



2018

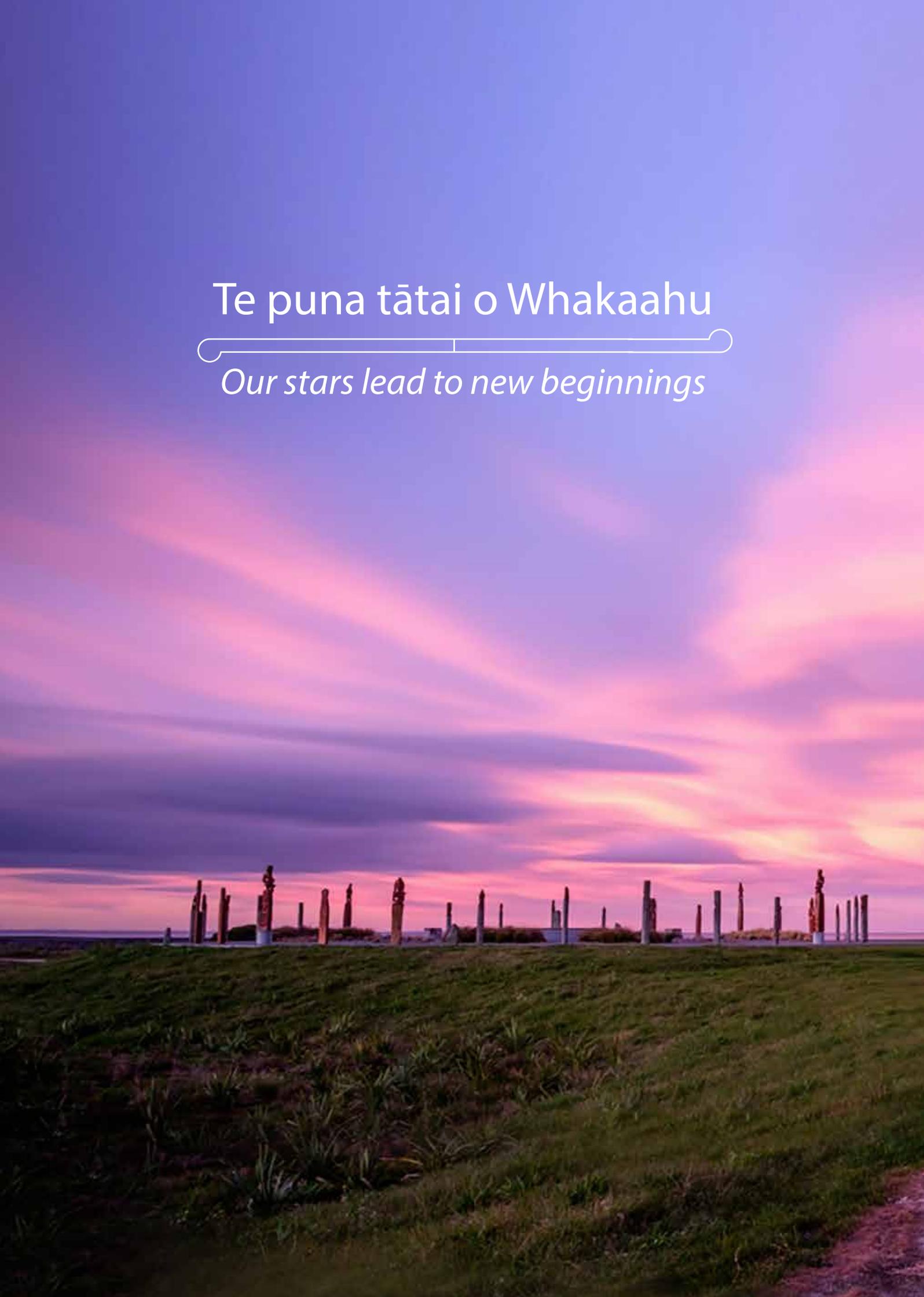
# HEALTH EQUITY REPORT

Kei tēnā, i tēnā, āna momo mahi

*We've all got a role to play*

# Te puna tātai o Whakaahu

*Our stars lead to new beginnings*





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### INTERPRETATION GUIDE:

**1. THE NEW ZEALAND HEALTH SURVEY:** A number of measures in this report are derived from the New Zealand Health Survey. The survey has a number of limitations to be kept in mind. Firstly, the survey is based on a sample of randomly selected households and the numbers of households sampled in Hawke's Bay is limited. The households chosen also change over time. This means that a break down of results into age or ethnic groups often requires information from several years to be combined to get a large enough sample. Secondly, the survey reports ethnicity in a different way to the rest of this report. People who identify as belonging to more than one ethnic group are counted

in each group whereas other measures in this report use prioritised ethnicity so that people are counted in only one group. The measures published so far this year also do not contain any measures for NZ European/Other. This means measures for Māori and Pacific must be compared with the total Hawke's Bay population measure. These comparisons are likely to reduce the magnitude of true differences in the measure between Māori or Pacific and the NZ European/Other ethnic group.

**2. ETHNICITY:** In this report, we have used the term NZ European/Other to denote the non-Māori, non-Pacific population of Hawke's Bay. Due to small Pacific

numbers, some graphs in this report show only Māori and NZ European/Other. It is therefore important to note that in these graphs, the NZ European/Other group does not include Pacific.

**3. AMENABLE MORTALITY:** In this 2018 Health Equity Report, a new definition for amenable mortality has been used. The new definition aligns Hawke's Bay's reporting to the national System Level Measure. This means that graphs for amenable mortality in this report cannot be compared with graphs in previous reports as the new definition includes some deaths that were not previously counted.

# Kei tēnā, i tēnā, āna momo mahi

*We've all got a role to play*



## Spotlights

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### ACKNOWLEDGEMENTS:

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## **What is this report about?**

*Equity in health means that all groups have a fair opportunity to reach their full potential for a healthy life.*

Inequities are differences in health that are not only unnecessary and avoidable but, in addition, are unfair and unjust. We cannot and must not allow these inequities to continue.

This is our third Health Equity Report.

## What is the purpose of this report?

### *Continue monitoring progress against previously reported measures*

**By tracking progress we can hold ourselves to account, identify successful approaches and identify the greatest opportunities to eliminate health inequities.**

As with the previous reports, we report on progress towards reducing early deaths (before the age of 75 years) that are avoidable through preventing disease or providing equitable health services.

These overarching measures provide a big picture view of health equity. They reflect our current services, the influence of service provision over many years, and our wider social and economic situation in Hawke's Bay.

We are mindful that death statistics are looking back in time. The process of collecting and checking information about why people die takes around three years and for the most part this report covers deaths up until the end of 2014. The number of deaths in any one year is affected by events or illnesses, health behaviours and services provided over a much longer period of time for many causes.

Although we do not yet have information on what has happened since 2014 for deaths, we do have access to current hospital stay information and information about changes in behaviours that we know are linked to health.

These measures provide a more forward-facing view that helps us to determine whether any recent changes are likely to have already impacted on numbers of deaths.

### *Explore key issues such as family violence and mental health in more depth*

More in-depth analysis allows us to begin to understand some of the root causes of inequity and some of the pathways by which social position contributes to inequity in Hawke's Bay.

### *Introduce a greater focus on the life course journey*

The introduction of a life course framework recognises the profound impact that events and illnesses, that occur early in life, have on health as we age.

**The underlying principle for health equity is that there is no fair justification for a person's social position (for example their socioeconomic status, gender, educational attainment, disability, sexual orientation or ethnicity) to determine their level of health or length of life.**

This report focuses more on ethnicity than other aspects of social position, such as socioeconomic status.

First and foremost, this reflects our obligations under Te Tiriti o Waitangi to ensure Māori achieve the level of health necessary to fully participate in society and to retain autonomy over the systems and resources needed for health.

We have reported on inequities according to socio-economic status where possible, but changes to the New Zealand Deprivation Index since our last Health Equity Report made this more challenging.

However, as ethnicity and other measures of social position are highly inter-related, it is reasonable to assume that many of the findings in this report would also apply for people living in greater socio-economic deprivation.

## What did we find?

*The starkest message is that Māori, Pacific people, and people living in greater socio-economic deprivation are still more likely to die early from avoidable causes.*

This message provides a central focus for this report as we look closely into how deaths from avoidable causes can be prevented.

**A recent study showed that Hawke's Bay DHB was one of New Zealand's most successful DHBs in improving life expectancy for Māori for the period 2006 to 2013<sup>1</sup>.**

This success was noted in previous reports along with other positive trends including a closing of the equity gap for early and avoidable deaths. The news this time is less positive with most measures of early and avoidable deaths showing no further progress has been made over the last two years of available data (2012-2014).

The findings in this report provide direction for actions to address health inequity:

- For Māori nearly a quarter of all avoidable deaths can be prevented if we can **improve heart health**
- Another quarter will be prevented when we prevent **lung cancer deaths** through smokefree living (and early detection and more effective treatment) and when we address the underlying causes of **suicide** and **vehicle crashes**
- For Pacific people we also need to focus on preventing and managing **diabetes** and preventing **stroke**
- Pacific pre-schoolers are experiencing higher rates of avoidable hospital stays, particularly for **skin infections**, and have the highest rates of **dental decay** by the time they reach school
- Avoidable hospital stays for Māori and Pacific adults aged 45-64 years are increasing. This is driven by increases in hospital stays for **heart attacks**, **chronic lung disease** and **skin infection**.

## The role of health services in eliminating inequity

**The potential for health services to eliminate health inequity is clearly demonstrated by the continuing progress in immunisation and screening.**

Successes in delivering these preventive services show what can be achieved when we purposefully set out to understand the needs of our community and deliver our services in a way that meets the needs of whānau. We need to learn from these successes to address other inequities such as those in sexually transmitted infection.

## A focus on mental health

**This report provides a new focus on mental health and well-being.**

The report describes important inequities in mental health such as the higher rate of hospital stays for mental illness and the higher rate of hospital stays resulting from self-harm for Māori and for women. The picture of higher psychological distress in Hawke's Bay, along with persisting levels of family violence, reinforce the need for more work to address these issues that in turn influence so many other aspects of health.

## Kia rangaranga tō haere

*An illustrious advancement*

### **The role of social and economic factors in eliminating inequity**

**This report finds that large disparities in socio-economic conditions that affect health persist for Māori and Pacific people in Hawke's Bay.**

As a measure of housing related illness we are still seeing a significant difference between Māori, Pacific and NZ European/Other rates for bronchiolitis.

The influences of the social, economic and physical environment are also linked to the way we live. It is not surprising that persisting inequities in socio-economic factors are accompanied by trends in behaviours that increase health risk.

New Zealand Health Survey data is used to measure trends in key risks such as obesity, nutrition, tobacco and alcohol use. Recent survey data show worsening trends in many of these measures. Reductions in physical activity and increased harmful alcohol use are prevalent across society and we need to strengthen our collaborative efforts if we are to increase wellbeing.

*We need to act on these findings. We can't afford to wait and see if more positive trends are around the corner.*

**Some of these issues of inequity are clearly linked to deterioration in socioeconomic conditions.**

For example, we know the housing situation for many whānau in Hawke's Bay has deteriorated. We will work across sectors with our partners locally and nationally on these issues.

In order to reduce avoidable hospital stays for adults, we will listen to our communities to understand what services they need and take action. This is particularly true for services to Māori and Pacific whānau and also for other groups such as people with disability. We need to understand better the biases that have been built into our systems that result in poorer quality of service for these groups.

**We know from successful programmes both in Hawke's Bay and elsewhere that tackling inequity requires system and culture change, deliberate and sustained focus, realistic resourcing, accountability at all levels, and real community partnership.**



Ko te Pae tata, whakamāua ki tina

*Furthest horizons are achieved, step by step*

# Summary of findings

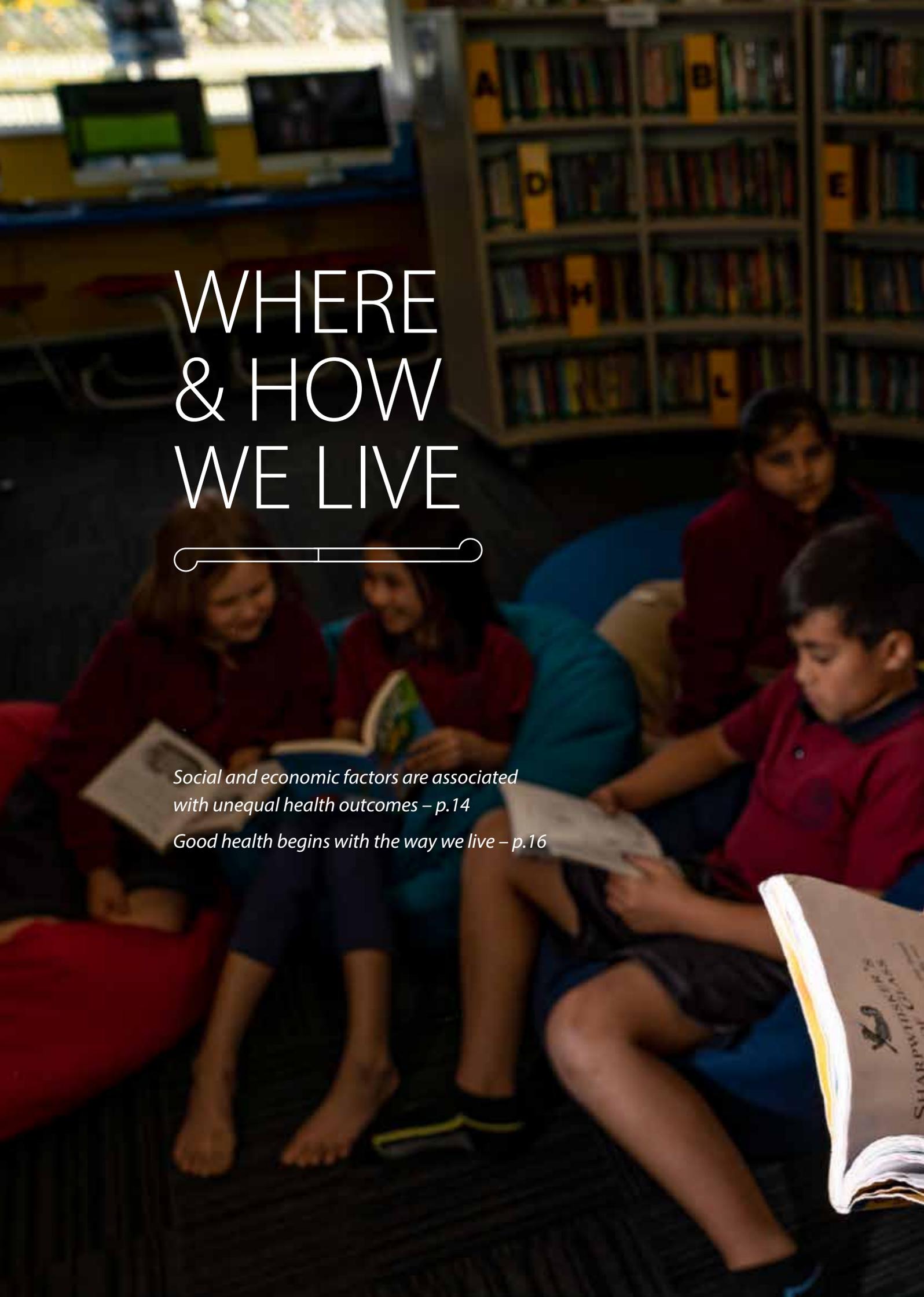


# WHERE & HOW WE LIVE



*Social and economic factors are associated  
with unequal health outcomes – p.14*

*Good health begins with the way we live – p.16*





Nāu te rourou, nāku te rourou, ka piki te ora

*With your basket and my basket the people will thrive*

## **Social and economic factors are associated with unequal health outcomes**

**The social and economic conditions that people are born into and live in have a profound impact on health outcomes.**

These factors include housing, education, income, social support and connection and they are closely linked. For example, education will impact on income, and income will subsequently impact on housing. These links lead to an accumulation of disadvantage among some people and an accumulation of privilege among others.

The health of Māori whānau is deeply rooted in the impacts of colonisation. Epidemics brought by European settlers decimated Māori communities and losses of land, languages, traditions and economic livelihood followed. These ordeals and accumulated trauma have induced further illnesses present in Māori today. Medical research suggests that molecular changes resulting from social trauma and illness may be passed on from one generation to the next.

Social and economic factors also underpin health behaviours: people living in poverty have fewer choices available to them, greater stress and poorer access to opportunities such as education, and all of these experiences can lead to higher levels of unhealthy behaviours.

*25% of Hawke's Bay 0-4 year olds live in a household* **receiving a main benefit**

Compared with **18%** nationally.

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*40% of Hawke's Bay tamariki Māori aged 0-4 years live in a household* **receiving a main benefit**

Compared to **19%** of Pacific children and **14.5%** of NZ European children.

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*61% of total food grants are to Māori*

Compared with **27%** to NZ European.

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**One in three Māori school leavers do not have an NCEA Level 2 qualification or equivalent**

Compared with **one in four** Pacific leavers and **one in seven** NZ European leavers.

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*22% of young Māori are not in employment, education or training*

Down from 30% in the 2014 Health Equity Report.

## CASE STUDY:

## MAKING HEALTH A CORE BUSINESS OBJECTIVE

**On average, adults spend at least one third of their life at work. This makes the workplace an ideal environment to promote health and wellbeing.**

*Tumu Timbers in Hastings is an example of a local business which has made workplace wellbeing a core business objective. The company manufactures timber bins, crates and pallets, beehive wood ware and packaging. Most of its 150 employees are men, and around half identify as Māori and/or Pacific.*

*The Tumu Timbers workplace health and wellbeing programme, now in its fourth year, aims to promote and improve the health and wellbeing of all Tumu Timbers employees and their whānau, resulting in a healthier workforce. The programme has been driven by staff who initiated a health and wellbeing committee. One of the first tasks of the committee was to conduct a health and wellbeing survey to find out what the staff wanted Tumu to focus on and what barriers exist for some.*

*Early initiatives focussed on making the healthy choice easier. This meant simple changes like switching to non-sugary drinks in the vending machine and providing fruit bowls with free fruit in lunch rooms. Other initiatives supporting nutrition, physical activity and smoking cessation have since been added. Employees are also offered subsidised health insurance.*

*A programme called "Mates in Manufacturing", renamed from "Mates in Construction", has been introduced which aims to create a culture that encourages talking about mental health issues and personal feelings, and to ensure staff know how to support each other and where to get help.*

*Hawke's Bay DHB's Population Health Advisory Team supported Tumu Timbers in the development of its wellness programme and continues to provide ongoing advice and support.*



Superintendent Tania Kura, Eastern Police District Commander

## CASE STUDY:

## PARTNERING FOR COMMUNITY GAINS

**Superintendent Tania Kura, Eastern Police District Commander, speaks on the importance of community partnerships.**

*"As Eastern Police District Commander, I believe in taking an open approach to developing partnerships within our communities. After six years here in Hawke's Bay, I've seen first-hand the strong, well-established relationships our officers have strived to build and maintain.*

*Real differences come when leaders collaborate with a common purpose. We're very fortunate to have a number of like-minded agency leaders across the Eastern District who are very willing to take a pragmatic approach to making things happen for the good of our communities.*

*An example of this is the positive approach we're taking to encourage truants back to school with the support of parents, the Ministry of Education, truancy services and schools. One key benefit of this initiative is a reduction in the number of young people going to Youth Court.*

*Our focus on crime prevention means thinking differently about how we solve problems as we aim to reduce both reoffending and re-victimisation. We can't be the safest country in the world unless we work with others. I'm grateful for the support extended to Police from other agencies, non-government organisations and iwi groups. I'm also heartened by the willingness of others to invite us to the table to help create coordinated solutions."*

## **Good health begins with the way we live**

*The environment we live in influences our day-to-day behaviours, including nutrition and obesity, smoking, alcohol and other drug use. Health behaviours have a large impact on our health and wellbeing.*

**Tama tu tama ora, tama noho tama mate**

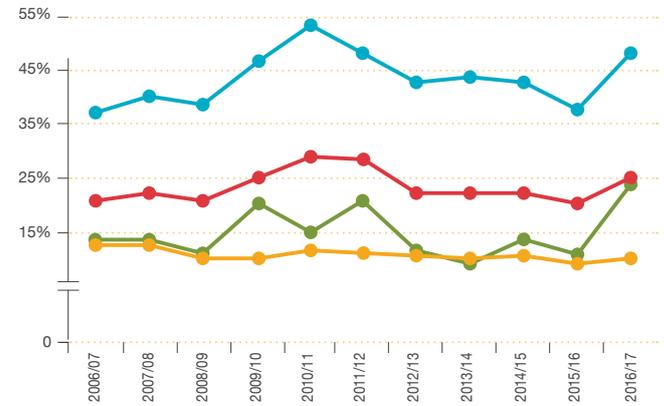
*An active person will remain healthy while a lazy one will become sick*

## Little change in reducing maternal smoking since 2007

**Maternal smoking is still of great concern with little change in the overall trend for maternal smoking since 2007.**

Maternal smoking is more likely among women living in more deprived areas. Helping women, and Māori women in particular, to stop smoking must remain a priority.

HAWKE'S BAY PERCENTAGE OF SMOKER STATUS OF WOMEN DELIVERING IN HBDHB FACILITIES BY ETHNICITY



Source: HBDHB Data Warehouse

KEY:

● Total ● Māori ● Pacific ● NZ European/Other

## Fewer youth are smoking but more Hawke's Bay adults smoke than nationally

**A growing proportion of young people in Hawke's Bay are choosing not to smoke.**

However one in five Hawke's Bay adults still smoke daily compared with one in six nationally. Māori have the highest smoking rates at 40 percent and Māori women are three times more likely to smoke than non-Māori women. Efforts to achieve the 2025 smokefree target (of less than 5 percent) must focus on supporting Māori to quit and on preventing uptake amongst rangatahi Māori.

## Hawke's Bay people are drinking more harmfully than New Zealanders as a whole

**29 percent of Hawke's Bay adults drink at harmful levels** compared with 21 percent nationally, and harmful drinking is rising over time. Alcohol-related hospital admission rates have doubled since 2009.

Recent age and ethnicity break-downs are not available for Hawke's Bay, but past and national patterns show:

- 15-24 year olds drink the most hazardously, although 25-44 year olds are not far behind
- fewer Māori drink alcohol than non-Māori (Pacific and Asian also lower) but Māori experience more harm overall than non-Māori.

In New Zealand, hazardous drinking is higher in more deprived areas, and there is a strong association with increased alcohol outlet density in these areas.

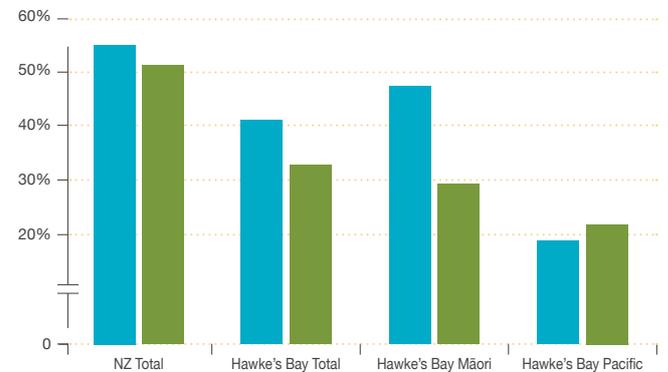
## Fewer adults and children are eating enough fruit and vegetables

**Just one third of Hawke's Bay adults and children meet the recommended guidelines for daily fruit and vegetable intake (3+ serves of vegetables and 2+ serves of fruit).**

This trend has worsened over the past three years. Adults living in the most deprived areas consume less fruit and vegetables than the least deprived areas. This finding is particularly troubling given the plentiful supply of locally grown produce in our region.

Our food environment influences our food choices. As shown in the table on the right, people living in our most deprived areas have more dairies and fast food outlets in their neighbourhoods than those in the least deprived areas. On the other hand there is little difference in the density of supermarkets and fruit and vegetable stores.

PERCENTAGE OF NEW ZEALAND & HAWKE'S BAY CHILDREN MEETING FRUIT & VEGETABLE INTAKE GUIDELINES (AGE STANDARDISED)



Source: New Zealand Health Survey

KEY:

● 2011-14 ● 2014-17

INDICATOR	MOST DEPRIVED	LEAST DEPRIVED
Average density of convenience stores per 10,000 people in Hawke's Bay census areas	10.2	3.4
Average density of fast food and takeaway outlets per 10,000 people in Hawke's Bay census areas	10.4	4.9
Average density of supermarkets and fruit and vegetable stores per 10,000 people in Hawke's Bay census areas	4.2	3.4

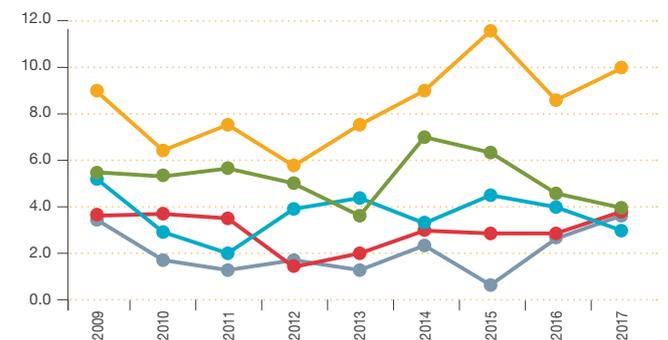
Based on/adapted from: INFORMAS (University of Auckland)

## Childhood obesity remains more common in our most deprived communities

**Children living in Quintile five (highest deprivation) remain more likely to be obese at their B4 School Check compared with children living in other Quintiles.**

Māori children are less likely to have a healthy weight than non-Māori children and an even smaller proportion of Pacific children have a healthy weight. Only 54 percent of Māori and 45 percent of Pacific children are at a healthy weight at their B4 School Check compared with 67 percent of NZ European/Other children.

PERCENTAGE OF OBESITY IN HAWKE'S BAY 4 YEAR OLDS AT B4 SCHOOL CHECK BY QUINTILE



Source: B4 School Check database extract provided by Health Hawke's Bay

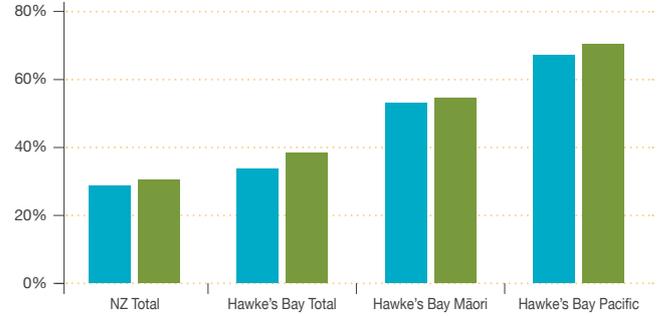
KEY:

● Quintile 1 ● Quintile 2 ● Quintile 3 ● Quintile 4 ● Quintile 5

## Adult obesity is increasing across all ethnic groups

Over a third (37.5 percent) of Hawke's Bay adults are obese compared with just under a third nationally (30.5 percent). Over the last three years, obesity rates in Hawke's Bay have worsened across all ethnic groups. Māori (53 percent) and Pacific people (70 percent) experience higher levels of obesity in Hawke's Bay. Adults who live in more deprived areas are more likely to be obese than those living in less deprived areas.

PERCENTAGE OF OBESITY IN NEW ZEALAND AND HAWKE'S BAY ADULTS (AGE STANDARDISED)



Source: New Zealand Health Survey

KEY:

● 2011-14 ● 2014-17

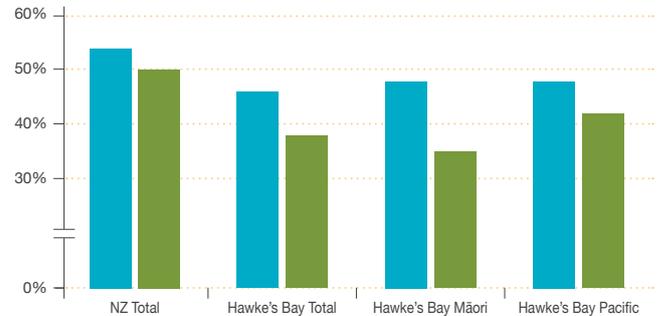
## Physical activity levels for Māori and Pacific have fallen

Hawke's Bay adults are less active than their New Zealand average counterparts.

Only 38 percent of Hawke's Bay adults meet physical activity guidelines compared with 50 percent nationally, a decline of 5 percent since the first Health Equity Report in 2014. The percentage of Māori meeting the guidelines has dropped from 48 percent to 35 percent in the period between 2011-14 and 2014-17 and the percentage of Pacific people has dropped from 47 percent to 42 percent.

Over recent years we have seen increasing participation in programmes such as Iron Māori but we need to work harder to ensure that activity gains from these programmes are carried over into daily life.

PERCENTAGE OF NEW ZEALAND AND HAWKE'S BAY ADULTS MEETING PHYSICAL ACTIVITY GUIDELINES (AGE STANDARDISED)



Source: New Zealand Health Survey

KEY:

● 2011-14 ● 2014-17

# EQUITY FOR LIFE



*Health is a resource for everyday living. It provides us with a capacity to participate in society and contributes to quality and length of life.*

Our “health capacity” accumulates over our life. If our health capacity grows, so does our resilience and ability to recover from health threats that occur later in life. But if our health capacity is depleted, our health becomes more vulnerable.

*Health capacity chart – p.22*

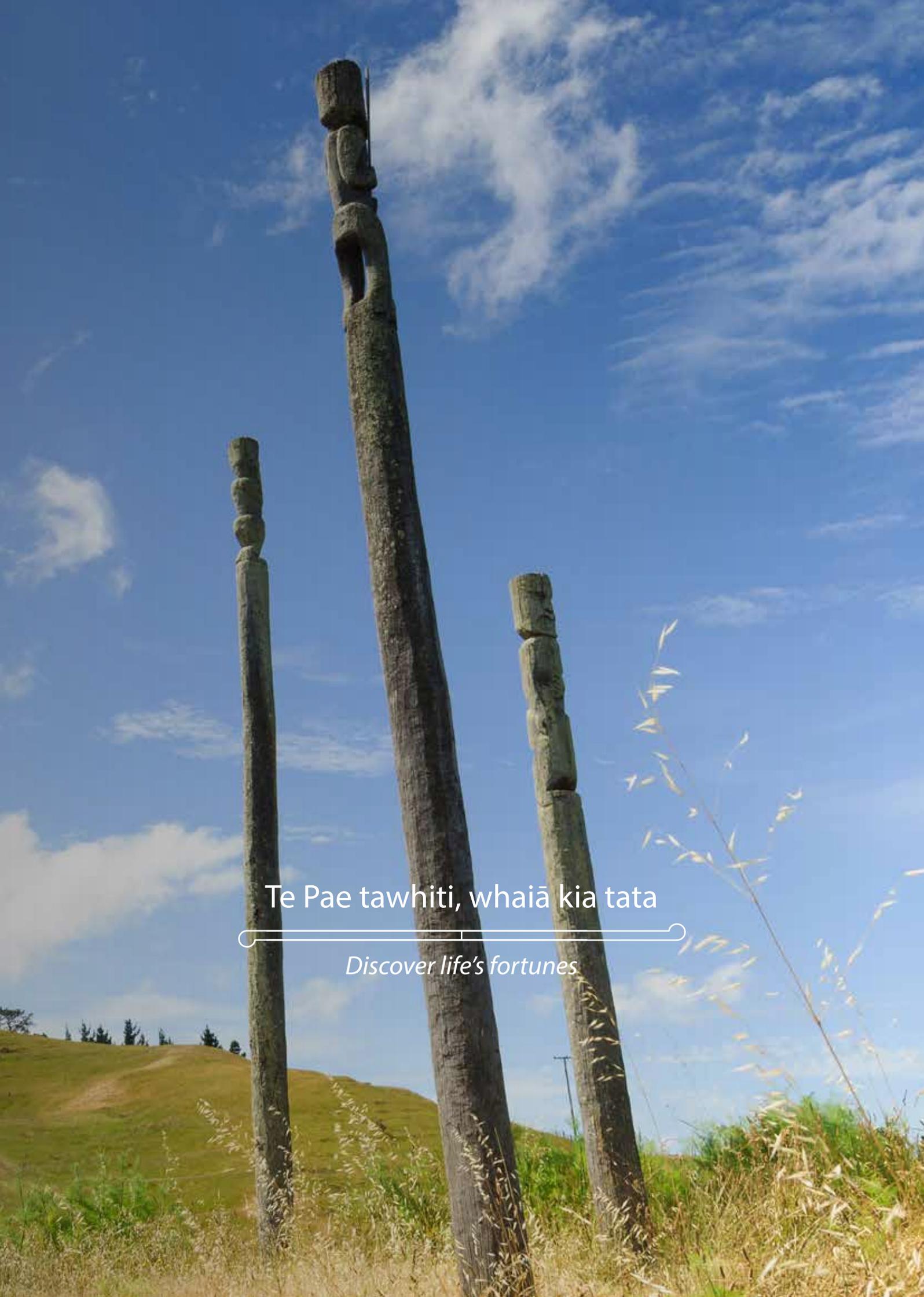
*Health across the life course:*

*- Childhood – p.24*

*- Youth – p.28*

*- Adulthood – p.30*

*- The end of life – p.34*

The image shows three tall, weathered wooden posts standing in a grassy field. The posts are made of dark, aged wood and have various carved or shaped sections at their tops. The background is a bright blue sky with scattered white clouds. In the foreground, there is a field of tall, golden-brown grasses. The overall scene is peaceful and natural.

Te Pae tawhiti, whaiā kia tata

*Discover life's fortunes*

# Our Health Capacity

*This chart shows how health related events, social, economic and physical environments, and behaviours can either grow or deplete our health capacity.*

**This is not intended to be a complete picture of all relevant factors. Its purpose is to illustrate how life experiences can contribute to inequities in illness and death.**

The dotted lines illustrate changes in health capacity for two hypothetical people. For one person their health capacity grows over their life, becoming depleted as death approaches late in life. For the other person their health capacity becomes depleted earlier in life ultimately resulting in a premature death. The lines also illustrate the difference in quality of life between the two life courses.

The chart illustrates the importance of building our health capacity early in life. But it also shows the potential for positive factors to increase our health capacity even after negative influences early in life.

In the middle of the chart is a line representing biology. Our genes are fixed but our biology can change and interact with other factors as we age.

*The first 1000 days of life have the biggest impact.*

**Fold out page to reveal factors affecting health capacity** →

*Increasing health capacity (increased resilience)*

*Reducing health capacity (increased vulnerability)*



## Kotahi te hā tā te mokopuna ki tā te kaumātua

An elder's life exemplifies the child's wellness

## Me mate ūruroa, koi mate wheke

Endless toil garners rich reward

## Ahakoia he tupu mātāngerengere, me ū

Although there are difficult phases  
of development, remain committed

Kotahi te hā tā te mokopuna ki tā te kaumātua			Me mate ūruroa, koi mate wheke		Ahakoia he tupu mātāngerengere, me ū			
An elder's life exemplifies the child's wellness			Endless toil garners rich reward		Although there are difficult phases of development, remain committed			
HE PĒPI preconception, pregnancy and infancy			NOHINOHI (0-1 year old) pre-school	TAMARIKI TAIŌHI (1-11 year old) middle childhood	TAITAMARIKI (12-18 year old) adolescence	RANGATAHI (19-40 year old) early adulthood	RANGATAKAKAU (40-60 year old) middle adulthood	RANGATIRA/PĀKEKE (60+ year old) late adulthood
<p>Access to sexual health services, safe from environmental toxins, supportive post natal care, Well Child checks and immunisation</p> <p>Good nutrition and health for mother at conception and during pregnancy, no alcohol and tobacco in pregnancy, breastfeeding</p> <p>Safe, warm and dry smoke free home; loving, emotionally stable violence free home; safe from environmental toxins</p>			<p>Immunisation and Well Child checks, oral health care</p> <p>Good family nutrition, regular adequate sleep</p> <p>Material wealth; safe, warm and dry smoke free home; loving, emotionally stable violence free home; early childhood education</p>	<p>Connected to primary care, oral health services</p> <p>Educational achievement, regular sleep, physical activity,</p> <p>Material wealth; safe, warm and dry smoke free home; loving, emotionally stable violence free home; safe connected urban environment; healthy nutritional environment</p>	<p>Access to sexual health and adolescent health services</p> <p>Engaged in school and community, culturally connected</p> <p>Mentoring; supportive relationships and whānau; whānau provides structure limits, rules and predictability</p>	<p>Maternity services</p> <p>Low or no alcohol use, active lifestyle</p> <p>Healthy and safe work environment</p>	<p>Screening on time</p> <p>Low or no alcohol use, active lifestyle</p> <p>Healthy and safe work environment</p>	<p>Good access to primary care and support services</p> <p>Maintain social connection</p> <p>Safe home environment</p>
<b>Interaction with Capacity Factors</b>								
<p>Unsafe cold damp smoking home, emotional distress, family violence</p> <p>Poor nutrition and health for mother at conception and during pregnancy, alcohol and tobacco in pregnancy, no breastfeeding</p> <p>Poor access to sexual health services, late or no antenatal care, not connected to post natal care, Well Child checks or immunisation</p>			<p>Poverty, unsafe cold, damp, smoking home, emotional distress, family violence, neighbourhood violence</p> <p>Poor nutrition e.g. sugar sweetened beverages, irregular or inadequate sleep</p> <p>Lack of access to immunisation, Well Child checks, oral health care, developmental or behavioural disorder</p>	<p>Poor nutritional environment, poorly connected unsafe urban environment, poor quality or transient housing</p> <p>Educational achievement limited, limited physical activity</p> <p>Not connected to primary care or oral health services, chronic disease or disability, developmental disorder, rheumatic fever</p>	<p>Low self-esteem, lack of cultural connection, parental substance use or mental illness, family violence or other traumatic event</p> <p>Early substance use, lack of social engagement e.g. no sport, lack of parental supervision and support</p> <p>Depression or anxiety</p>	<p>Criminal conviction or prison unhealthy or unsafe work environment</p> <p>Harmful alcohol and other substance use</p> <p>Late maternity services</p>	<p>Unhealthy or unsafe work environment</p> <p>Harmful alcohol use, poor nutrition, inactivity</p> <p>Late or no access to screening services</p>	<p>Unsafe home environment</p> <p>Poor social connection and loneliness</p> <p>Poor access to primary care and support services, increased frailty, dementia</p>
<p>Other accidents, SUDI, cancer, vehicle crashes, diarrhoea &amp; pneumonia</p>			<p>Suicide, vehicle crashes, other injuries, cancer, neurological disorders</p>			<p>Cancers, cardiovascular (heart disease &amp; stroke), suicide, vehicle crashes, diabetes</p>		<p>Cardiovascular (heart disease &amp; stroke), cancers, neurological, chronic lung, diabetes</p>



## Health across the life course

In this part of the report we have grouped some measures into life stage to show the importance of equity across the life course and to tell the story of how events earlier in life can influence our health as we age.



### HEALTH ACROSS THE LIFE COURSE: **Childhood**

*“Many challenges in adult society have their roots in the early years of life, including major public health problems such as obesity, heart disease and mental health problems.”*

– WHO, 2008

### Kotahi te hā tā te mokopuna ki tā te kaumātua

*An elder's life exemplifies the child's wellness*

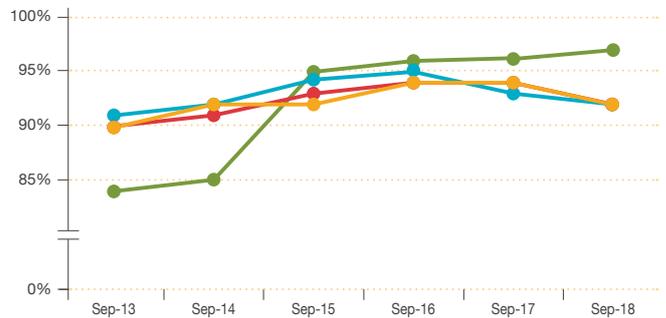
## Immunisation shows equity is possible

**Equity has been achieved in eight month immunisation rates for both Māori and Pacific infants. 97 percent of Pacific eight month olds are immunised. This is an increase of 12 percent since 2013.**

Hawke's Bay continues to achieve good immunisation coverage at 24 months of age with 94.6 percent of two year olds fully immunised (just under the Ministry of Health target of 95 percent). As at September 2018, 94 percent of NZ European/Other, 93 percent of Māori and 92 percent of Pacific children were fully immunised at 24 months of age.

The school based Human Papilloma Virus (HPV) programme, that prevents cervical and other cancers, has achieved greater coverage among Māori and Pacific adolescents than for NZ European/Other. This shows the pro-equity value of delivering programmes through schools by removing barriers to service.

PERCENTAGE OF HAWKE'S BAY 8 MONTHS OLDS IMMUNISED



Source: National Immunisation Register

KEY:

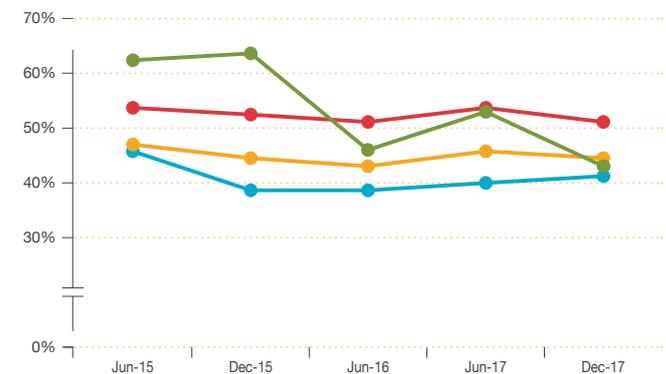
● Total ● Māori ● Pacific ● NZ European/Other

## Breastfeeding rates for Māori and Pacific are lower than in 2015

**Breastfeeding rates in Hawke's Bay at six weeks, three months and six months are persistently below the national average** and show consistent inequity for Māori, Pacific and people living in areas of high deprivation. Breastfeeding rates at three months are lower than in 2015 for all ethnic groups.

We have however seen some improvements in the percentage of women (including for Māori and Pacific) breastfeeding at two weeks after discharge. The challenge is to support women in maintaining these higher rates of breastfeeding for longer.

PERCENTAGE OF HAWKE'S BAY INFANTS BREASTFEEDING (FULLY OR EXCLUSIVELY) AT THREE MONTHS



Source: Wellchild Tamariki Ora dataset

KEY:

● Total ● Māori ● Pacific ● High Deprivation Area

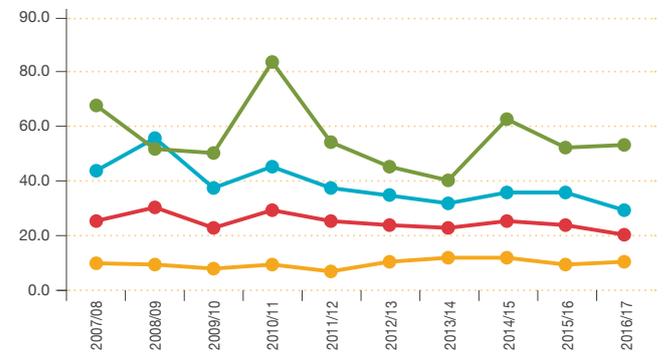
## The gap in housing-related childhood illness stopped closing in 2013

**Bronchiolitis (an acute respiratory illness which affects infants) is linked to housing conditions and other environmental factors such as smoking in the home.**

The gap between Māori and NZ European/Other for bronchiolitis hospital stays reduced between 2009 and 2013. There has been little or no decline for Māori infants since that time and rates for Māori infants remain significantly higher than NZ European/Other. Pacific infant hospital stays for bronchiolitis remain significantly higher than Māori and NZ European/Other infants.

Over the same period, housing demand has increased and demand for social housing has tripled over the last three years. Families are forced to share housing and to accept unhealthy living conditions.

HAWKE'S BAY ACUTE BRONCHIOLITIS HOSPITALISATION RATE PER 1000 POPULATION (0-4 YEARS)



Source: National Minimum Dataset

KEY:

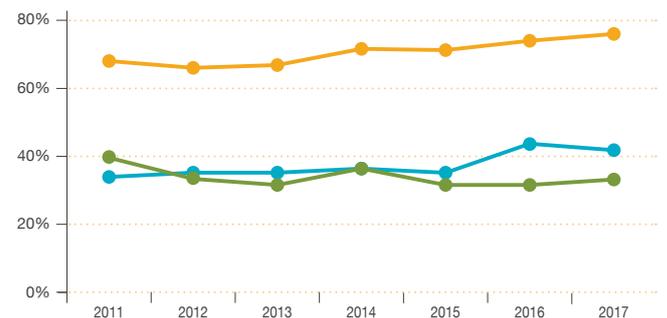
● HB Total ● Māori ● Pacific ● NZ European/Other

## Māori five year olds have less dental decay, but a large and persistent equity gap remains for Māori and Pacific children

**There has been a small improvement in the percentage of Māori children who are free of dental decay since 2015.**

However a large inequity persists which is partly due to the improvements for NZ European/Other children. There has been no improvement in dental health for Pacific children and rates are worse now than they were in 2011.

HAWKE'S BAY PERCENTAGE OF FIVE YEAR OLDS FREE OF DENTAL DECAY BY ETHNICITY



Source: HBDHB Oral Health Information System

KEY:

● Māori ● Pacific ● NZ European/Other

## Progress stalled in reducing Māori and Pacific children’s hospital stays for conditions that could be prevented by better community care

Ambulatory Sensitive Hospitalisations (ASH) are hospital stays for conditions that could be avoided through better community care. ASH rates provide a useful gauge for primary care access and quality.

**Overall, Hawke’s Bay ASH rates for 0-4 year olds remain lower than New Zealand and Hawke’s Bay DHB is ranked 6th lowest out of all DHBs.**

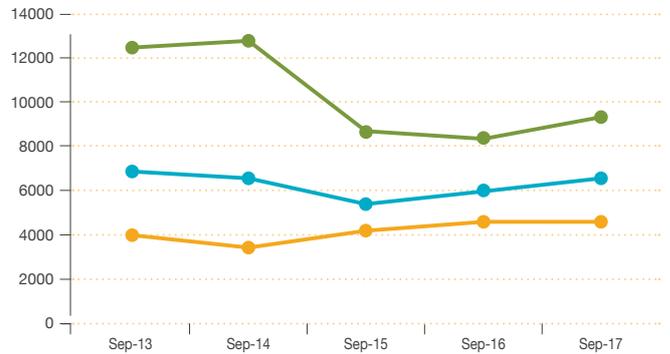
Between 2013 and 2015, considerable progress was made towards closing the equity gap for Māori and Pacific children. However since 2015 this trend has stalled, with ASH rates increasing for Māori, Pacific and NZ European/Other children.

Despite the fact that Hawke’s Bay ASH rates for Pacific children are amongst the lowest of all eight DHBs with high Pacific populations, Pacific children living in Hawke’s Bay have the highest ASH rates of all ethnic groups.

Good progress continues in reducing avoidable hospital stays for asthma and oral health problems.

Progress on reducing ASH rates for cellulitis (skin infections) in Pacific children has been reversed over the last 12 months.

HAWKE’S BAY AMBULATORY SENSITIVE HOSPITALISATION RATE PER 100,000 POPULATION BY ETHNICITY (0-4 YEARS)

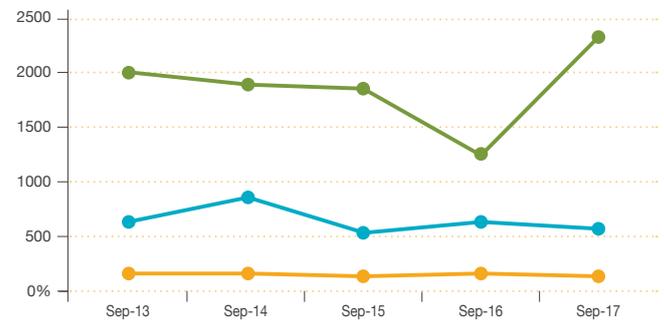


Source: National Minimum Dataset

KEY:

● Māori ● Pacific ● NZ European/Other

HAWKE’S BAY AMBULATORY SENSITIVE HOSPITALISATION RATE PER 100,000 POPULATION FOR CELLULITIS BY ETHNICITY (0-4 YEARS)



Source: National Minimum Dataset

KEY:

● Māori ● Pacific ● NZ European/Other



HEALTH ACROSS THE LIFE COURSE:

## Youth



*Pregnancy (under 18s) and sexually transmitted infections are two key measures where there are significant and persistent inequities for our young people.*

These measures provide an indication of the quality and adequacy of our youth health services.

*Iti rearea, kahikateā, ka taeā*

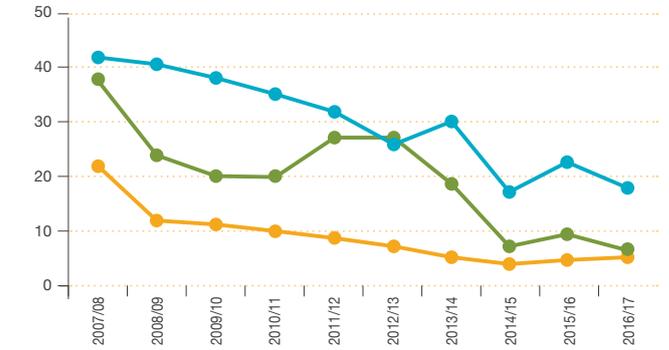
*Lofty heights are surmountable*

## Significant progress made in reducing pregnancy in under 18 year olds but access to services remains an issue

Since 2007/08 the Māori rate of pregnancy for under 18 year olds has decreased by more than half from 41.4 per 1000 to 18.5 per 1000. Rates for Pacific under 18 year olds are now similar to NZ European/Other.

Despite these health gains, persistent equity gaps for Māori remain and Hawke's Bay rates remain higher than New Zealand overall. In 2016/17, Māori under 18 year olds were almost four times more likely to have a pregnancy than NZ European/Other. Adolescent pregnancy can have negative health, social and economic effects on girls, their families/whānau and communities, which makes access to appropriate health care for young men and women even more important.

HAWKE'S BAY CONCEPTION (BIRTHS AND TERMINATIONS) RATE PER 1000 POPULATION FOR UNDER 18 YEAR OLDS BY ETHNICITY



Source: National Minimum Dataset

KEY:

● Māori ● Pacific ● NZ European/Other

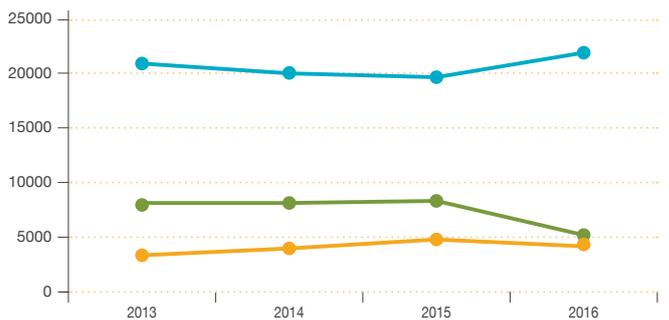
## Large inequities continue in sexually transmitted infections (STIs) and some STIs are increasing

Large equity gaps exist across most STIs, with young Māori (male and female) most vulnerable to undetected and untreated STIs.

Chlamydia and gonorrhoea levels are higher in Hawke's Bay than nationally and syphilis is on the increase.

Improving access to youth-friendly and culturally appropriate care is critical to reduce the harmful effect on individuals and prevent wider STI spread in the community. This will also help to protect the health of future generations, given the harmful impact of STIs on reproductive health and fertility.

HAWKE'S BAY LABORATORY-CONFIRMED CHLAMYDIA RATE PER 100,000 POPULATION FOR 15-19 YEAR OLD FEMALES BY ETHNICITY



Source: Institute of Environmental Science & Research (ESR)

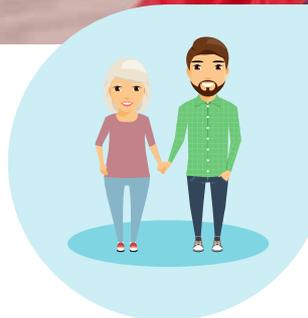
KEY:

● Māori ● Pacific ● NZ European/Other



HEALTH ACROSS THE LIFE COURSE:

## Adulthood



*Long-term conditions are the leading cause of poor health and early death for adults in Hawke's Bay.*

This section describes trends for some of the key conditions that contribute most to health loss: cancer, cardiovascular disease, respiratory conditions and diabetes.

Me mate ūruroa,  
koi mate wheke

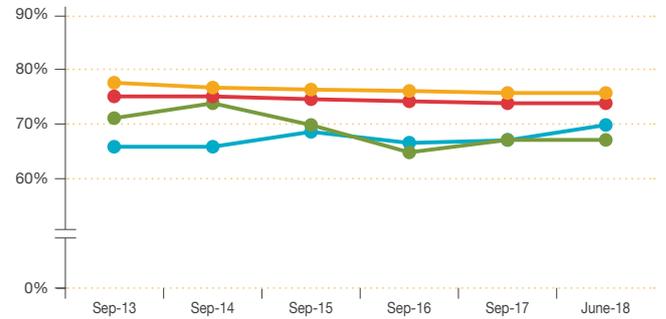
*Endless toil garners rich reward*

## Breast screening target for wahine Māori achieved this year for the first time

In June 2018, Hawke's Bay reached the Ministry of Health target for breast screening for wahine Māori of 70 percent. This is the first time this target has been achieved.

However, rates for Pacific women have decreased, creating an increasing inequity for Pacific women.

HAWKE'S BAY PERCENTAGE OF WOMEN RECEIVING BREAST SCREENING IN THE PREVIOUS TWO YEARS BY ETHNICITY (50-69 YEARS)



Source: BreastScreen Aotearoa

**KEY:**

- Total
- Māori
- Pacific
- NZ European/Other

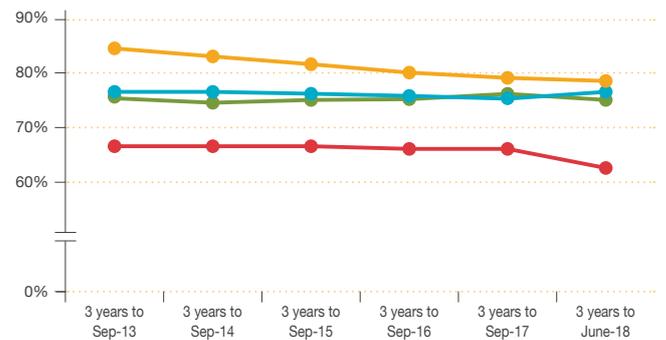
## Māori and Pacific cervical screening rates are holding despite an overall decline

At a national level, cervical screening rates are in decline and this trend is also reflected in Hawke's Bay.

However in Hawke's Bay, Māori and Pacific screening rates are remaining constant, and this is most likely due to the increased efforts of outreach services for Māori and Pacific women (refer page 52).

Of concern is that Asian screening rates are persistently lower than other ethnic groups and have declined further in the most recent period to June 2018.

HAWKE'S BAY PERCENTAGE OF WOMEN RECEIVING CERVICAL SCREENING IN THE PREVIOUS THREE YEARS BY ETHNICITY (25-69 YEARS)



Source: National Cervical Screening Programme

**KEY:**

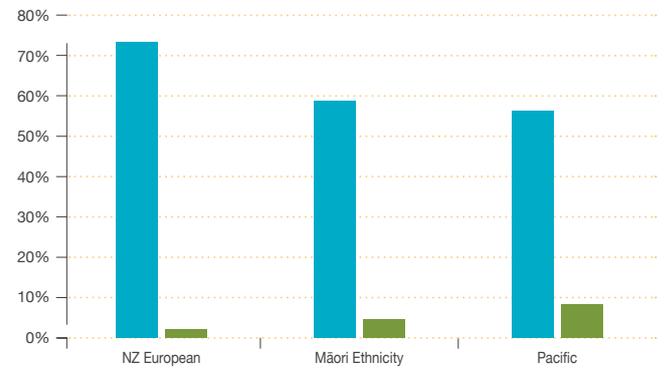
- Asian
- Māori
- Pacific
- NZ European/Other

## Diabetes remains more common among Pacific and Māori and is less likely to be well controlled

Diabetes is responsible for a significant burden of ill health including cardiovascular disease, kidney disease, and blindness. This is especially the case for Māori and Pacific people who have the highest prevalence of diabetes but are also less likely to have had an annual diabetes check or have their diabetes under good control (HbA1c <65). This is a significant area of mismatch between health need and health service provision.

Furthermore, equity between Māori and Pacific and NZ European<sup>2</sup> populations does not appear to have improved between 2015 and 2018.

HAWKE'S BAY DIABETIC CONTROL BY ETHNICITY (2017/18)



Source: Health Hawke's Bay

KEY:

● Well controlled (HbA1c <65)

● Very poorly controlled (HbA1c >100)

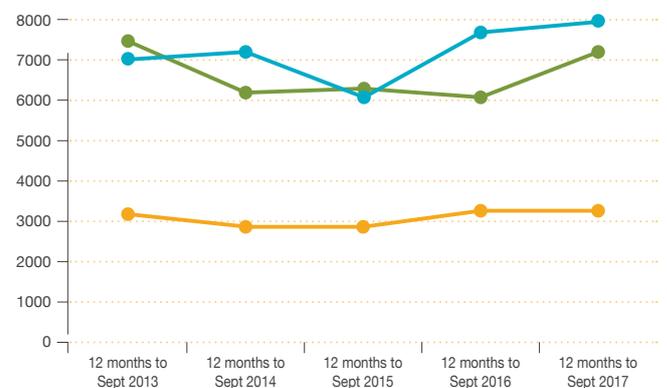
## Hospital stays for Māori and Pacific adults (45-64 years) for conditions that could be prevented by better community care are increasing

Ambulatory Sensitive Hospitalisations (ASH) are hospital stays for conditions that could be avoided through better community care. ASH rates provide a useful gauge for primary care access and quality.

Māori and Pacific ASH rates for 45-64 year olds were reducing between 2013 and 2015 but now appear to be increasing. ASH rates for 45-64 year olds in Hawke's Bay are now significantly higher than New Zealand.

The increase in the overall ASH rate for 45-64 year olds is driven by growth in ASH rates for heart attacks, skin infections and chronic bronchitis and emphysema (COPD).

HAWKE'S BAY AMBULATORY SENSITIVE HOSPITALISATION RATE PER 100,000 POPULATION BY ETHNICITY (45-64 YEARS)



Source: National Minimum Dataset

KEY:

● Māori

● Pacific

● NZ European/Other



*Hospital stays for Māori and Pacific adults (45-64 years) for conditions that could be prevented by better community care are increasing*



HEALTH ACROSS THE LIFE COURSE:

## **The end of life**



*We have stopped making progress towards equity in early avoidable deaths.*

**Ahakoā he tupu mātāngerengere, me ū**

*Although there are difficult phases of development, remain committed*

## Premature deaths

An increasing gap in premature death rates for Māori due to lung cancer, suicide and heart disease has resulted in an overall stalling of the previous trend towards reducing inequity. Not all deaths prior to 75 years are considered avoidable.

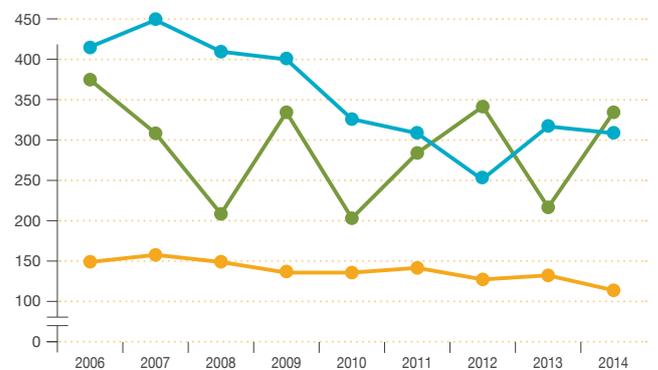
*In this report, **premature deaths** are deaths that occur before the age of 75 years*

## Avoidable deaths

**Avoidable deaths are deaths before the age of 75 years that could have been avoided either by disease prevention or effective treatment and health care**

Avoidable death rates for Māori improved considerably from 2006 to 2012 but there have been no further improvements since that time. For Pacific people, there has been no discernible decline in avoidable deaths since 2006/2007. Avoidable death rates for NZ European/Other have been in slow decline since 2006. The result is an increasing equity gap in avoidable deaths for Māori and Pacific people.

HAWKE'S BAY AVOIDABLE DEATHS AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY (0-74 YEARS)



Source: National Mortality Collection 2018

KEY:

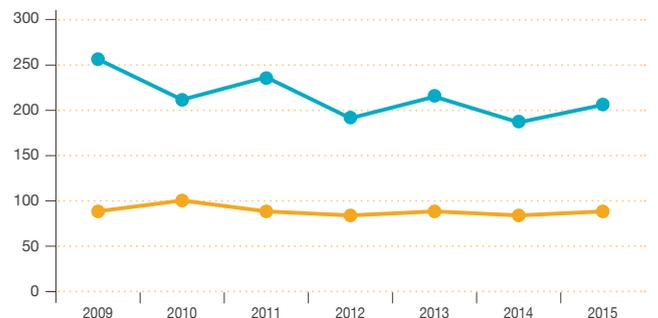
● Māori ● Pacific ● NZ European/Other

## Amenable deaths

**Amenable deaths (a sub-set of avoidable deaths) are deaths which could have been avoided through access to quality health care.** Amenable deaths are therefore a good “big picture” indicator of how the health system is performing.

Between 2009 and 2012, amenable deaths for Māori were in decline but in the last three years of available data (2012-2015) that positive trend has stalled.

HAWKE'S BAY AMENABLE DEATHS AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY (0-74 YEARS)



Source: National Mortality Collection 2018

KEY:

● Māori ● NZ European/Other

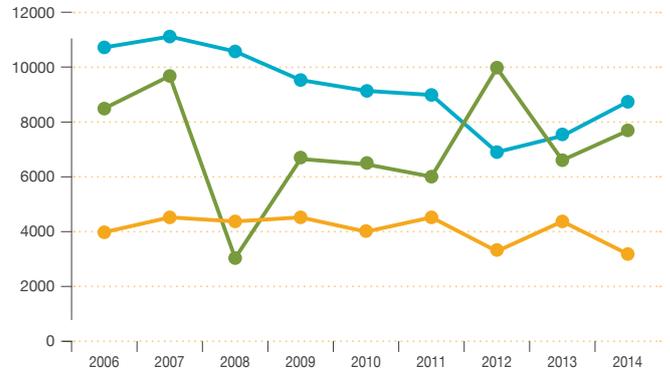
## Years of Life Lost

Another way of looking at premature deaths is to calculate the average years a person would have lived if they had not died early.

This method, known as Years of Life Lost (YLL), emphasises the importance of deaths which occur at earlier ages because there are more years of life lost. The equity gap in YLL between Māori and NZ European/Other reduced between 2007 and 2012 but in the last two years of available data (2012-2014), progress has stalled. YLL is also increasing for Pacific people.

**Top causes of Years of Life Lost for Māori are coronary heart disease, suicide, lung cancer and road traffic crashes.**

HAWKE'S BAY YEARS OF LIFE LOST AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY (0-74 YEARS)

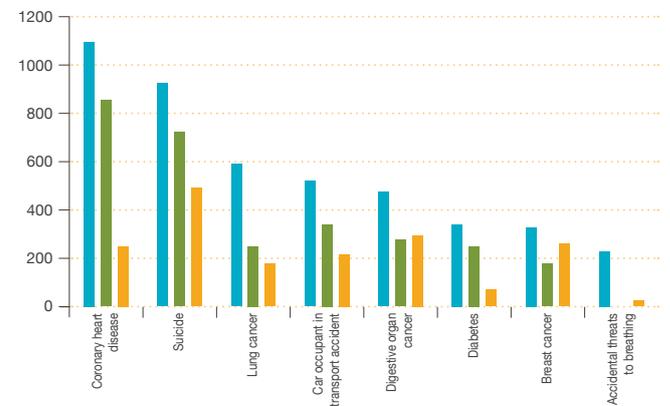


Source: National Mortality Collection 2018

KEY:

● Māori ● Pacific ● NZ European/Other

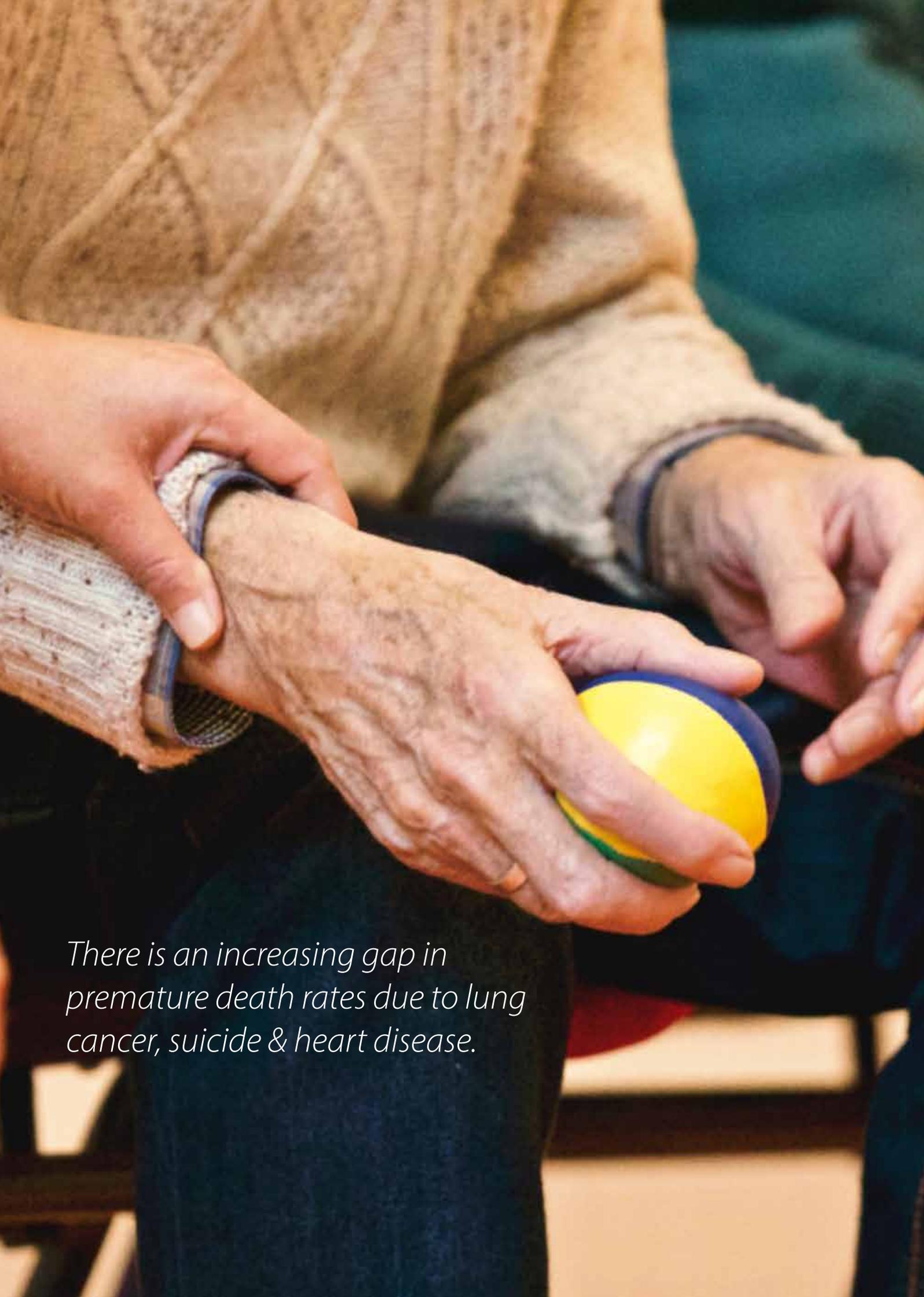
TOP CAUSES OF YEARS OF LIFE LOST AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY (2010-2014)



Source: National Mortality Collection 2018

KEY:

● Māori ● Pacific ● NZ European/Other



*There is an increasing gap in premature death rates due to lung cancer, suicide & heart disease.*

# SPOTLIGHTS

*Pacific health – p.40*

*Mental health – p.42*

*Family violence – p.46*

*Housing and health – p.50*

*Screening –p.52*





Mahia te mahi

*The work is ready to do*

A SPOTLIGHT ON:

## Pacific health in Hawke's Bay

Talalelei Taufale, Hawke's Bay DHB's Pacific Health Manager

*It is important to acknowledge that Pacific people want to live healthy, strong lives.*

**But many Pacific families struggle with socio economic pressures, as well as the demands of balancing Pacific values, culture, language, family and church expectations with societal norms and expectations.**

**Pacific communities are made up of separate and unique ethnic groups, and approaches may need to vary between them. Also, Pacific and Māori are often addressed as one group.**

Our current health system presents obstacles for the Pacific community such as language barriers, cost, transport and hours of opening. The local Pacific community would benefit from a health system that is culturally responsive to Pacific people; and from a greater understanding of what quality care for Pacific people looks like.

Some health services serve the local Pacific community very well, for example breast and cervical screening. These services have made an effort to understand the Pacific world view and to orient their services to work better for Pacific people.

The Hawke's Bay DHB's Pasifika health service was established in 2017 and includes a team of outreach navigators (further detail in the story over the page). **It is the only dedicated Pacific health team in the Hawke's Bay DHB; and is culturally responsive, delivering a whānau-centred service that is making a difference. One Pacific family described our navigators as "angels from heaven".**

**97%** of Pacific eight month olds are **immunised**

---

*Pacific five year olds have the **highest rates of tooth decay***

---

*Pacific children have the **highest rates of avoidable hospital stays***

---

The Pasifika health service works closely with other health services on how to provide the best service for Pacific people but this takes time. The willingness of services to be involved and undertake this journey of learning is encouraging and will create some real shifts in the way we work with the Pacific community and the outcomes we achieve.

## What are the building blocks for improving Pacific health?

### 1

We need to cement a “turangawaewae” - a place to stand and a sense of belonging for Pacific health at all layers and levels of the Hawke’s Bay DHB. Having a place to stand and a voice to effect change will give assurance to the community that Pacific health is a priority - not an afterthought or an add on.

### 2

Growing the Pacific health workforce is a priority, especially in the services that Pacific people are using most frequently. We need to create working environments where Pacific staff and patients feel welcomed and supported.

### 3

We need to reshape the way our health services work with Pacific communities and we need to deliver services in Pacific community settings including established church networks, family and other social and sporting settings.

### 4

The traditional approach of working with individuals does not work for Pacific families. A flexible, whole-of-family approach is a lot more effective. This way we can capture other health conditions and outstanding health checks, as well as improve community understanding of how and when to use services. In working with families we are also more likely to gain buy in from our Pacific clients and to build genuine relationships that support effective service provision.



Back row: Paul Faleono, Talalelei Taufale  
Front row: Silia Momoisea, Olive Tanielu, Amataga Iuli

#### CASE STUDY:

## WORKING WITH FAMILIES, PACIFIC STYLE

**Paul Faleono is a Pacific Health Navigator with the Hawke’s Bay DHB’s Pasifika Health Service and shared this story of how a Pacific-based, whānau centred approach works.**

*“The Kaotira family migrated from Kiribati to Hawke’s Bay in early 2017 to work on a Patoka dairy farm with their five children. Their house was an hour’s drive from the nearest doctor. They were isolated geographically and culturally, and they spoke little English.*

*When we first visited the family, we greeted them in Kiribati and Samoan then sat on the floor and began to talk. We spoke about their family, their village, their island and the reasons they had migrated. From there we were able to talk about health and other issues. We then went away and connected with other health and social services as well as the Healthy Homes team to get the Kaotira family the support they needed.*

*During the following school holidays we visited the family again, accompanied by a public health nurse. In just one visit, all the children received health checks, were shown how to brush their teeth, skin and ear infections were addressed, and the family was shown how to use their unopened asthma medication. We also provided the father with some patches and gum to help him quit smoking.*

*The Kaotira family emerged from this visit with more knowledge about the health issues affecting their family and a greater connection with the services that can help them. We visit the Kaotira family at regular intervals and continue to support them on their health journey.”*

A SPOTLIGHT ON:

## Mental health in Hawke's Bay

*A strong sense of mental wellbeing is vital to enable people to live life to the fullest and engage actively in their family or whānau, in employment, hobbies and the wider community.*

Data on self-rated health, psychological distress, alcohol and other drug use and mood/anxiety disorders are sourced from the New Zealand Health Survey.

E tipu, e rea, hei ōranga

*Grow o tender shoot*

### Self-rated health

Self-rated health is an important measure of both physical and mental wellbeing. Rather than simply capturing physical disease, it provides an insight into a person's lived health experience.

- 87 percent of Hawke's Bay adults describe their health as excellent, very good, or good.
- However only 81 percent of Māori report excellent, very good or good health.
- People living in our least affluent communities also rate their health lower.

### Psychological distress

Psychological distress is where someone is significantly affected by feelings of anxiety, confused emotions, depression or rage.

- Levels of self-reported distress slowly increased in New Zealand between 2011 and 2017. For the 2014 to 2017 period Hawke's Bay DHB was among the DHBs with the highest levels of self-reported distress and Hawke's Bay's rate was significantly above the rate for New Zealand.
- Psychological distress is highest for Māori and Pacific people<sup>3</sup>.

## Alcohol and other drugs

- 29 percent of Hawke's Bay adults are hazardous drinkers. This means they are likely to be harming their own health or harming others through their drinking. Young people are particularly vulnerable as earlier initiation and heavier drinking sessions are more likely to lead to the development of a harmful drinking pattern later in life.
- Amphetamine use in Hawke's Bay appears to be slowly decreasing and is now in line with the rest of New Zealand (having previously been much higher).
- Cannabis use remains significantly higher than the rest of New Zealand. Māori men are the highest users of cannabis in Hawke's Bay. Unfortunately, the New Zealand Health Survey data do not include synthetic substances which are a serious concern for many whānau.

*29% of Hawke's Bay adults are hazardous drinkers*

*Cannabis use remains significantly higher than the rest of New Zealand*

*Synthetic substances are a serious concern for many whānau*

## Mood/anxiety disorders

Mood/anxiety disorders include depression, bipolar disorder, panic attacks, phobia, post-traumatic stress and obsessive compulsive disorders.

- Almost one in five Hawke's Bay adults report being diagnosed with a mood or anxiety disorder during their lifetime.
- Women's rates are double those of men.
- People living in our most deprived communities have higher rates than those living in least deprived areas.

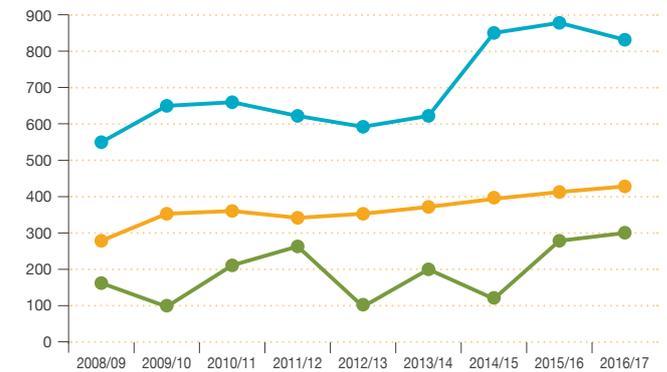
*Almost 1 in 5 Hawke's Bay adults report being diagnosed with a mood or anxiety disorder during their lifetime*

## Mental Health Inpatient Services and Compulsory Treatment Orders

Mental health inpatient services and compulsory treatment orders provide for the most severely ill patients. A compulsory treatment order is a court order requiring a person to receive treatment for up to six months.

- While mental health inpatient hospital stays have been slowly increasing since 2008/9, the more rapid increase following 2013/14 has likely been influenced by the way clinical services have been delivered with less respite care available in the community, rather than being driven by a significant increase in community need.
- Māori are 2.5 times more likely to be admitted to mental health inpatient services than non-Māori.
- Compulsory treatment orders for Māori are three times those of non-Māori.

MENTAL HEALTH INPATIENT HOSPITALISATIONS (HAWKE'S BAY DHB FACILITIES & HAWKE'S BAY RESIDENTS) AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY



Source: HBDHB Data Warehouse

KEY:

- Māori
- Pacific<sup>4</sup>
- NZ European/Other

## Intentional self harm

Intentional self-harm is a deliberate act which may not be done with the intention of ending life but nevertheless reflects extreme emotional distress. Traumatic life experiences and a lack of secure relationships increases the risk of self harm.

- The rate of Hawke's Bay self-harm hospital stays has increased by 30 percent between 2013/14 and 2016/17. While the overall numbers are not large (180 admissions in 2013/14 increasing to 241 admissions in 2016/17) it is a concerning marker of suffering for both individuals and whānau. This is not solely a Hawke's Bay phenomenon with a similar increase in self-harm hospital stays occurring for New Zealand over the same time period.
- Women's hospitalisation rates for self-harm are double those of men and Māori are more likely to self harm than non-Māori.

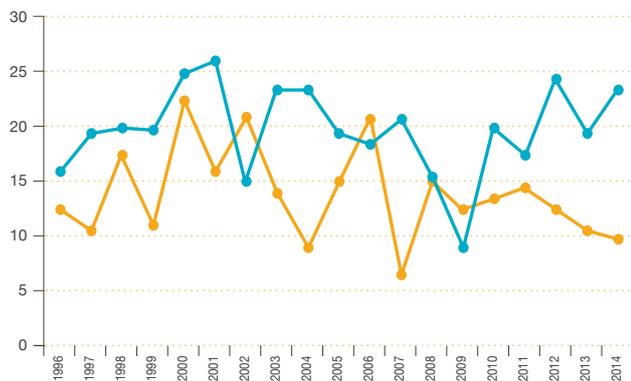
The rate of **self-harm** hospital stays has **increased by 30%** between 2013/14 and 2016/17

**Women's** hospitalisation rates for **self-harm** are **double** those of men

## Suicide

- Suicide is a major cause of premature, avoidable death in Hawke's Bay, especially for Māori. Suicide is the second highest cause of years of life lost (YLL) for Māori and Pacific people (refer page 36).
- The rate of suicide deaths appears to have been reducing for NZ European/Other while Māori suicide rates appear to have increased. Suicide data does need to be interpreted with caution given the small number of deaths that occur each year.
- Provisional coronial data (which haven't been adjusted to account for population growth) indicate that suicide deaths are increasing over time.
- Alcohol intoxication or a history of alcohol abuse are often associated with youth suicide<sup>5</sup>.

HAWKE'S BAY SUICIDE AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY (0-74 YEARS)



Source: National Mortality Collection 2018

**KEY:**

● Māori ● NZ European/Other

**Suicide is a major cause of premature, avoidable death in Hawke's Bay**

CASE STUDY:

## PARTNERING TO SUPPORT YOUNG PEOPLE WITH MENTAL HEALTH ISSUES

**For Luke, detail is very important so a job researching and digitising historic cemetery records at Hastings District Council was ideal. Luke was employed for six months to get Hastings' old hand-written burial records into an easily searchable on-line format. During this time, Luke built up his computer and research skills while growing his confidence. His completed proposal to Council identified further work – he proposed a 12 month contract and is now the official 'cemetery intern'.**

*Luke's initial job with Hastings District Council was created as part of the Rangatahi mā Kia eke programme - a programme designed to support young people who are experiencing mental health issues (or other health and disability conditions) to overcome barriers to employment. Sponsor organisations identify a project which delivers community or environmental good. A young person is recommended and both the sponsor and young person are supported to deliver the project by the partner agencies.*

*Over the past 12 months, Rangatahi mā Kia eke has delivered some really positive outcomes including re-engaging young people with education, career direction and experience and employment opportunities. The young people have also made a positive contribution to the sponsor organisations they worked for.*

*The programme is a great example of collaboration in action. The programme is delivered by Hastings District Council and funded by the Ministry of Social Development, who also provide Work Broker support and links to other Work and Income services. EIT, Oranga Tamariki, Te Puni Kokiri and Hawke's Bay DHB provide expert information, links to services and advisory group membership.*

*Engagement in society including employment is an effective tool in supporting wellbeing and for rangatahi on this programme experiencing mental health issues, it has been life changing.*

<sup>5</sup> Sir Peter Gluckman. Youth suicide in New Zealand – a discussion paper.

A SPOTLIGHT ON:

## Family Violence

*“Family violence is a long-standing and complex problem. It has contributing factors from multiple levels of society. Family violence is preventable, but it will require long-term commitment and sustained action across many sectors. Along the way, we will continue to need high quality responses to those who have experienced violence, and those who have perpetrated it.”*

– New Zealand Family Violence Clearinghouse

### Ka whati te kupenga, ka hao te rangatahi

*A tattered net signifies change is on the horizon*

**There is no monitoring framework for family violence in Hawke’s Bay and there is no straight forward way of measuring the prevalence of family violence in our community.**

**For this report, we look first at a snapshot of key national statistics and we then present two indicators at the Hawke’s Bay level.**

The first is female hospital stays due to assault and the second is the relationship of offenders of serious assaults to their victims. Both of these indicators capture only the most serious cases of assault and therefore are no measure of the prevalence of family violence in our community.

While society-wide efforts are essential if we are to address family violence, health services have an important role to play in effective screening and early intervention.

**The National Picture  
in Family Violence<sup>6</sup>**

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**47%** of all homicide deaths in New Zealand are **family related**

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Almost a **third** of all family violence deaths in New Zealand are **children**, who have died as a result of **abuse & neglect**

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**1 in 3** New Zealand women experience **physical and/or sexual abuse** from a **partner** in their lifetime

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**3/4** of intimate **partner violence** is perpetrated by **men** and **1/4** by **women**

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**3/4** of interpersonal **offences** by a family member are **not reported** to Police

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Pacific young people are **3 times more likely** to be exposed to **family violence** than NZ European young people

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Māori **children** are **6 times more likely** to **die** from **child abuse** or **neglect**

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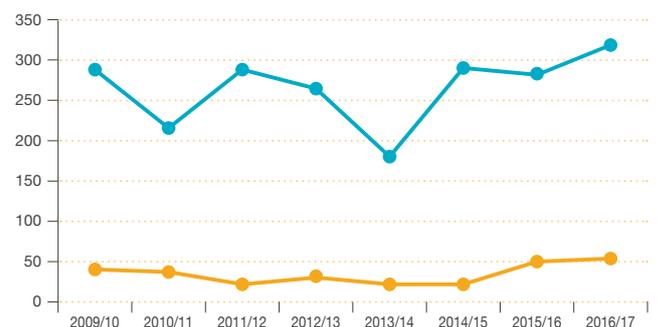
<sup>6</sup> Family Violence Clearinghouse



## Female hospital stays for assault in Hawke's Bay<sup>7</sup>

- Hawke's Bay female hospital stays due to assault include assaults by any person, not just family members. They are not, therefore, a direct measure of family violence but they do provide part of the picture.
- Female rates of hospital stays for assault are increasing over time and, in 2016/17, Hawke's Bay female rates were higher than New Zealand females (reaching statistical significance). Hawke's Bay Māori female rates of hospital stays due to assault are six times those of NZ European/Other.

HAWKE'S BAY FEMALE ASSAULT HOSPITALISATION RATE  
AGE STANDARDISED PER 100,000 POPULATION BY ETHNICITY



Source: National Minimum Dataset

KEY:

● Māori ● NZ European/Other

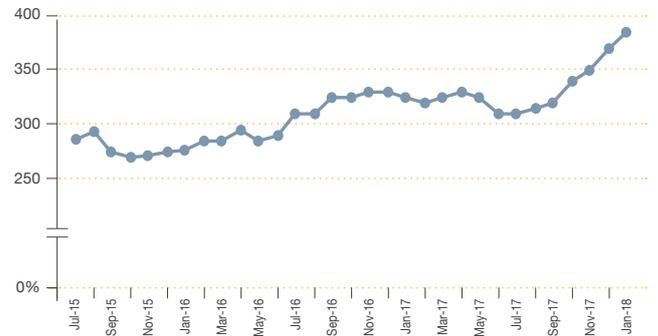
## Serious assault causing injury

Police data records serious assaults causing injury and the relationship of the offender and victim. Over half of the victims of serious assault causing injury are a current or past partner of the offender. A further 16 percent are other family members.

Over **half** of the **victims** of serious **assault** causing injury are a current or past **partner** of the **offender**

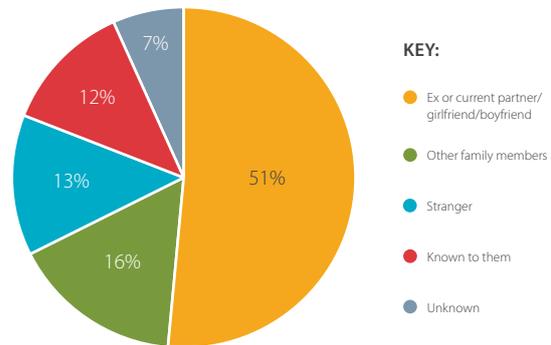
**16%** of the **victims** of serious **assault** causing injury are non-partner family members of the **offender**

NUMBER OF OFFENDERS FOR SERIOUS ASSAULTS RESULTING IN INJURY - HAWKE'S BAY POLICE AREA BY ROLLING 12 MONTH PERIOD



Source: New Zealand Police

HAWKE'S BAY OFFENDERS FOR SERIOUS ASSAULT CAUSING INJURY IN 12 MONTHS TO JANUARY 2018 - % BY RELATIONSHIP OF VICTIM



Source: New Zealand Police

Mahia te mahi  
  
 The work is ready to do

A SPOTLIGHT ON:

## Housing and Health

*Poor housing causes poor health. Cold and damp housing coupled with household crowding continues to affect the health and wellbeing of many Hawke's Bay families.*

E kore au e ngaro he kākano i ruia mai

*As a seedling, my growth is maintained*

**Poor housing conditions are regularly linked to presentations of young children suffering from acute bronchiolitis – a viral infection of the airways.**

**Māori children are three times and Pacific children five times more likely to need to stay in hospital for bronchiolitis than NZ European/Other children.**

Acute bronchiolitis is not easily treated by a visit to the doctor, but there is clear evidence it can be reduced with warm, dry, smokefree and uncrowded housing.

Household crowding is also an important risk factor for a range of infectious diseases including pneumonia, bronchiolitis, gastroenteritis, rheumatic fever, tuberculosis and skin infections.

Pacific children are more likely to be admitted to hospital for a skin infection while acute rheumatic fever and tuberculosis continue to impact Māori and Pacific people at much higher rates than NZ European.

### **Hawke's Bay's challenges**

- Demand for social housing has tripled over the last three years
- Two thirds of people on the social housing register are Māori
- There are many rental homes in the private rental market in substandard condition adding to poor health outcomes for tenants.

Turning health outcomes around for Māori and Pacific families requires addressing these challenging housing situations. Hawke's Bay DHB has responded to this need with a Child Healthy Housing Programme where there are many initiatives making a positive impact on the health and wellbeing of families. Complementing this work is a Ready to Rent programme, supported by the Hawke's Bay Housing Coalition and wider networks.

These programmes are a step in the right direction to achieving healthier homes and a healthier population but there is much work to be done to address the lack of housing and unacceptable housing situation faced by many.



#### CASE STUDY:

## HOME IS WHERE THE HEALTH IS

**Mel West is a kaiāwhina for the Hawke's Bay DHB's Child Healthy Housing Programme and shares a story about the work it does to support families in need.**

*"A grandmother and her five grandchildren were referred to Hawke's Bay DHB's Child Healthy Housing team after one child got pneumonia. All six of the family had respiratory issues and one child was in a wheelchair with high health needs.*

*The rental property the family were in was uninsulated and draughty. Weatherboards and flashings were missing and black mould was growing in the bedrooms. The ceiling was sagging in parts and falling down in others. Mouse droppings and other debris would fall into the house through holes in the ceiling. There was not a single smoke alarm in the house.*

*The Child Healthy Housing team helped this family to find a long term rental which was dry, insulated, had new carpets and curtains as well as a compliant fireplace. The team arranged for wheelchair modifications and donated bunks and bedding. This family are feeling very happy and secure in their new home thanks to the instant health benefits. They enjoyed a warm winter with no hospital admissions."*

**The Child Healthy Housing Programme has helped over 800 families to improve the health of their homes.**

#### CASE STUDY:

## READY TO RENT

**Ready to Rent (R2R) began as a small idea which is fast growing into a local gem, receiving nationwide attention.**

*This local initiative is aimed at up-skilling tenants who are struggling to find a rental property and providing them with a 'support letter' they can use when applying for tenancies in the future.*

*The brainchild of the Hawke's Bay Housing Coalition, a group of local organisations who joined forces to improve access to quality housing, R2R is led by Hawke's Bay DHB, supported by the Hawke's Bay Property Investor's Association, Te Taiwhenua o Heretaunga, WINZ, Budget First and others.*

**Since its launch in 2017, 140 people have attended R2R, of which 75 percent have been Māori.**

*The programme has assisted attendees to successfully enter a competitive private rental market by building their skills and knowledge around renting. The programme includes sessions on the rights and responsibilities of tenants, what landlords want in a tenant, how to keep your home warm, dry and healthy as well as managing money and debts.*

*The New Zealand Property Investors' Federation (NZPIF) has praised the initiative saying that combined with compulsory insulation, the Ready to Rent programme was a cost-effective solution that would see the living standards of renters improve considerably.*

**"The New Zealand Property Investors' Federation (NZPIF) fully supports the Hawke's Bay DHB's Ready to Rent Programme,"** it stated in a press release.

**"A study of local landlords showed that 85 percent would use this scheme to find the best candidate for their property."**

*Ready to Rent is a great example of local people with local relationships, ready and willing to address a local issue.*

A SPOTLIGHT ON:

## Screening

*A new pathway implemented in 2017 has resulted in the most successful breast screening year yet in Hawke's Bay.*

Te kekēte te āra mai i te āra

*Many veins direct my paths*

### Reaching Out

**A new pathway implemented in 2017 has resulted in the most successful breast screening year yet in Hawke's Bay, with record numbers of wahine (female) Māori receiving their mammogram in 2018 and the region achieving national Ministry of Health targets for wahine Māori of 70 percent for the first time.**

The new pathway was implemented to prioritise women (Māori and Pacific) who were due or overdue for breast screening. The women were invited to attend a mobile screening facility, offered incentives to attend their appointment, and were well supported through their journey. The initiative's success came down to a collaboration between the Hawke's Bay DHB's population health screening team, BreastScreen Coast to Coast, general practices and Māori health providers.

In cervical screening, an increased focus on Māori and Pacific women has seen their screening rates hold constant, despite overall declines both in Hawke's Bay and nationally.

**An increased focus on Māori and Pacific women has seen their cervical screening rates hold constant, despite overall declines both in Hawke's Bay and nationally**



*Many of the women we screen tell us that they wouldn't have done it if we hadn't come to them. So we know we are saving lives.*

**CASE STUDY:**

## **CERVICAL SCREENING OUTREACH SERVICE**

**Margaret Alexander is a kaiāwhina working with Hawke's Bay DHB's cervical screening outreach service and shares her insights.**

*"Our service reaches out to Māori and Pacific women in high need communities by visiting them in their own homes and offering a smear service within their home environment. The women we reach out to do not typically engage with their doctor or respond to recalls because the system hasn't met their needs. The first thing we do is be accessible and gain trust and understanding of their situation. We also educate these women about the positive health benefits of screening. If you can engage positively you're half way towards meeting their needs.*

*We will often visit hesitant women a number of times, but we don't give up. In a culturally sensitive way, and in their own time and space, we get to the bottom of why someone may be unsure about having a smear.*

*We know our approach is working because most women will re-engage with their general practice at the end of our time with them. New relationships are also made with other women in the whānau who express a desire to connect with the service.*

**The outcomes**

*Cervical cancer is one of the easiest cancers to prevent, so long as cell changes are detected early. Many of the women we screen tell us that they wouldn't have done it if we hadn't come to them. So we know we are saving lives.*

*We support women to come together and recognise their worth as individuals, get aboard the waka and tautoko (support) each other to address their health needs and complete their smear as whānau. The benefits of having three generations of women in the same room giving each other awahi is so rewarding.*

**Benefits beyond screening**

*The nature of our service means that once kaiāwhina are in the homes, other health needs can also be discussed and guidance or referrals given."*

# EARLY & AVOIDABLE DEATHS



*Avoidable deaths are deaths before the age of 75 years that could have been avoided either by disease prevention or effective treatment and health care.*

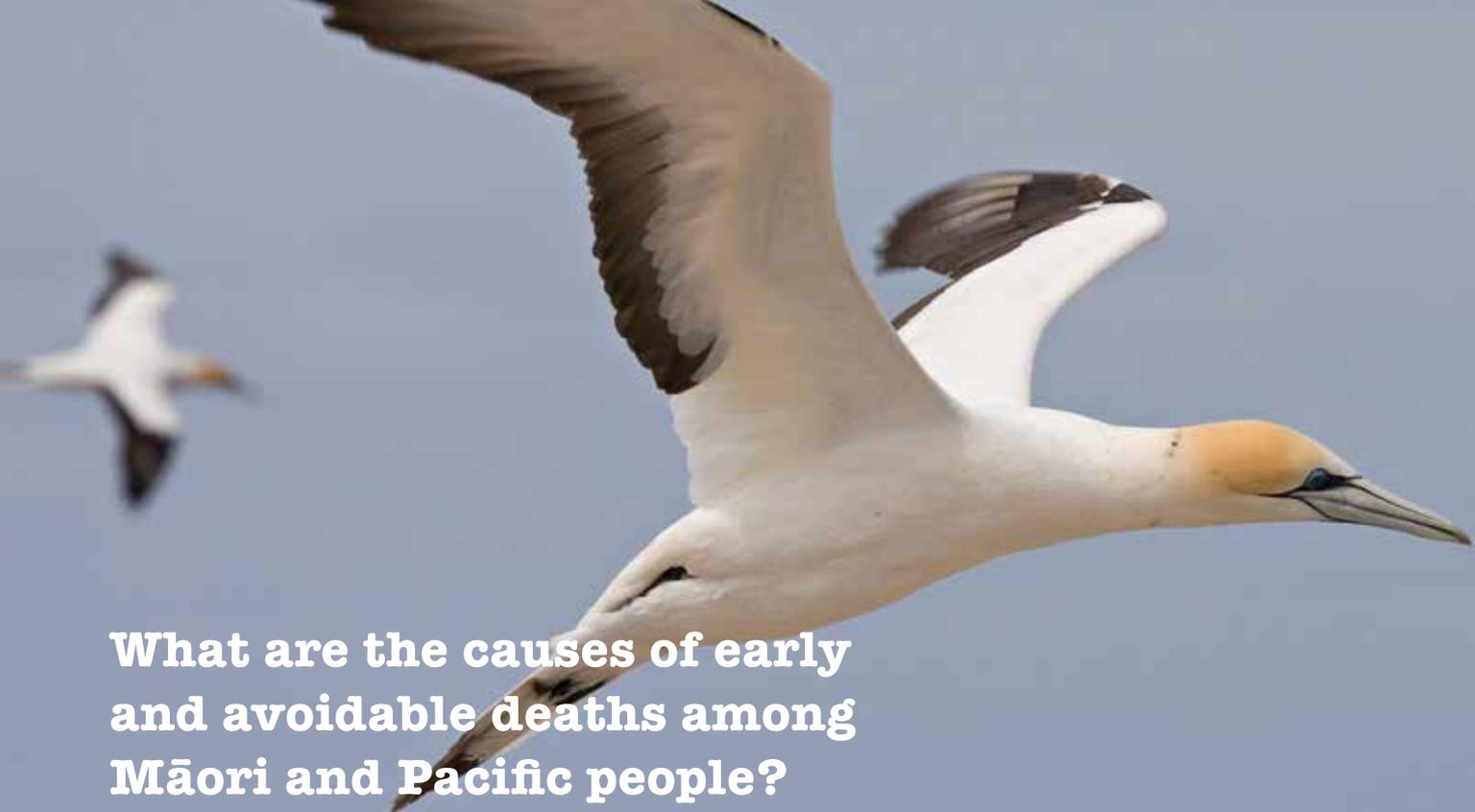
*What are the causes of early and avoidable deaths among Māori and Pacific people? – p.56*

*How can early and avoidable deaths be prevented? – p.58*



Mēna, ka huu te ringahora, ka ora te rangi, ka ora te iwi

*If it resounds from the east, the skies clear, the iwi thrives*



## What are the causes of early and avoidable deaths among Māori and Pacific people?

*In Hawke's Bay, the gap in life expectancy between Māori and non-Māori is 8.2 years for males and 7.7 years for females<sup>8</sup>.*

**This shorter life expectancy is because Māori, along with Pacific 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. We call these "avoidable" deaths.**

After a long period of improvement, avoidable death rates for Māori have stopped declining. For Pacific people, there has been no discernible change in avoidable deaths since 2006/2007. Meanwhile, the long term picture for NZ European/Other is one of steady improvement, resulting in a widening of the equity gap.

Māori and Pacific people also live less years in good health. Living with long-term conditions such as diabetes, cancers, cardiovascular diseases, respiratory diseases and mental illness are part of the modern Māori and Pacific health story.

**Avoidable death rates for Māori have stopped declining**

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*There has been **no discernible change** in avoidable deaths for **Pacific people** since 2006/2007*

# Mēna, ka huu te ringahora, ka ora te rangi, ka ora te iwi

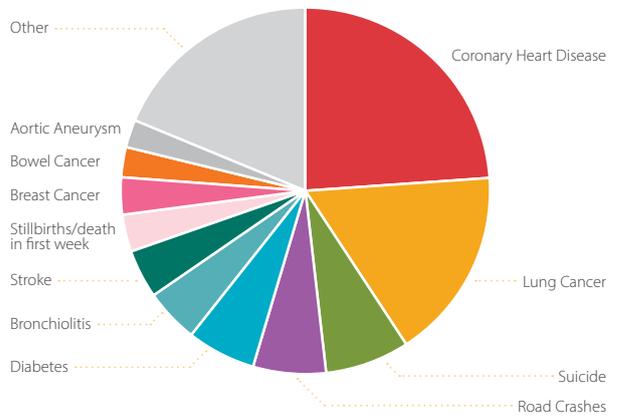
*If it resounds from the east, the skies clear, the iwi thrives*

## Top causes of avoidable deaths

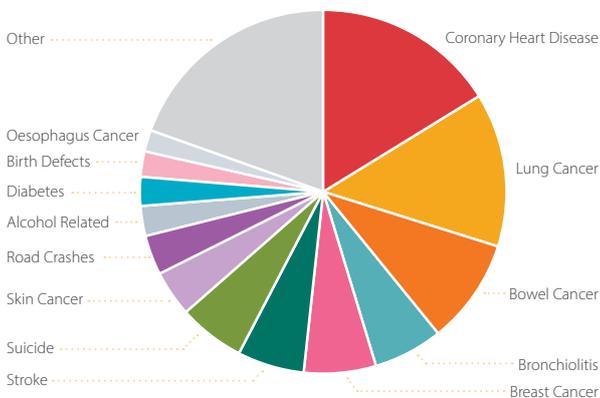
**Coronary heart disease is the biggest cause of avoidable death across all ethnic groups.**

For Māori, lung cancer is the second biggest, followed by suicide and road crashes. For Pacific people, coronary heart disease is followed by diabetes, suicide and stroke. For NZ European/Other, coronary heart and lung cancer are also top causes, alongside bowel and breast cancer.

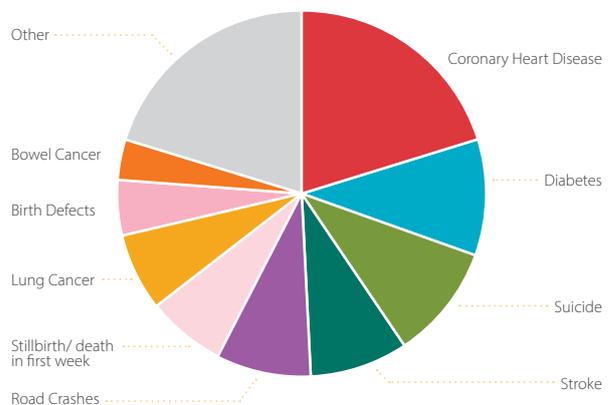
MĀORI



NZ EUROPEAN/OTHER



PACIFIC





## How could these early deaths be prevented?

### *Prevention*

---

Most of the top causes of early avoidable deaths are underpinned by behavioural factors including smoking, poor nutrition, insufficient physical activity and hazardous drinking.

However, the solution is not as simple as saying people need to change their behaviour. Health behaviours are linked to underlying social conditions, emotional trauma early in life, inter-generational disadvantage and the effects of colonisation, feelings of empowerment (which are lower in more deprived communities) and the ease of healthy choices in the surrounding environment. An example of this is the higher density of fast food and alcohol outlets in low income communities, making the healthy choice much harder.

A recent New Zealand study<sup>9</sup> found that socioeconomic factors are responsible for 42-46 percent of inequities. This tells us that reducing socioeconomic disparities would greatly reduce the equity gap in deaths over the long term.

### *Providing equitable and timely health care services*

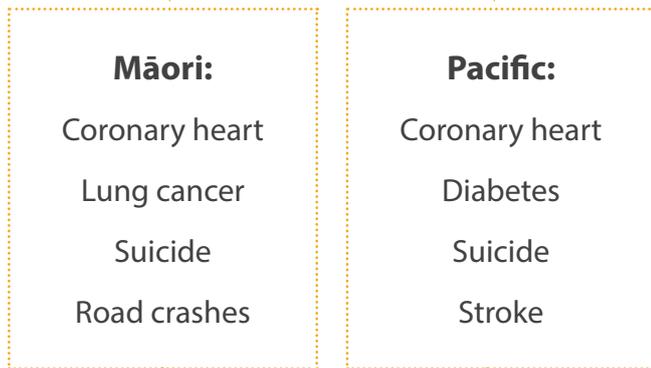
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Māori are more likely to die early from a condition which was potentially avoidable through the effective and timely use of health services than NZ European/Other. Coronary heart disease is by far the largest of these causes of death.

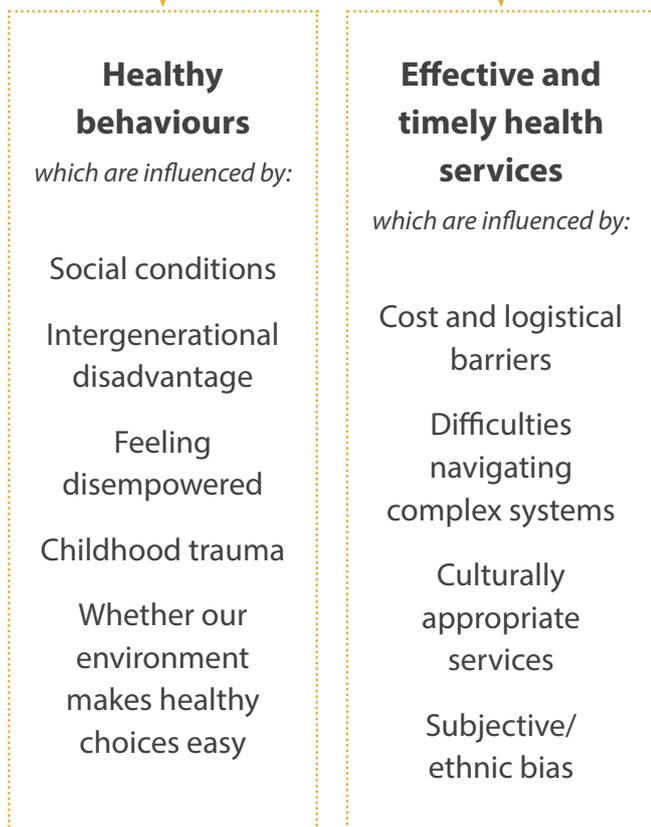
Why are Māori and Pacific people not using the health services that will help them to live longer? What is preventing them from entering the system at the right time, and what is happening on their journey through the system? Key factors include opening hours, transport and cost, difficulties navigating a complex health system, cultural responsiveness of the services they use and subjective/ethnic bias within the system.

The key elements to be considered in our plan to address the inequity in life expectancy are summarised in the table opposite.

**TO ELIMINATE INEQUITIES IN LIFE EXPECTANCY WE MUST FOCUS ON PREVENTING MĀORI AND PACIFIC PEOPLE FROM DYING EARLY**



**AVOIDABLE THROUGH:**



## CULTURE COUNTS: THE SIGNIFICANCE OF AGE IN MĀORI SOCIETY

As a society everyone values a long and healthy life. Yet for Māori, Pacific and people living in greater deprivation, the reality is one of a shorter, less healthy life.

Premature mortality (earlier death) and living with long term conditions takes a huge toll on Māori leadership, whānau, hapū and iwi and it erodes Māori culture or “cultural capital”.

### **What is cultural capital?**

“Cultural capital” is the fabric that holds a society together. For Māori it is about holding fast to the treasures of your ancestors. Acquiring cultural capital takes a life-long dedication to its practice, recital and song. It is also the expected behaviour under the leadership of kaumātua, koroua and kuia. The marae, or centre for cultural and traditional activities, remains the most enduring Māori institution.

### **Age, mana and tribal integrity**

A flourishing community and culture depends on the transfer of tradition, roles and responsibilities, and language down through the generations. With age comes mana. It is the older generation who carry the status, tradition and integrity of their people. Elders are recognised for their life experiences and the knowledge they have accumulated over the years. Without leadership at that level, a Māori community will be the poorer and, at least in other Māori eyes, unable to function effectively or to fulfil its obligations.

Yet many are not surviving long enough to take up the challenge and to play their role in ensuring the continuation of Māori culture.

It is well established that a strong sense of “cultural identity” has benefits for physical, mental and spiritual health for Māori and Pacific people. The loss of culture through premature mortality, therefore, has important implications for younger generations.

### **Mauri ora!**

# NEXT STEPS

*In the same way as providing equal educational opportunities for all children requires different approaches and resources for different groups, achieving health equity in Hawke's Bay will require different approaches and resources for different groups to get the same health outcomes.*

*What does this all mean? – p.62*

*What are our next steps? – p.66*



Rūia taitea kia tū ko taikaka ānake

*Discard the sapwood to uncover the heartwood*

## Equality



## Equity



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## What does this all mean?

*This report demonstrates that in Te Matau a Māui/ Hawke's Bay, different groups within our population experience differences in health outcomes that are not only avoidable or preventable, but are also unfair and unjust.*

**As New Zealanders we have a strong sense of fairness. We understand that life can provide more challenges to some than to others but we don't accept that disadvantage should prevent any of us from participating fully in society.**

We believe everyone should have enough nutritious food to eat, safe and healthy housing and that all children should have the opportunity to enjoy educational success.

This report reflects the view that social and economic disadvantage should not prevent any of us from enjoying a full and healthy life. In fact, health is one of the most important resources each of us needs to achieve the goal of full participation.

## The priority health issues

**All of the findings in this report are important but when we consider the picture overall some common themes emerge.**

- Rates of early and avoidable deaths for Māori and Pacific people have stopped declining while decline has continued for NZ European/Other. Reducing inequity will require focusing on heart disease, lung cancer, suicide and vehicle crashes for Māori and heart disease, diabetes, suicide and stroke for Pacific people. The analysis of deaths by life years lost highlights the particular importance of suicide and vehicle crashes. The deaths due to these causes occur at a higher rate among young people, making these issues a particular priority.
- Similar patterns of inequity are also evident in hospital stays that can be avoided through better community care. For adults aged 45-64 years, inequity for Māori and Pacific people is increasing and the biggest inequities are in avoidable hospital stays for heart attacks, chronic lung disease and skin infections.
- For preschool children good progress continues in reducing avoidable hospital stays for asthma and oral health problems, but skin infection hospital stays are increasing for Pacific children.
- There is more to health than hospital stays and dying. Other measures of health service performance such as those linked to sexual health show persisting inequities reflecting the need for an increased focus on youth health services. This report also highlights the importance of mental health and family violence as key issues.

## The underlying causes

**The health issues identified above are influenced by inequities in behavioural and other known risk factors.**

These factors operate over a lifetime so trends in deaths will be linked to behaviours over many years. However, it is also concerning to find that alcohol use is increasing, tobacco use remains much higher in Hawke's Bay, and smoking among hapū (pregnant) wahine Māori is not declining. An adequate intake of fruit and vegetables is still not being achieved by many despite the horticultural resources of our district and physical inactivity is increasing despite pro-activity initiatives such as the iWay cycle programme and Iron Māori.

Our reviews of mental health and family violence highlight key health issues that can also be seen as a symptom of more fundamental causes.

Inequities for Māori in; hospital stays for mental illness, self-harm and assault, and suicide rates all point to more fundamental and persisting inequities in socioeconomic determinants of health within our society. Differences in socioeconomic determinants can in turn be linked to the inter-generational, traumatic and long term impacts that colonisation has had on Māori health, wellbeing and culture in Hawke's Bay.



## *Learning from our successes*

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**The successes in immunisation, screening programmes, reductions in teenage pregnancy and youth not in employment, education or training (NEET) all demonstrate that equity can be achieved.**

When we deliberately focus on eliminating inequity and provide culturally appropriate services to whānau at a time and place that meets their needs, we can succeed. Other successes, such as the reductions in some ASH rates for children, demonstrate the potential for achieving equity with whānau centred and integrated approaches to healthcare or, in the case of the NEET rates, through concerted multi-agency action. We need to take the lessons from these successes and incorporate them into our social and organisational structures so we create health sector and society-wide equity promoting systems. Our Clinical Services Plan makes it clear that we must go beyond providing navigators to help families find their way through a “foreign” system to more fundamental change that makes the system itself navigable by all, with the whānau at its centre.

## *Learning from world best practice*

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**The Nuka System of Care is a holistic healthcare system owned, created, and implemented by Alaska Native people to maximise physical, mental, emotional, and spiritual well-being.**

There is much that we can learn from Nuka which is recognised internationally for its success. Relationship is at the core of the Nuka model. Nuka is particularly skilled in fostering relationships between providers and clients, and at asking communities about their health priorities and negotiating with them around delivering these services. They use real time feedback from the communities they serve, as well as clinical data to rapidly improve services to meet desired outcomes. In Hawke’s Bay, this will mean changing the nature of our relationships with Māori to one where Māori led approaches gain greater attention and relevance.

This will also mean challenging non-Māori, non-Pacific world views of health care systems, funding, and power. Partnering with people and whānau in meaningful, participatory ways where power is shared is critical if we are going to understand the root causes of inequities and design successful solutions.



## *Wider opportunities to achieve equity*

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We know that health care is responsible for between 10 and 20 percent of health inequities. This is something that is within our control as a sector, and we can make immediate progress on this. Barriers to high quality health care include: difficulties in navigating our complex systems, the cultural competence of providers, limited knowledge of how and when to use services, lack of transport, out-of-pocket costs and co-payments for GP services.

The Nuka example can help guide us as we address these issues.

### **Almost half of inequities would be eliminated by addressing disparities in socio-economic conditions.**

We all know that this is not simple, nor is it something we can resolve quickly. But we must work together as a whole community to find ways to increase the pace of change. Current government priorities align well with increased focus on issues such as: reducing child poverty, increasing housing supply, and improving mental health. Locally we have already established the Mātariki partnership. As this partnership moves to focus more on equitable outcomes as a key priority there will be more opportunity for local system change to achieve health equity.

Meeting our treaty obligations remains critical to achieving health equity. As treaty settlement groups move into their post settlement phase there is much cause for optimism. Post treaty settlement groups will not only assist in addressing economic disadvantage for Māori but will become key partners in eliminating health inequities.

## What are our next steps?

01

### *Listen to our communities most impacted by health inequities and act to change services*

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This report identifies some priority health issues and determinants but this is just a starting point. Our next step must be to go to our communities and ask 'what matters to them' and 'how they can inform service responses to meet their needs'.

02

### *Partner with Māori and Pacific leaders to deliver on the commitments made in our Clinical Services Plan that are focused on eliminating health inequities*

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This report discusses some of the ingredients of success, and our Clinical Services Plan identifies commitments to take us forward. However, the detail about how we will implement those strategies remains for us to decide. Many of the solutions to the issues identified in this report will come from the communities most affected. A next step must be to establish an equity action planning process with Māori and Pacific communities that sets out a pathway for the rebalancing of service provision to more kaupapa Māori and Pacific based models.

03

### *Invest in whānau ora approaches to community needs*

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Better understanding of specific issues such as heart health inequity will assist in designing issue specific responses. However, we also need to ensure we take a system wide perspective that focuses on total system and cultural change based on whānau ora approaches.

04

### *Establish an equity promoting system and explicitly tackle structural ethnic bias*

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In order for us to achieve equity we must establish equity as core property of the health system in Hawke's Bay. This means changing the way we do things across the system and making sure that everything we do will reduce inequity. Part of that process will involve dealing with ethnic bias within our system. The existence of bias or disadvantage based on ethnicity and socioeconomic status are well established in New Zealand and elsewhere. Even when we account for socioeconomic factors inequities based on ethnicity remain. This bias, sometimes known as institutional or structural racism, remains an important cause of inequity and we will engage in fearless, honest and respectful discussions about this so that we can work together to address it.

Kei tua i te awe māpara, he tangata kē



*Behind the tattooed face, a different man appears*

Kei tēnā, i tēnā, āna momo mahi

*We've all got a role to play*



*“Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one’s life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.”*

**– Ottawa Charter (WHO 1986)**



Te Puni Tūmatawhānui | Health Improvement & Equity Directorate | Hawke's Bay District Health Board

[www.ourhealthhb.nz](http://www.ourhealthhb.nz)