of 1 indicates that the area is in the least deprived 10% of areas. This index is a measure of relative socioeconomic deprivation (relative to New Zealand) not absolute socioeconomic deprivation. The measure also applies to the geographical area and may not be completely accurate for all the people who live in that area. However it is a useful way of assessing socioeconomic deprivation in different communities.

In Hawke's Bay 35% of our population live in the most deprived areas (NZDep2013 decile scores 9 and 10, or Quintile 5, census area unit weighted) compared to the New Zealand baseline of 20%. This is an increase from 29.7% in 2006.

More than half of the Hawke's Bay Māori population (57%) and approximately 70% of the Pasifica communities live in Quintile 5 areas in Hawke's Bay. While the distribution of Māori and Pasifica is heavily skewed towards the more deprived decile areas there are still significant numbers of non-Māori and non-Pasifica living in those decile areas also.

45% of children aged less than five years live in Quintile 5 areas and 42% of children less than 15 years live in Quintile 5 areas. 40% of 15-24 year olds live in Quintile 5. By contrast 28% of people over 65 years live in Quintile 5 areas with a generally more equal spread across the quintile areas.

The percentage of the Hawke's Bay population living in Quintile 5 has increased for both Māori and non-Māori between census periods but because the growth is larger for Māori, there is a widening in the disparity between Māori and non-Māori living in Quintile 5.

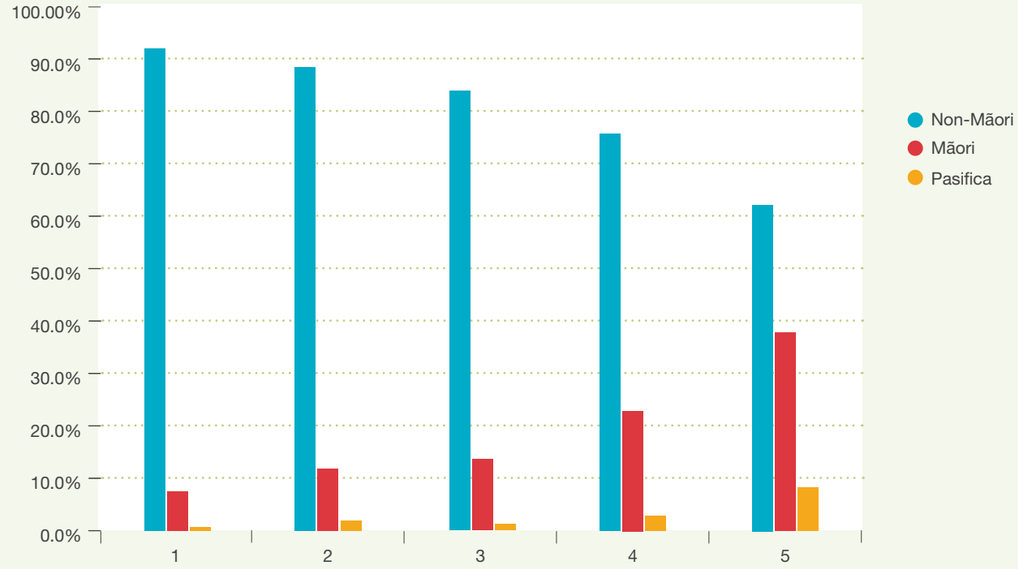
HAWKE'S BAY DHB POPULATION 2013

QUINTILE	NON - MĀORI		MĀORI		PASIFICA		TOTAL	
	n	%	n	%	n	%	n	%
1	13872	11.9	1071	3.1	123	2.0	14943	9.9
2	27930	24.0	3684	10.6	504	8.0	31614	20.9
3	18059	15.5	2952	8.5	321	5.1	21009	13.9
4	23175	19.9	7272	21.0	918	14.6	30447	20.2
5	33399	28.7	19677	56.8	4401	70.2	53076	35.1
TOTAL	**116433**	**100**	**34656**	**100**	**6267**	**100**	**151089**	**100**

Source: NZ census 2013

A THIRD OF OUR CHILDREN ARE GROWING UP IN POVERTY

% MĀORI, NON-MĀORI AND PASIFICA IN EACH QUINTILE, HAWKE'S BAY 2013



CHILDREN LIVING IN POVERTY

Growing up in poverty damages children's health and well-being, adversely affecting their future health and life chances as adults. Ensuring a good environment in childhood, especially early childhood is important.

A considerable body of evidence links adverse childhood circumstances to poor child health outcomes and future adult ill health. These adverse health outcomes include low birth weight, infant mortality, poor dental health, poorer mental health and cognitive development and hospital admissions from a variety of causes. Research also suggests that exposure to low family income during childhood and early adolescence may also increase the risk of leaving school without qualifications, economic inactivity, early parenthood and contact with the justice system. The pathways linking low family income to long term outcomes are complex, and in part may be influenced by other socioeconomic factors.

In New Zealand, the Ministry of Social Development uses a range of income-based measures to monitor child poverty. All are based on a family's disposable income (i.e. market income, less tax, plus social assistance) adjusted for family size and composition. An income poverty threshold commonly used is a household equivalent disposable income of less than 60% of the median, after adjusting for housing costs.

The NZ Child Poverty Monitor publishes results of poverty analysis for New Zealand as a whole. No Hawke's Bay specific analysis is available at present but we can assume that figures for Hawke's Bay are at least equal to the New Zealand average, and probably worse given our relative position in relation to deprivation.

27% of New Zealand children are living in poverty with one in three Māori children, one in three Pasifica children and one in six European children living in poverty. For children living in poverty, 63% of the households are beneficiary households with 37% having adults in paid employment. Of the families of children living in poverty 47% are two parent families and 53% are sole parent families. Poverty is therefore not just something that affects beneficiary households or single parent families.

NEARLY HALF OF MĀORI CHILDREN UNDER FIVE IN HAWKE'S BAY LIVE IN HOUSEHOLDS THAT DEPEND ON BENEFITS

CHILDREN LIVING IN HOUSEHOLDS RECEIVING BENEFITS

Data on the number of children living in households receiving a working age main benefit has been obtained from the Ministry of Social Development. This shows higher percentages in Hawke's Bay compared to New Zealand; 32% of 0-4 year olds in Hawke's Bay live in households receiving a working age main benefit compared with 23% for New Zealand, and 27% of 0-14 year olds in Hawke's Bay compared to 21% in New Zealand.

There are significant disparities by ethnicity with 49% of Māori children and 24% Pasifica children aged 0-4 years living in such households compared to 19% non-Māori/non-Pasifica children.

Since 2009, there has been an increase in the percentage of Māori children aged 0-4 years living in households receiving working age benefits and only very small reductions for children of other ethnicities.

FUEL POVERTY

Low income, poor energy efficient homes and energy prices can all be drivers of fuel poverty – whereby families are unable to heat their homes adequately.

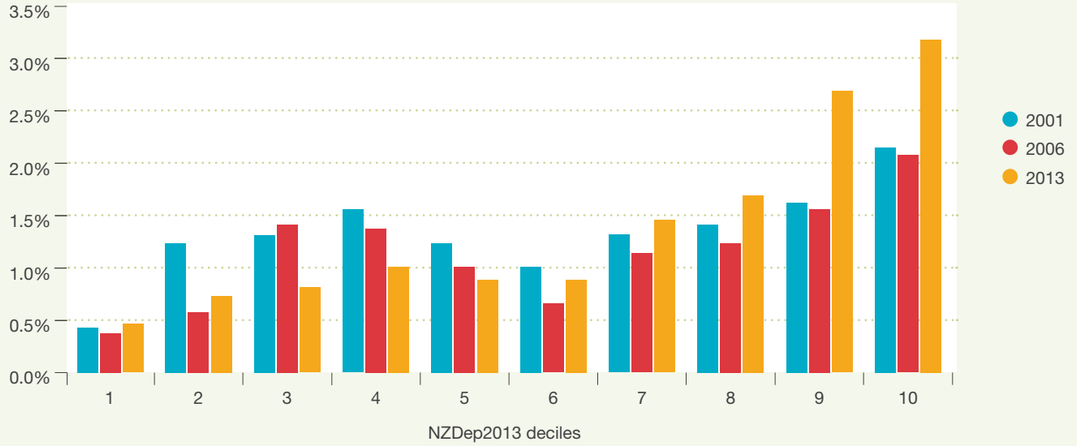
The World Health Organisation recommends indoor temperatures be maintained between 20°C and 22°C.

During colder months many New Zealand homes do not maintain temperatures in this range due to both inadequate insulation and heating. Inadequate heating is in turn associated with increased illness including asthma and respiratory infection. When indoor air temperatures are below 16°C the body needs to expend energy to maintain core temperature and children and elderly persons are at risk of hypothermia. Despite an improvement in the insulation of New Zealand homes resulting from subsidisation of insulation retrofitting, many homes are still not achieving optimum temperatures because of inadequate heating.

Hawke's Bay is subject to a wide range of temperatures in winter and all homes can be expected to require heating to maintain optimum temperatures. Census data from 2013 show some homes have no form of heating in Hawke's Bay and the proportion increases with socioeconomic deprivation - 1.7% of dwellings in Hawke's Bay but this ranges from 0.4% in Decile 1 areas to 3.2% in Decile 10 areas. There are 933 dwellings with no form of heating – of which 531 are in Quintile 5 areas.

When compared with previous censuses the proportion of dwellings with no heating increased in the lower decile areas, particularly between 2006 and 2013 in Decile 9 and 10.

HAWKE'S BAY: PERCENTAGE DWELLINGS WITH NO FUELS USED FOR HEATING DWELLING BY NZDEP2013 DECILE AREAS 2001, 2006, 2013 CENSUS



NOT IN EDUCATION OR EMPLOYMENT

Young people not in employment, education, or training (NEET) are young people aged 15–24 years who are unemployed (part of the labour force) and not engaged in education or training, and those not in the labour force and not engaged in education or training for many reasons. These young people are at greater risk of a range of negative health outcomes including poorer health, depression or early parenthood, and their future employment opportunities are more limited.

There has been a fluctuation in the percentage of young people NEET in Hawke's Bay since 2009. In Hawke's Bay it is currently higher at 15.8% than the New Zealand average (11.4%). Rates of NEET in Hawke's Bay reached a peak in September 2012 when there were 22.1% of young people NEET.

There is a dramatic difference within Hawke's Bay in the percentage NEET between Māori and European young people with consistently higher rates in Māori young people - twice and at times three times higher. Since 2012 there has been a reduction in NEET amongst European young people with little change for Māori leading to a widening gap in this area. The most recent figures show that 30% of young Māori in Hawke's Bay are not in education, employment or training compared to 9.4% European young people.

UNEMPLOYMENT

Māori (at 16.4%) have approximately four times higher rates of unemployment compared to European (4%).

There is good evidence to show that work is generally good for physical and mental health and well-being and being unemployed does tend to be associated with poorer physical and mental health.

Being unemployed is defined as all people in the working-age population who during the reference week were without a paid job, available for work, and had either actively sought work in the past four weeks ending with the reference week, or had a new job to start within the next four weeks.

Unemployment rates in Hawke's Bay have fluctuated over the period March 2009 to December 2013 but with very little change in overall unemployment rates; at 6.4% Hawke's Bay rates are just higher than the New Zealand average of 5.9%. However, there are persistent differences in unemployment between Māori and European with Māori (at 16.4%) having approximately three-times higher rates of unemployment compared to European (4%).

The gap in unemployment rates between European and Māori has closed slightly during the 12 months from December 2012 to December 2013 with reductions in unemployment for both groups.

30% OF YOUNG MĀORI IN HAWKE'S BAY ARE NOT IN EDUCATION, EMPLOYMENT OR TRAINING COMPARED TO 9.4% OF EUROPEAN YOUNG PEOPLE

CHILDHOOD DISEASE LINKED WITH SOCIOECONOMIC CONDITIONS

Admission rates for medical conditions linked to social conditions have increased since 2006 for all ethnic groups but this increase has been greater for Pasifica children. There is a widening of health inequity for both Pasifica and Māori children.

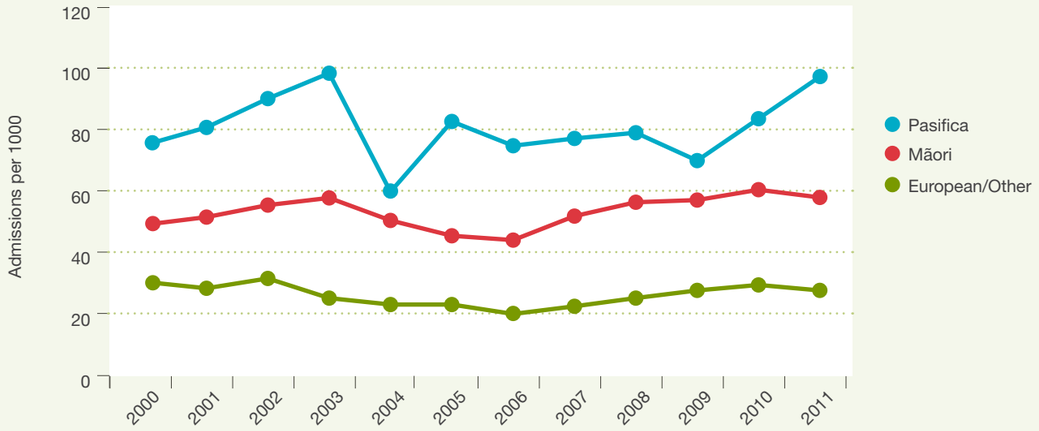
There are many childhood diseases that are known to be sensitive to socioeconomic conditions with much higher rates or worse outcomes seen in those children living in the most socio-economically deprived areas. Most of these conditions are infectious and respiratory diseases and are directly linked to cold, damp houses and overcrowding.

The NZ Child and Youth Epidemiology service produces regular reports on child health across New Zealand and also at a DHB level. In Hawke's Bay for the period 2007-2011, the largest single cause of admission amongst 0-14 year olds for conditions with a social gradient was acute bronchiolitis (an infection of the airways), followed by asthma and gastroenteritis. The rates of admissions in Hawke's Bay fell between 2002 and 2006 but have increased from 2007-2010.

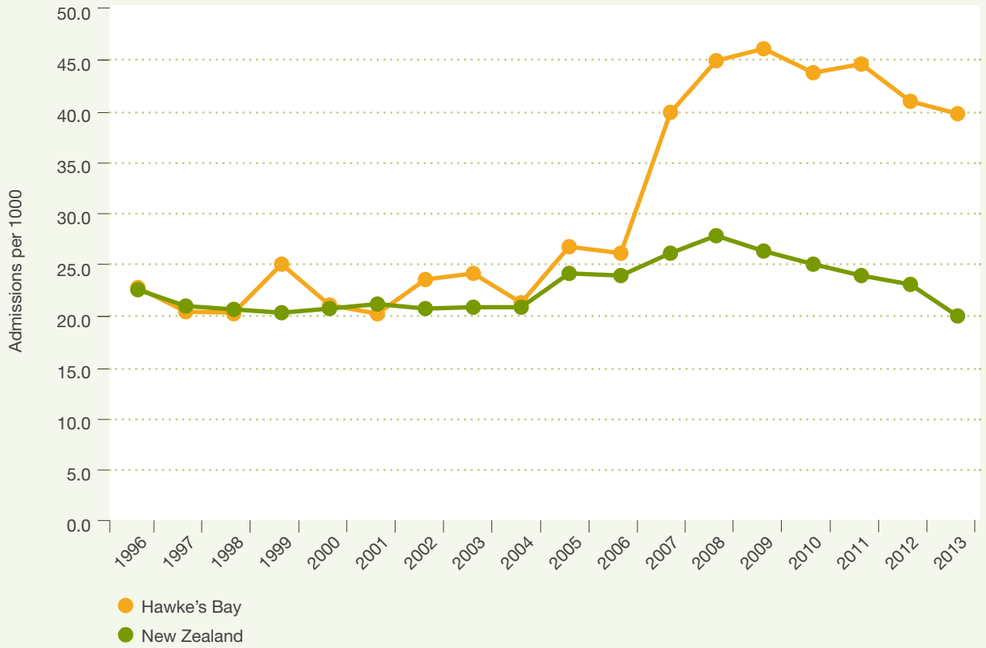
There is a marked inequity in admission rate by ethnicity with Pasifica children having three and a half times the admission rates and Māori children twice the admission rate of European children. Pasifica numbers however are small and do fluctuate.

Admission rates for medical conditions with a social gradient have increased since 2006 for all ethnic groups but this increase has been greater for Pasifica children. There is a widening of health inequity for both Pasifica and Māori children.

HOSPITAL ADMISSIONS FOR MEDICAL CONDITIONS WITH A SOCIAL GRADIENT, 0-14 YEAR OLDS, HAWKE'S BAY



RECORDED SERIOUS ASSAULT RESULTING IN INJURY OFFENCE RATE PER 10,000 POPULATION HAWKE'S BAY AND NZ



PREVALENCE OF VIOLENT CRIME

The rate of serious assaults resulting in injury in Hawke's Bay is twice the New Zealand average. People living in Quintile 5 are six times more likely to be admitted to hospital because of an assault.

The links between crime and health are complex. Violent crime may result in temporary or permanent disability and in some cases death. Some victims of crime may suffer psychological distress and subsequent mental health problems. Crime and fear of crime can also alter people's lifestyles and impact on their physical and psychological health.

NZ Police data has been analysed to try to ascertain the prevalence of violent crime in Hawke's Bay. The data only includes violent offences which are reported to the police and is susceptible to changes in police crime reporting procedures.

There was an increase in recorded assault offences between 2006 and 2009 and a gradual decline between 2009 and 2013. Hawke's Bay rates are 1.5 times higher than the New Zealand average.

Serious assaults resulting in injury are a subset of recorded assaults. This shows a similar pattern to recorded results with Hawke's Bay rates twice the rate for New Zealand.

Admissions to hospital as a result of assaults

During 2012/2013 there were 228 admissions to hospital as a result of an assault. Generally the number and rates of admissions due to assaults has been falling since 2009/10 but Hawke's Bay rates of admission are consistently higher than NZ rates.

Rates of admission vary by ethnicity with higher rates seen for Māori and Pasifica - Māori rates of admission are about three times and Pasifica rates are twice those of European/Other. There is a large difference in admission rates due to assault by quintile with rates in Quintile 5 nearly six times that of Quintile 1.

Admission rates are generally decreasing across ethnicities and across quintiles.

Hospital admissions and mortality arising from assault, neglect or maltreatment

The NZ Child and Youth Epidemiology service in its report 'The Determinants of Health for Children and Young People in Hawke's Bay 2013' analysed hospital admissions due to assault, neglect or maltreatment. This shows that Hawke's Bay rates are similar to the New Zealand average with on average about six admissions per year. Numbers are generally decreasing.

THE RATE OF SERIOUS ASSAULTS RESULTING IN INJURY IN HAWKE'S BAY IS TWICE THE NEW ZEALAND AVERAGE

CHAPTER 3.0 HEALTH BEHAVIOURS

The measures in this section look at health behaviours. These are known risk factors which have a direct influence on health and are modifiable through changes in behaviour - tobacco use, diet and exercise, alcohol consumption, sexual activity and intentional self-harm.

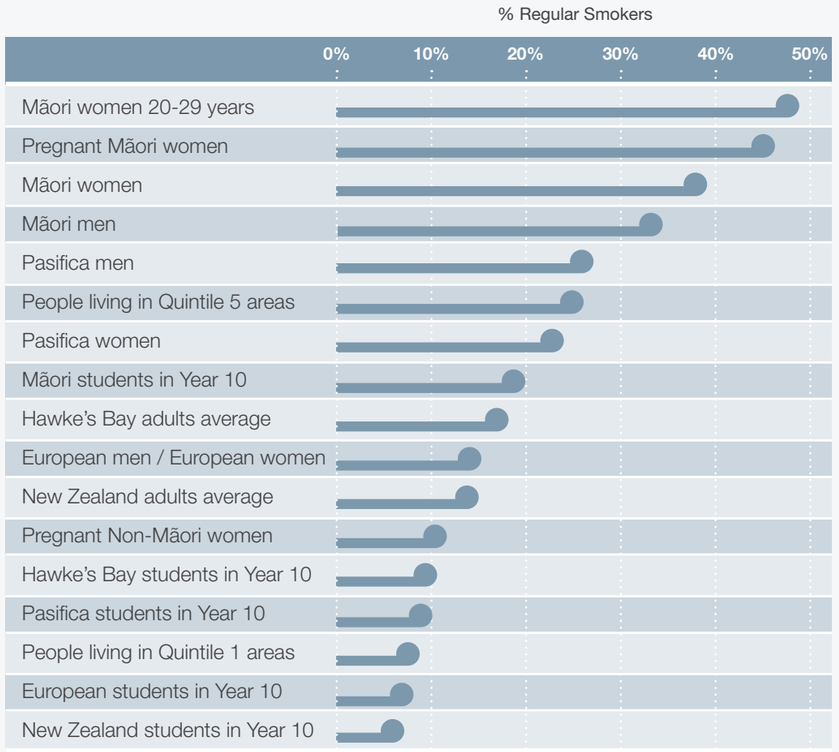
TOBACCO USE

Smoking is the single biggest cause of inequity in death rates in Hawke's Bay - it is the single most important cause of preventable ill health and premature mortality. The high rate of smoking amongst Māori women giving birth is a public health crisis, given the effects that this will have on the long-term health of the next generation.

Higher smoking rates amongst Māori and amongst people living in less affluent areas leads to higher rates of preventable ill health and premature death in Hawke's Bay.

Smoking is linked to a range of illness, most of which only become apparent after many years of smoking – heart disease, chronic obstructive pulmonary disease (COPD), lung cancer, and other cancers including lip, mouth and throat cancers, bladder cancer, cervical and stomach cancer. Exposure to second-hand smoke increases the risk of sudden unexpected death in infancy (SUDI), asthma attacks, chest infections, and glue ear in children. Smoking during pregnancy affects the growth and development of the baby and can cause miscarriage, stillbirth, premature birth and low birth weight.

THE VARIATION IN SMOKING RATES IN HAWKE'S BAY



THE HIGH RATE OF SMOKING AMONGST MÃORI WOMEN GIVING BIRTH IS A PUBLIC HEALTH CRISIS

The 2013 census shows that currently just under 1 in 5 (18%) of the Hawke's Bay population are regular smokers - nearly 20,000 people. This is higher than the New Zealand average (15%) but a significant drop since the last census in 2006 when 25% of the population were regular smokers. Māori smoking rates are more than twice that of non-Māori with 36% regular smokers compared to 15% European. Māori women are more likely to be smokers than Māori men (39% Māori women, 33% Māori men).

People living in the poorest quintile areas are three times more likely to be regular smokers than those living in Quintile 1 with 26% regular smokers in Quintile 5 compared to 8% smokers in Quintile 1.

These rates have all improved since the last census with approximately a 6% decrease for people living in Quintile 5, a 6% for non-Māori and a 9% decrease for Māori. However this decrease for Māori is not yet sufficient to achieve equity.

The highest rates of smoking by age group are among young people aged 20-24 years (32%) with the highest smoking rates seen in Hawke's Bay amongst Māori women aged 20-29 years - 49% are regular smokers.

Prevalence of smoking amongst Year 10 students

Smoking is an addiction largely taken up in childhood and adolescence. The ASH Year 10 latest survey shows that 10.8% of Year 10 students in Hawke's Bay are regular smokers - this is a statistically higher percentage than the 6.8% for New Zealand. Māori continue to have higher rates of regular smokers (20%) with the lowest rates seen amongst Asian students (1.7%) and 7.8% European.

Year 10 girls are more likely to be regular smokers than Year 10 boys with 6% of European boys and 7% European girls regular smokers compared to 15% Māori boys and 24% Māori girls and 9.6% Pasifica boys and 12% Pasifica girls.

Smoking in pregnancy

24% of all women who had a baby at one of the Hawke's Bay DHB facilities during 2013 were current smokers with big differences seen both by ethnicity and by deprivation.

- 46% of all Māori women giving birth were smokers compared to 11% of non-Māori/ non-Pasifica women
- 35% of women living in Quintile 5 compared to 9% living in Quintile 1

OBESITY

One in three adults in Hawke's Bay is obese. One in two Māori adults and two in three Pasifica adults are obese – this is a significant issue for us all as well as being an area of health inequity

Maintaining a healthy weight is a balancing act between the energy we consume through our food and the energy we use through daily activities.

Obesity is a major public health problem in New Zealand and is a known risk factor for numerous health problems, including hypertension, high cholesterol, diabetes, cardiovascular diseases, respiratory problems (asthma), musculoskeletal diseases (arthritis) and some forms of cancer.

New Zealand is ranked 4th worst in the OECD for rates of obesity (behind the United States, Mexico, and Hungary) with 31% of the population obese – this is higher than Australia (25%) and the OECD average (17%). Furthermore, the rates of obesity have increased substantially and significantly over the past 15 years from 19% in 1997 to 26.5% in 2006 and 31% in 2012/2013.

A similar pattern is seen in Hawke's Bay - 34% of the adult population in Hawke's Bay are obese - or 1 in 3 adults - according to the latest results from the NZ Health survey. This is an increase of 8 percentage points from 26% in 2006. Whilst our percentage is higher than the New Zealand figure this is not statistically significant.

Obesity rates amongst Māori are significantly higher than non-Māori with 51% of Māori adults obese (1 in 2 Māori adults) and 29% of non-Māori adults – and these figures have both increased since the survey in 2006. There is no local data for the Pasifica population in Hawke's Bay due to the small numbers in the survey but obesity rates for Pasifica adults for New Zealand are even higher with 68% obese (2 in 3 adults)

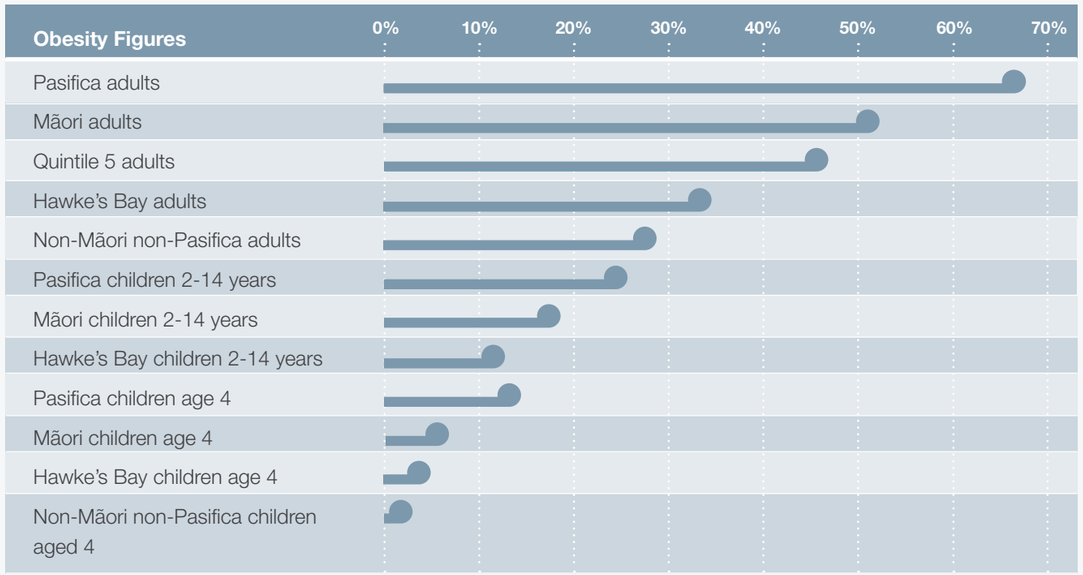
Adults living in the most deprived areas are 1.5 times more likely and children living in the most deprived areas are 3 times more likely to be obese than those living in the least deprived areas.

About 12% of children in Hawke's Bay aged 2-14 years are obese, again similar to the New Zealand figure of 11%, which is an increase in rate from 8% in 2006/07. The rate of obesity is higher in Māori children (19% Hawke's Bay and New Zealand) and Pasifica children (25% NZ).

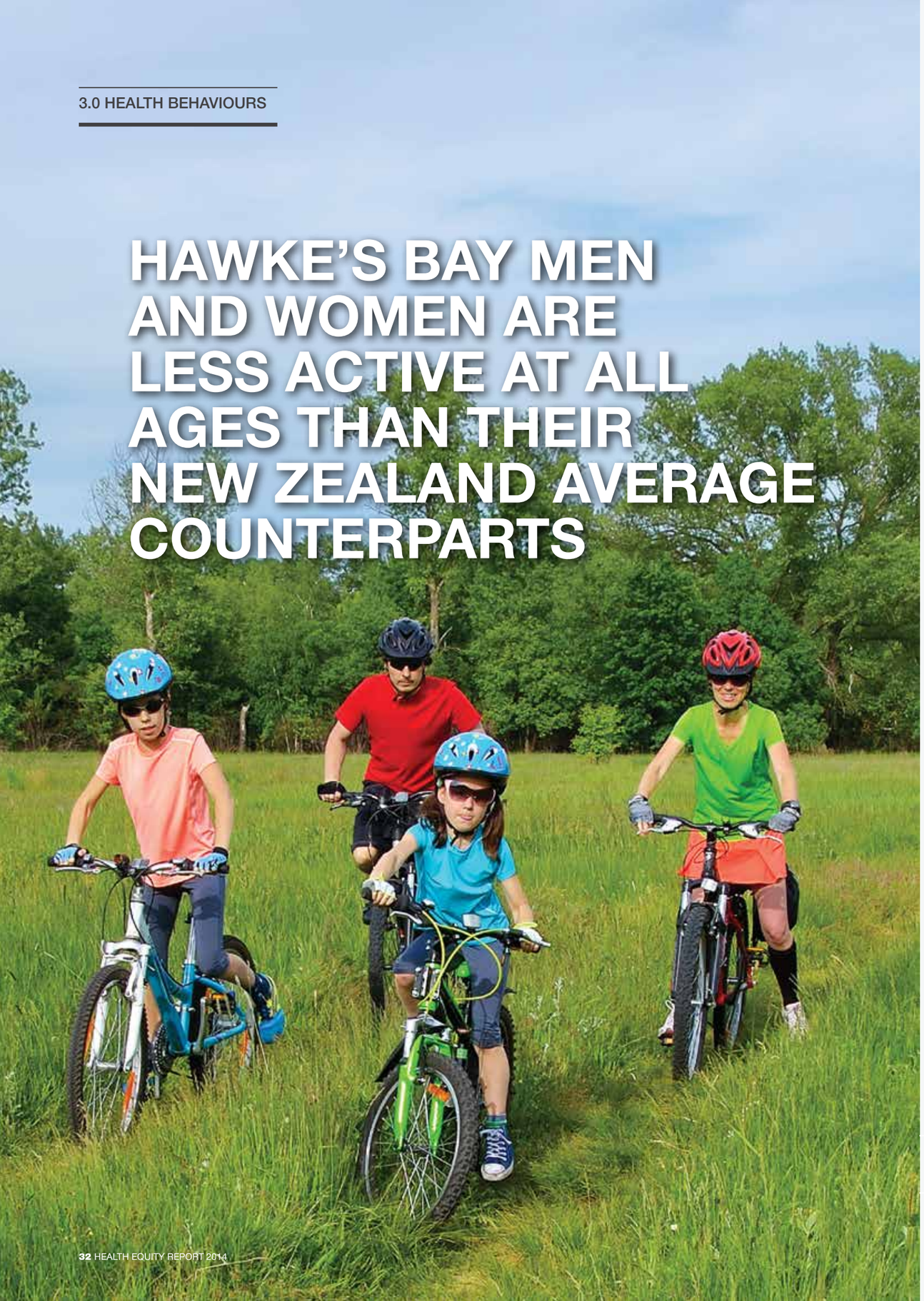
The B4 School Check is part of the Well Child schedule of childhood milestone checks. In 2012 the overall obesity prevalence rate in children who had a B4 School Check was 4.2% but nearly 14% of Pasifica children and 6% of Māori children were obese. There is a clear socioeconomic gradient in prevalence with the most recent data showing 6% of four year olds in quintile were obese compared to 1.8% in Quintile 1. Encouragingly though the prevalence of obesity has dropped slightly since 2009 (5.7%) with a closing of the disparity by ethnicity and deprivation.

There are no simple solutions to obesity but we must work together across the whole community to find solutions to obesity otherwise we will see the gains made in other health areas lost. There are health inequities but this is also an issue for us all as obesity rates continue to rise across the whole community.

THE VARIATION IN OBESITY IN HAWKE'S BAY



HAWKE'S BAY MEN AND WOMEN ARE LESS ACTIVE AT ALL AGES THAN THEIR NEW ZEALAND AVERAGE COUNTERPARTS



NUTRITION

We have very little local data on eating patterns other than fruit and vegetable consumption (sourced from the NZ Health Survey). This shows that in Hawke's Bay just over half of the adult population (58.3%) eat at least two servings of fruit per day. This is identical to the New Zealand figure and there are no significant differences by gender or ethnicity in Hawke's Bay.

The recommended vegetable intake is at least three servings per day. In Hawke's Bay, 66.2% of the adult population meet these guidelines with no significant difference by either gender or ethnicity seen in Hawke's Bay or nationally.

Breastfeeding has many well-known benefits both for the child and for the mother in later life. It provides the best form of nutrition for infants and has been shown to have health and social benefits including helping to protect infants against respiratory infections, gastroenteritis, ear infections, urinary tract infections, allergies and obesity.

Māori rates for breastfeeding are persistently lower than that for non-Māori. In 2012/13, 57% of Māori infants were fully or exclusively breastfed at six weeks compared to 67% other infants. The Pasifica rates vary due to the smaller numbers of women. The national target at six weeks is 75%.

At three months, the rate of Māori infants being fully or exclusively breastfed drops to 40% compared to 53% other infants. The national target is 62%. By six months only 26% of infants are exclusively or fully breastfed – with only 14% Māori infants. The national target is 36%.

PHYSICAL ACTIVITY

Hawke's Bay men and women are less active at all age groups than their New Zealand average counterparts and are less active than they were in 2006. There is no obvious inequity within Hawke's Bay accounting for this.

The recommended guidelines for physical activity are at least 30 minutes of exercise on five or more days in the past week. Only 42.9% of the Hawke's Bay population met these guidelines, a decline of 12.8% since 2006. This figure is significantly lower than the New Zealand average of 53% with both men (49%) and women (38%) in Hawke's Bay lower than the New Zealand averages (New Zealand men 56.6%, New Zealand women 49.6%).

Māori males and Māori females in Hawke's Bay are similar to New Zealand Māori males and females; however non-Māori males and females in Hawke's Bay are less likely to meet the recommended guidelines than non-Māori males and females in New Zealand. The only age group getting close to the New Zealand average are 45-64 year old men with 55% meeting the recommendations. For 15-24 year olds only 38% of women and 42% of men met the recommended levels of physical activity compared to 50% New Zealand women and 63% New Zealand men.

The biggest gap in activity between Hawke's Bay and New Zealand rates is seen in Quintile 1 with only 35% physically active in Hawke's Bay compared to 59% in New Zealand.

ALCOHOL

One in every four adults in Hawke's Bay is a "hazardous drinker" - this means they are likely to be harming their own health or harming others through their behaviour.

For both men and women (Māori and non-Māori) in Hawke's Bay the rates of hazardous drinking are nearly twice the New Zealand averages. The Hawke's Bay population as a whole is drinking more hazardously than New Zealand and this is not explained by our younger population or our higher proportion of Māori. Alcohol is a problem across the community in Hawke's Bay with all groups drinking more hazardously in 2012 compared to 2006.

Alcohol leads to a range of health problems with both short and long term effects. The consumption of more than two standard drinks per day increases the risk of health problems in many organ systems, including the central nervous system, gastrointestinal system, and cardiovascular system, as well as affecting foetal development and increasing the risk of several cancers. Alcohol also contributes to death and injury due to vehicle collisions, drowning, suicide, assault and domestic violence.

The NZ Health Survey reports on the prevalence of hazardous drinking. This is an established drinking pattern that carries a risk of harming physical or mental health, or having harmful social effects to the drinker or others. It is defined as a score of 8 or more on the 10 question Alcohol Use Disorders Identification Test (AUDIT).

24.1% of the adult population in Hawke's Bay has hazardous alcohol consumption - this is significantly higher than the New Zealand average (15.3%). Rates have increased for both men and women with the largest percentage increase seen amongst non-Māori women.

There are significant disparities by ethnicity with all Māori having significantly higher hazardous drinking rates than non-Māori (58.9% Māori men, 26.3% non-Māori men, 33.7% Māori females, 11.1% non-Māori females).

The rates of hazardous drinking decreases with age with peak rates seen amongst 15-24 year olds – 62% of 15-24 year old men in Hawke's Bay have a hazardous drinking pattern compared to 34% average for New Zealand and 36% of 15-24 year old women in Hawke's Bay women compared to 18% in New Zealand – a doubling of rate for both genders.

Another measure of alcohol-related harm is hospital admissions which are wholly attributable to alcohol. Analysis by age and ethnicity shows that Māori rates of admission are one and a half times higher than non-Māori rates. The highest rates of admissions are amongst those under 30 years.

Alcohol use is clearly a problem across our community.

ONE IN EVERY FOUR ADULTS IN HAWKE'S BAY IS A "HAZARDOUS DRINKER"

SEXUAL ACTIVITY

Teenage pregnancy rates (under 18 years) in Hawke's Bay are consistently higher than the New Zealand average – rates for Māori are three times higher than non-Māori and rates for teenagers living in Quintile 5 areas are 7 times higher than teenagers living in Quintile 1 areas.

Most teenage pregnancies under 18 years are unplanned and around 40% end in abortion. As well as being an avoidable experience for the young woman, abortions are also an avoidable cost to the health service. While for some young women having a child when young can be a positive experience, for many more teenagers bringing up a baby can be difficult and often results in poor outcomes for both the teenage parent and the child - in terms of the baby's health, the mothers emotional health and well-being and the likelihood of both the parent and child living in long-term poverty. Teenage mother's are less likely to finish their education, are more likely to bring up their child alone and in poverty, and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers.

Teenage pregnancy rates in Hawke's Bay are consistently higher than the New Zealand average although rates have been dropping since 2007/08. There are higher rates of conceptions for Māori and Pasifica girls, although actual numbers of Pasifica conceptions are very low. Māori conception rates have been declining since 2006/2007 but still remain three times higher than non-Māori.

There is a very strong relationship with deprivation, with conception rates amongst young women under 20 years living in Quintile 5 seven times higher than the rate for young women living in Quintile 1.

INTENTIONAL SELF-HARM

Intentional self-harm is an expression of personal distress but there are many varied reasons why a person might wish to harm themselves. There is often a significant risk of future suicide following an episode of self-harm. Hospital admissions for intentional self-harm are a very small proportion of presentations to emergency departments for self-harm but are currently the only data source available.

The rates of hospital admission for self-harm have been gradually increasing across New Zealand but with a mixed trend in Hawke's Bay. In 2012/13 there were 183 admissions per 100,000 in Hawke's Bay compared to 165 per 100,000 across New Zealand – this difference is not significant. There are no significant variations by ethnicity although numbers for Pasifica fluctuate. Admission rates are higher amongst people living in Quintile 5 areas.

CHAPTER 4.0 HEALTH CARE

The measures in this section look at access to healthcare and quality of healthcare received.

UNMET NEED IN PRIMARY CARE

One third of Hawke's Bay adults have had difficulty accessing primary care when they needed to. Cost is reported as the main reason for this. Children living in the most deprived areas were seven times more likely as children living in the least deprived areas to have an unfilled prescription due to cost in the past year.

Barriers to accessing health care can occur for a number of reasons. For example, a person may be unable to get an appointment soon enough, may not have enough money to pay for an appointment at a medical centre or may not have the transport to get there. Questions about unmet need in primary care were included in the NZ Health Survey and have been analysed for Hawke's Bay.

Most adults were able to access primary care when they needed to. However 35% of adults in Hawke's Bay compared to 28% in New Zealand had experienced unmet need in primary care in the past 12 months. After adjusting for age and sex differences, Hawke's Bay adults were one and a half times more likely to have had an unmet need for primary care as New Zealand adults and this is statistically significant.

The most common reasons for this unmet need were being unable to get an appointment within 24 hours (16% of adults), unmet need for GP services due to cost (14%) and unmet need for after-hours services due to cost (7%). Lack of transport was a less common reason for unmet need for primary health care.

Māori adults were more likely to have experienced unmet need in the past year - 44% Māori in Hawke's Bay compared to 33% non-Māori non-Pasifica.

Across New Zealand, adults living in the most deprived areas have higher rates of unmet need in the past year (34%) than those living in the least deprived areas (22%). After adjusting for age, sex and ethnic differences, adults in Hawke's Bay living in the most deprived areas were one and a half times more likely to have had an unmet need for primary care than those living in the least deprived areas.

Across New Zealand for adults and children living in the most deprived areas, cost was reported as being the main contributor to unmet need. Children living in the most deprived areas were seven times more likely than children living in the least deprived areas to have an unfilled prescription due to cost in the past year.

DENTAL HEALTH

Nearly two-thirds (65%) of Hawke's Bay adults, 84% Māori and 83% of people living in Quintile 5 areas never visit a dental health worker or only visit for toothache.

In New Zealand only a limited range of dental services for adults is publicly funded. 65% of Hawke's Bay adults reported never visiting a dental health care worker or only visiting for toothache compared with 55% of adults in New Zealand. These are both significant increases since 2006/07.

84% of Māori and 59% of non-Māori in Hawke's Bay reported never visiting a dental health worker or only visiting for toothache.

83% of adults living in Quintile 5 reported never visiting a dental health care worker, or only visiting for toothache – this is statistically higher than the New Zealand figure (74%) after adjusting for age differences. In Hawke's Bay, adults living in the most deprived areas were 1.4 times as likely to never visit a dental health care worker or only visit for toothache as adults in the least deprived areas.

There is an apparent closing of the disparities between Māori and non-Māori for this indicator between 2006 and 2012, mainly due to a greater increase amongst the number of non-Māori who never visit a dental health worker. The disparity between New Zealand and Hawke's Bay as a whole has increased over this period. It is likely that these disparities are linked to the costs of care.

AVOIDABLE HOSPITAL ADMISSIONS

Avoidable hospital admissions for Māori are nearly twice that of non-Māori, suggesting ongoing inequities in access to primary care.

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through preventive interventions or treatments deliverable in a primary care setting. They are often used as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers. However other aspects of the health care system, such as hospital supply, emergency care and community care provision, can have an effect on ASH rates.

ASH accounts for around a fifth of all acute and arranged medical and surgical discharges across New Zealand with Hawke's Bay rates similar to New Zealand.

There are significant differences in ASH rates by ethnicity with Māori ASH rates 1.9 times that of non-Māori rates. Whilst Māori rates have reduced over the past 5 years there has only been a small reduction in the gap between Māori and non-Māori.

0-4 year olds

There has been a decline in ASH rates for 0-4 year olds in Hawke's Bay since 2008/09 and rates are similar to New Zealand.

However the inequities in ASH rates by ethnicity remain, with Māori rates 1.6 times that of non-Māori rates. ASH rates have declined faster for Māori and if current trends continue this gap should have closed by 2019. This decline is either due to generally improved primary care access or to specific achievements in key conditions. No data is available for Pasifica children or by quintile of residence.

Dental conditions account for a large number of ASH admissions in this age group and rates for Māori are 4.3 times those of non-Māori. This reflects a higher prevalence of severe dental caries in this age group, of which some may have been preventable through better access to oral health services and use of preventative treatment.

There are marked differences in admission rates for dermatitis, asthma and cellulitis – these may be due to delays in accessing early intervention at a primary care level – and this may be a mixture of both access issues and health literacy.

Higher rates of admission for respiratory and ENT infections are probably reflective of higher prevalence of these conditions amongst Māori, linked to environmental factors such as housing and exposure to tobacco smoke.

Rates of admission are high for gastroenteritis/dehydration rates of ASH but in Hawke's Bay Māori rates are similar to that of non-Māori. This may be in part due to the impact of a local pilot programme targeted at high needs general practices offering rotavirus vaccine.

45-64 years

By contrast there has been little change in rates for 45-64 year olds although Hawke's Bay rates are similar to New Zealand.

Rates of ASH for Māori remain 2.4 times higher than for non-Māori. Heart disease, skin infections, respiratory infections and diabetes all feature highly as causes of the inequity in ASH rates for this age group. It is highly likely that there are similar findings for Pasifica and people living in Quintile 5 areas.

Much more needs to be done to improve equity of primary care access and treatment. This will be achieved through a combination of reducing barriers to primary care such as cost, cultural appropriateness and improving understanding of the need to visit primary care (health literacy).

CANCER SCREENING RATES

Cancer is a major cause of death, accounting for around a quarter of deaths. There are two national cancer screening programmes in New Zealand at the moment – the breast and cervical cancer screening programmes. Attainment of targets for screening coverage is a measure of both access and quality. The breast screening programme is fully publicly funded whereas the cervical screening programme is only fully publicly funded for women meeting certain high needs criteria.

Breast screening

Breast screening supports the early detection of cancer thereby saving lives. Targets have been set in New Zealand of 70% coverage across all ethnic groups. As of May 2014 targets have been achieved in Hawke's Bay for total eligible women, Pasifica women and for European/Other women, but have not yet been reached for Māori women. There has been little improvement on closing the gap for Māori over the past year with a persistent 5 percentage points away from target coverage.

Cervical screening

The target of 80% coverage has been achieved for all ethnic groups apart from Māori – there has only been a very slight increase in Māori coverage since November 2012 with Māori still 6% short of target.

IMMUNISATION RATES

There have been steady improvements in immunisation rates and reduction of inequity for children at both eight months and at two years. The current target for eight months reflects the importance of on-time vaccinations and achievement of coverage rates at this time is a measure of access to primary care, access to other immunisation providers and quality of overall service provision.

Whilst the immunisation event in itself is important being up to date at eight months means that the infant has been in contact with a registered nurse or medical practitioner at least three times over that time; ideally at six weeks, three months and at five months. The requirement to stay for 20 minutes after the vaccination event enables many other health promoting conversations to be had with caregivers.

The most recent figures for eight month immunisation coverage in Hawke's Bay (to end March 2014) shows a total of 93.7% children fully immunised; 95.5% European, 91.6% Māori and 92% Pasifica. The target is currently 90%. There has also been steady progress across all the quintile areas with all quintile areas reaching over 93% coverage.

At 2 years of age equity has been achieved in immunisation coverage, with Māori and Pasifica coverage consistently high (Māori 95.6%, Pasifica 95.8%, European/Other 88.9%).

AVOIDABLE HOSPITAL ADMISSIONS FOR MĀORI ARE NEARLY TWICE THAT OF NON-MĀORI SUGGESTING ONGOING INEQUITIES IN ACCESS TO PRIMARY CARE

ONLY HALF OF PASIFICA PEOPLE HAVE THEIR DIABETES WELL-CONTROLLED

Photos supplied by Ngati Kahungunu Iwi Incorporated

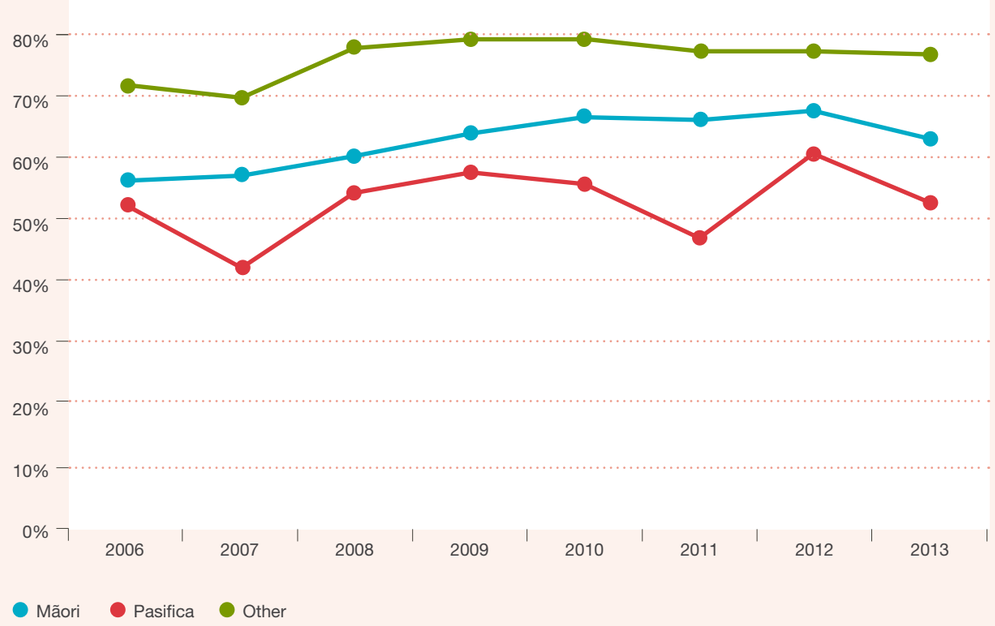
DIABETIC MANAGEMENT

An annual review of all patients with diabetes is recommended good practice in primary care. It provides an opportunity to assess aspects such as long-term blood glucose control, cholesterol levels and blood pressure, height and weight. Data collected from this annual review on the level of HBa1C is used as an indicator of diabetes control – with good diabetes control achieved with an HbA1C level equal or less than 64 mmol/ml.

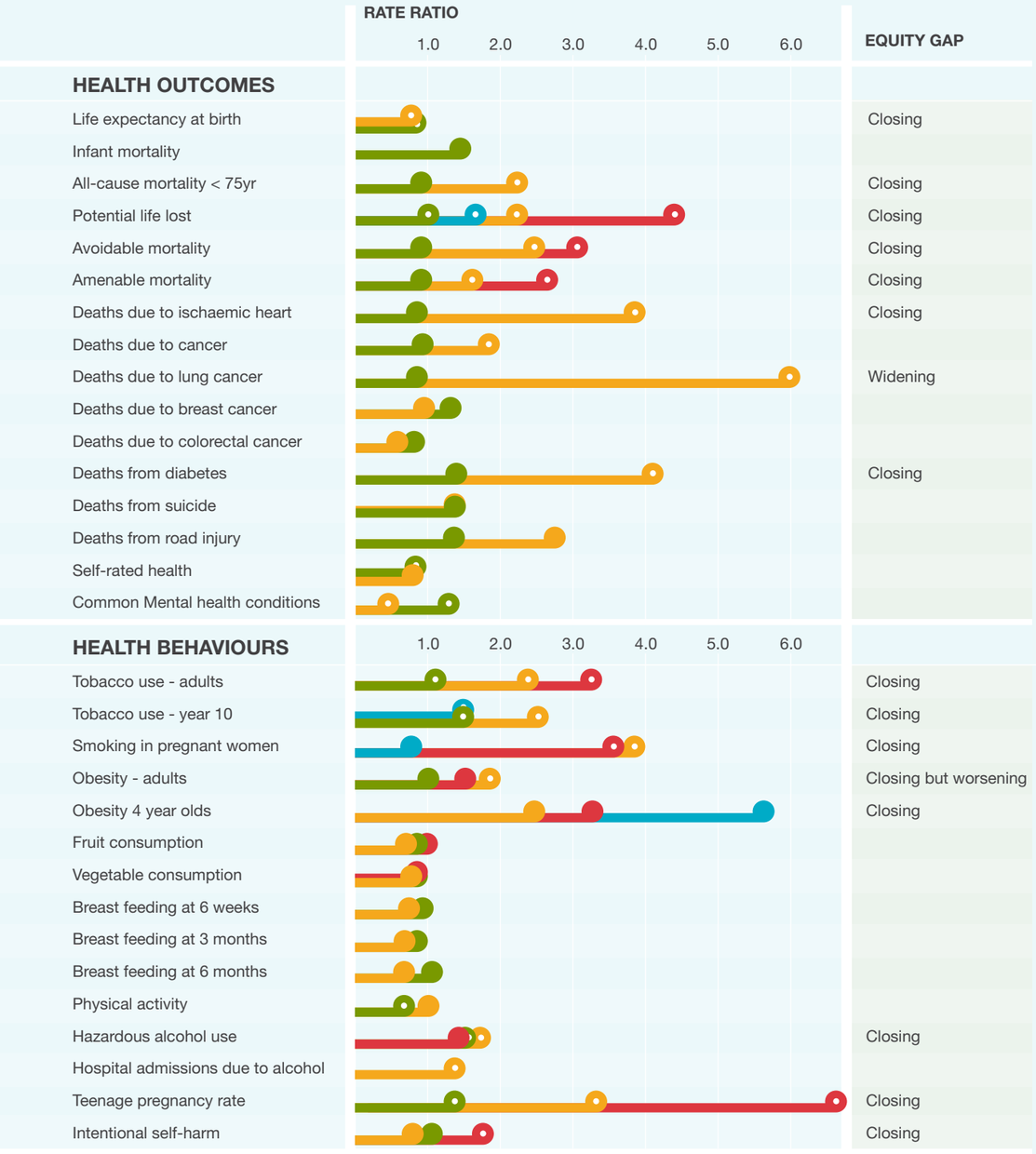
Data on HBa1C has been analysed annually from 2006 by ethnicity for Hawke's Bay. There are persistent and significant differences by ethnicity in the percentage attaining good diabetic control with Māori 0.8 times and Pasifica 0.7 times less likely to achieve good control.

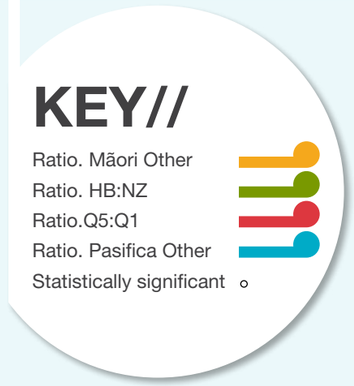
The percentage of Māori with good control has increased by 7.5% since 2006 compared to only a 1.7% increase for Pasifica. The equity gap for Māori is closing but the equity gap for Pasifica is widening.

HAWKE'S BAY DHB: % OF PEOPLE HAVING A DIABETES ANNUAL REVIEW WITH HBA1C EQUAL TO OR LESS THAN 64 MMOL/ML (15 - 74 YEARS)



SUMMARY OF FINDINGS





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