2011-2012

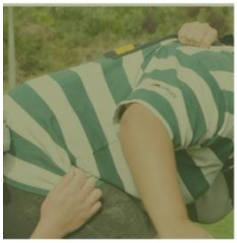














Canterbury DHB

Māori Health Actions

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CONTENTS

1 INTRODUCTION

1.1 Background

On 30 June 2010, an amendment was made to the *New Zealand Public Health and Disability (NZPHD) Act* governing DHBs. Under the amendment, DHBs are required to complete Regional Health Services Plans, Annual Plans and Māori Health Plans. The NZPHD Act lays out the responsibilities that DHBs have in ensuring Māori health gain as well as Māori participation in health services and decision making. The Act also indicates our responsibility to recognise and respect the principles of the Treaty of Waitangi in the health and disability support sector and our relationship with the Crown's Treaty partner, in our case, Ngāi Tahu. This Māori Health Action Plan is prepared in accordance with this legislation.

1.2 Introduction

The Canterbury population generally has better access to health services and better health status than the average New Zealand population. This is true for all ethnicities living in Canterbury, but nonetheless, there are real disparities between Māori and non-Māori in relation to health outcomes and life expectancy. Generally Māori in Canterbury have better health than Māori across the country, but their health outcomes are not as good as those of the rest of the Canterbury population.

This Canterbury DHB Māori Health Action Plan draws principles from a number of documents. Key amongst these is the national Māori Health Strategy *He Korowai Oranga*. This plan follows the key strategies in *He Korowai Oranga* while remaining closely linked to our mission to facilitate and improve the wellbeing of the people of Canterbury. The aim of *He Korowai Oranga* is "Whānau ora; Māori families supported to achieve their maximum health and wellbeing". This aim is reflected in our own action plan and remains the basis of action.

Implementing this plan will require a collaborative effort from across the Canterbury health system. In particular, our plans to improve health outcomes for Māori in Canterbury have a strong focus on strengthening whānau engagement in health services and in empowering whānau to take more responsibility for own care and wellbeing. This approach is linked to Canterbury's vision for improving the health and wellbeing of our population and with the Canterbury Clinical Networks '*Better, Sooner, More Convenient'* Business Case.

This is not a strategic plan for Māori health in Canterbury. Rather, this is an action plan bringing together the diverse range of activities occurring across the Canterbury health system that will improve health outcomes for our Māori population in 2011/12. We will monitor performance against this plan and look to the other key groups that support Māori health in Canterbury to take part in improving outcomes for our Māori population.

1.2.1 Key Māori Health Organisations

The key groups in Canterbury that guide health initiatives for Māori at various levels are:

- **Manawhenua ki Waitaha (MkW)** – This is a collective of the seven Ngāi Tahu Rūnanga health representatives within Canterbury that have a treaty-based relationship with the Canterbury DHB. This group has an obligation to improve the health for all Māori in Canterbury and work in partnership with the Canterbury DHB, with some MkW members on each of the PHO boards in Canterbury. Over the coming year, MkW work with other iwi, Taura Here and Maata Waka groups to establish a Māori advisory group for the Canterbury region.
- **He Oranga Pounamu (HOP)** – The charitable trust mandated by Te Rūnanga o Ngāi Tahu with a focus on Māori provider development and with an established affiliated local and South Island Māori provider network.
- **Te Tumu Whakahaere** – The senior Māori health managers forum that sits across Canterbury hospital and secondary care services.
- **Te Kāhui o Papaki Ka Tai** – The joint Māori health advisory group to Pegasus Health IPA and Partnership Health Canterbury PHO.
- **Canterbury Māori and Pacific Provider Forum** – Members are those Māori and Pacific providers that hold Canterbury DHB health contracts. The forum enables providers to engage with the DHB's Planning & Funding division as a collective group.

2 THE CANTERBURY MĀORI POPULATION & THEIR HEALTH NEEDS[1]

Approximately 33,417 people in Canterbury identified as Māori in the 2006 Census, making up 7.2% of the whole Canterbury population and 5.9% of the New Zealand Māori population. This group was composed of 13,629 people who indicated only Māori ethnicity and 19,788 who indicated Māori ethnicity among others.

Ngāi Tahu/Kāi Tahu are the Manawhenua for the Canterbury region. The most common iwi affiliations are Ngāi Tahu/Kāi Tahu (29%), Ngāpuhi (11.1%) and Ngāti Porou (8.9%), though over 120 iwi are represented in Canterbury.

As with the national Māori population, Māori in Canterbury are youthful compared to non-Māori and have a higher fertility rate, meaning that the growth of the Māori population is faster than that of the non-Māori population.

- From 2001 to 2006, there was a 16% increase in the size of the Māori ethnic group, with the proportion of people indicating Māori ethnicity in the total Canterbury population increasing from 6.7% to 7.2%. By 2021, Māori are predicted to make up 9.2% of the total Canterbury population.
- 34.5% of the Canterbury Māori population is under the age of 15, compared to 18% for non-Māori.
- The proportion of the Māori population in Canterbury that is aged over 65 years is projected to double from 3.3% in 2006 to 6.6% in 2021.

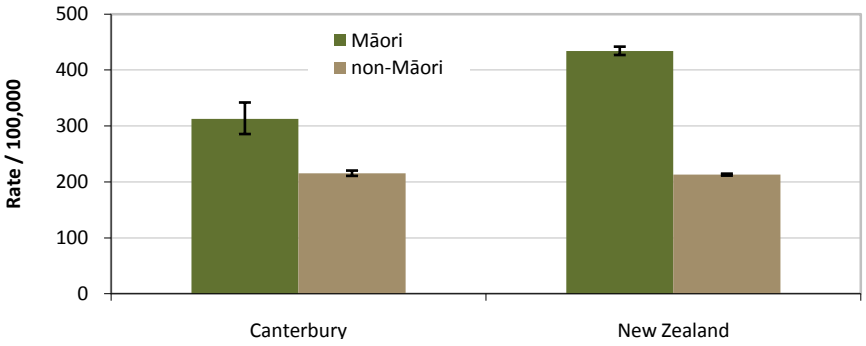
2.1 Overall health status and access

In general, Māori in Canterbury have better health than Māori nationally, but poorer health than non-Māori in Canterbury.

2.1.1 Mortality

All-cause mortality is significantly higher for Māori than non-Māori in Canterbury, but lower than that for Māori at the national level, where there is a greater difference between Māori and non-Māori.

Figure 1 All-cause mortality, all ages, Canterbury and New Zealand, 2000-2004[2]



The leading causes of death for Māori in Canterbury are circulatory system diseases, cancer, accidents, respiratory diseases, and endocrine, nutritional and metabolic diseases (mostly Type 2 diabetes). For all of these, the mortality rate for Māori is significantly higher than for non-Māori. Compared to non-Māori, Māori in Canterbury are:

- More than five times as likely to die from type 2 diabetes;
- Almost twice as likely to die from accidents;
- One and a half times as likely to die from cardiovascular or respiratory disease; and
- One and a third times as likely to die from cancer.

Mortality from external causes of injury is higher for Māori in Canterbury than non-Māori, particularly for deaths due to drowning, fires and accidental poisoning.

[1] *Much of the following is draw from Hauora Waitaha – A health profile for Māori in Canterbury (2010, Dr Matthew Reid, CDHB).*
[2] *Source: Te Rōpū Rangahau Hauora a Eru Pōmare*

2.1.2 Hospitalisation

The overall rate of hospitalisation is lower for Māori than non-Māori in Canterbury, in contrast to a higher rate for Māori than non-Māori nationally. Māori in Canterbury also have lower rates of hospitalisation than Māori nationally, both overall and for every major cause. Compared to non-Māori, Māori in Canterbury have:

- Higher rates of hospitalisation for pregnancy and childbirth, respiratory disease, mental and behavioural disorders and circulatory diseases.
- Lower rates of hospitalisation for injury and poisoning, and digestive system disease.

2.1.3 Health service utilisation

In terms of health service utilisation:

- PHO enrolment is lower for Māori in Canterbury than for 'Other' ethnicities. Māori are more likely to have had an unmet need for a general practitioner.
- Māori in Canterbury are under-represented in hospital activity.
- Spending per capita on prescriptions and laboratory testing is lower for Māori in Canterbury.
- A lower proportion of older Māori in Canterbury are living in Aged Residential Care facilities.

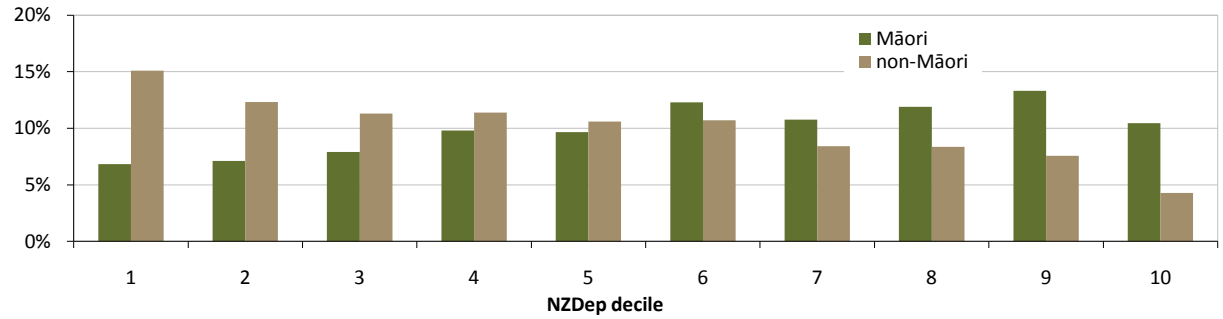
2.2 Disease prevention

Many of the outcomes for which Māori in Canterbury fare worse than non-Māori have a strong association with socio-economic status, as well as with smoking and other risk factors.

2.2.1 Social circumstances

Māori in Canterbury live in relatively more deprived areas than non-Māori, but in relatively less deprived areas than Māori nationally. The general Canterbury population is also less deprived than the New Zealand population.

Figure 2 Deprivation profile, Canterbury, 2006[3]



With respect to individual socio-economic indicators, Māori are more socio-economically disadvantaged compared to non-Māori in Canterbury. The differences in age-structure between the two populations contribute to differences in socio-economic status, but Māori in Canterbury are more deprived than non-Māori in terms of factors such as income, unemployment, educational qualifications, home ownership, household crowding and phone and motor vehicle access.

2.2.2 Risk factors

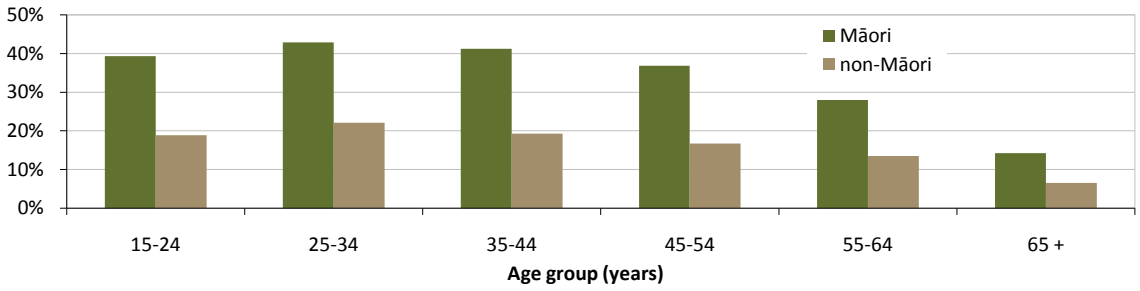
Māori in Canterbury have a higher prevalence of obesity than non-Māori and appear to have a higher prevalence of hazardous drinking and marijuana use.

The prevalence of smoking is also higher for Māori in Canterbury than non-Māori, especially for females and young people, but lower than for Māori nationally. Māori women in Canterbury are almost two and a half times more likely to smoke than non-Māori; two in every five Māori women are current daily smokers. While youth smoking is decreasing

[3] *Source: Statistics New Zealand 2006 Census*

over time, more than four times as many Māori Year 10 students smoke daily than non-Māori, and a higher proportion of Māori than non-Māori young people are exposed to smoke at home.

Figure 3 Current regular smokers, 15+ years, by age group (age-standardised), Canterbury, 2006[4]



2.3 Child and youth health

Together, children and young people (aged 0 to 24) make up over half (54.6%) of the Māori population in Canterbury (compared with 32.3% of non-Māori).

- Immunisation coverage is slightly lower for Māori in Canterbury than non-Māori, but significantly higher than for Māori nationally.
- Māori children in Canterbury have poorer oral health status than non-Māori in Canterbury and Māori living in fluoridated areas of New Zealand, but better than Māori living in other non-fluoridated areas nationally.
- The rate of hearing test failure at school entry is higher for Māori children than 'Others' in Canterbury, as is the rate of admission for grommets insertion.

2.3.1 Maternity

The rates of preterm birth, low birthweight and infant mortality appear higher for Māori than Europeans, while the rate of breastfeeding is lower. This suggests a relationship between higher risk (preterm birth and low birth weight) and lower protective (breastfeeding) factors for infants, and worse outcomes in terms of mortality. The rate of teenage pregnancy is much higher for Māori than for Europeans in Canterbury.

2.4 Chronic conditions

Māori in Canterbury suffer from a significant burden of long-term conditions, with four of the five leading causes of death for Māori in Canterbury associated with chronic conditions: cardiovascular disease, cancer, respiratory disease and endocrine/nutritional/metabolic diseases such as diabetes.

2.4.1 Cardiovascular disease (CVD)

Māori in Canterbury have a larger burden of cardiovascular disease in terms of mortality and hospitalisation, but this is smaller than for Māori nationally.

- For ischaemic heart disease, the mortality rate is higher for Māori in Canterbury than non-Māori, but hospitalisation rates are the same, suggesting an area of unmet need for Māori.
- Canterbury Māori have a lower rate of angioplasty and a higher rate of coronary artery bypass grafting than non-Māori, which may indicate a higher level of disease severity among Māori.
- Stroke mortality and hospitalisation rates are not significantly different for Māori and non-Māori in Canterbury, but the rates for Māori in Canterbury are significantly lower than for Māori nationally.

[4] *Source: Statistics New Zealand Census 2006*

2.4.2 Cancer

Although incidence and mortality from cancer are lower for Māori in Canterbury than nationally, Canterbury Māori have a larger burden of cancer than non-Māori in Canterbury. Incidence overall for Māori is lower, but the mortality rate for Māori is higher than that for non-Māori. In Canterbury:

- Lung cancer incidence and mortality rates are higher for Māori than non-Māori.
- Incidence of colorectal cancer is lower for Māori, but there is no difference in the mortality rate.
- Incidence of breast cancer is the same for Māori and non-Māori, but the mortality rate is higher for Māori.

Māori in Canterbury with various forms of cancer seem therefore to die more frequently from those cancers than non-Māori. In keeping with this, screening coverage rates for breast and cervical cancer are lower for Māori than non-Māori (though breast screening rates improved dramatically in 2009/10), and this suggests an area of unmet need for Māori.

2.4.3 Respiratory disease

Respiratory disease mortality and hospitalisation rates are higher for Māori than non-Māori in Canterbury, but lower than for Māori nationally. Māori are hospitalised more than non-Māori in Canterbury for asthma, chronic obstructive pulmonary disease and bronchiectasis, but less than Māori nationally. Respiratory disease presents an area of opportunity for early intervention to improve outcomes for Māori.

2.4.4 Diabetes

Canterbury Māori mortality, hospitalisation and complications rates for diabetes are much higher than for non-Māori, but lower than for Māori nationally. A lower proportion of Māori in Canterbury have annual diabetes reviews and retinal screening than non-Māori, suggesting important unmet need for Māori with diabetes in Canterbury.

2.4.5 Mental health

Māori in Canterbury access mental health services more than non-Māori, but at a level lower than the target set by the Mental Health Commission (based on population and prevalence estimates).

- The rates of hospitalisation for schizophrenia, manic episodes, bipolar disorder and psychoactive substance use disorders are higher for Māori than for non-Māori in Canterbury.
- The overall rate of hospitalisation for Māori for mental health problems is similar in Canterbury and nationally, although lower for schizophrenia and higher for psychoactive substance use and depression.

The World Health Organisation predicts that depression will be the second highest cause of death and disability globally by 2020, so this is a potential area of future focus for improving Māori health.

2.5 Earthquake Impact

The February earthquake has had a damaging impact on the health and wellbeing of people in Canterbury, and many of our worst-affected communities have proportionally higher Māori populations.

Cantabrians face colder homes, increased stress and overcrowding in homes, schools and workplaces. These factors increase their vulnerability to both mental and physical illness. Many families have shifted from their homes and are effectively disconnected from their usual primary care networks. Other families that have stayed in their homes face different challenges that have interrupted their usual routines and health-seeking behaviours. Loss of personal income and interruption of transport links present further barriers in accessing health care. Health services also sustained significant damage, impacting on our system's ability to deliver health and disability care at our usual levels.

We will continue to encourage people to engage with primary care as their point of continuity for health care provision. However, it is expected that the focus of whānau and primary health teams on immediate issues will see less priority being placed on routine recalls and systematic management of long term conditions. In addition, population shifts have shifted baseline assumptions, making prediction of achievement against normal measures challenging. Accordingly, targets have not been set for the Health Targets relating to long term conditions (diabetes and CVD) and immunisation. Despite this lack of official targets, providers will be encouraged and supported to re-engage with their populations and bring standards of care back up to prior levels. Performance against these measures will continue to be reported.

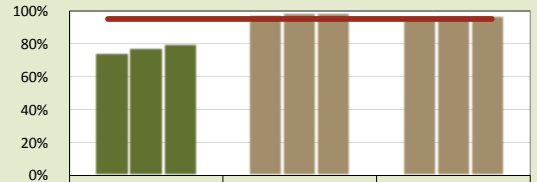
3 NATIONAL MĀORI HEALTH PRIORITIES

The following priorities and associated indicators for Māori health have been identified nationally. Identified alongside each is a list of the key actions and activity Canterbury is undertaking over the coming year to address the priority area and reach the targets set.

3.1 Data quality

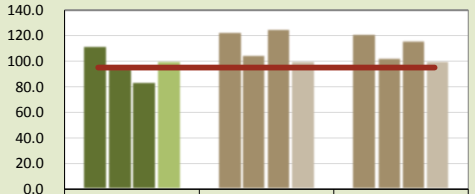
Objective	Planned Actions & Activity 2011/12	Indicator
Improve the accuracy of ethnicity reporting. Collecting robust quality ethnicity data allows us to monitor trends and performance by ethnicity, enabling health planners, funders and providers to design and deliver better services for our community that improve health outcomes and reduce inequalities.	▪ Regularly review and compare PHO ethnicity data for accuracy and follow up with any PHOs with more than 2% of their population 'Not Stated'. ▪ Monitor our hospital ethnicity data quarterly to ensure that less than 2% has ethnicity 'Not stated' or 'Response Unidentifiable' in the National Health Index. ▪ Train frontline administrators to improve data capture.	Accuracy of ethnicity reporting in PHO registers. *Data to be provided by MoH annually.*

3.2 Access to care

Objective	Planned Actions & Activity 2011/12	Indicator
Promote early intervention through greater Māori engagement in primary care. Primary care is the point of continuity in health – providing services from disease prevention and management through to palliative care. Increasing PHO enrolment and thus access to primary care services will improve early intervention and reduce health disparities between Māori and non-Māori.	▪ Monitor PHO enrolment data, with particular focus on Māori enrolment, and identify any changes in the proportion of the populations enrolled with primary care. ▪ Continue to support a range of PHO-based initiatives to promote Māori enrolment, including community events, work with community groups and the use of health promoters and community workers to focus on high need populations. ▪ Ensure PHOs have approved Māori Health Plans in place and monitor the implementation of these.	The percentage of the population enrolled in a PHO. [5] 

	Maori	Non-Maori	Total
2007/08	74.8%	97.4%	95.7%
2008/09	77.6%	98.8%	97.1%
2009/10	79.7%	99.0%	97.4%
Target	95%		

[5] *Not all people who identify as Māori on their Census identify as Māori when they enrol with a general practice, so it is impossible to accurately measure if all Māori are enrolled with a PHO.*

Objective	Planned Actions & Activity 2011/12	Indicator
Improve access to care and early intervention to reduce avoidable hospital admissions amongst Māori. Some admissions to hospital are for conditions which are seen as preventable through appropriate early intervention and a reduction of risk factors. As such, these admissions provide an indication of the access and effectiveness of screening, early intervention and the continuum of care across the system. The rate of preventable hospitalisations for Māori in Canterbury is lower than the national rate and the rate for non-Māori in Canterbury, which is positive. However, it still highlights opportunities to better support people to seek intervention early and manage their long-term conditions. A reduction in these admissions will reflect better management and treatment of Māori across the whole of the system. In particular, the 0-4 age group has been selected for special focus because it facilitates interventions for young children. *Note: As these measures reflect effectiveness across the entire health system for a range of preventable conditions, many of the actions listed elsewhere in this plan will contribute towards this indicator.*	▪ Monitor ASH admissions, following up on any trends (too low or too high) and identifying areas of significance for Māori to support future service planning and delivery. ▪ Support the implementation of the Canterbury Clinical Network Māori Health work stream, including regular input into Māori community events and workshops that support primary healthcare teams to provide care to Māori whānau consistent with the emerging direction on whānau ora.[6] ▪ Support the establishment of integrated family health centres to enable multidisciplinary teams to deliver care and support closer to people own homes and communities. ▪ Continue to expand the range of clinical pathways agreed between general practice and hospital based specialists In order to ensure that patients receive the right care at the right time from the right provider, reducing unnecessary hospital admissions and reducing waiting times. ▪ Support rural Canterbury's rollout of the 'Warm Families' programme and coordinate the Warm Homes for Elder New Zealanders study via our Community and Public Health. ▪ Promote marae-based dietary education and the Health Promoting Schools programme, which targets schools with a high proportion of Māori children.	The ratio of actual to expected ambulatory sensitive (avoidable) hospital admissions for those aged 0-4.[7]  		Maori	Non-Maori	Total
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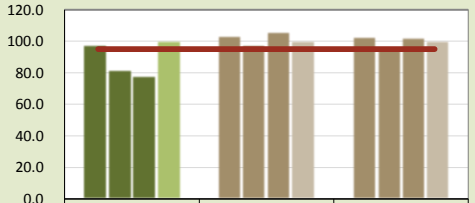
2007/08	111.9	123.3	121.3
2008/09	94.6	105.3	103.5
2009/10	83.5	125.1	116.1
National Average	100.0	100.0	100.0
Target	95		| Ratio of ASH admissions for those aged 0-74.[7]  |	Maori	Non-Maori	Total
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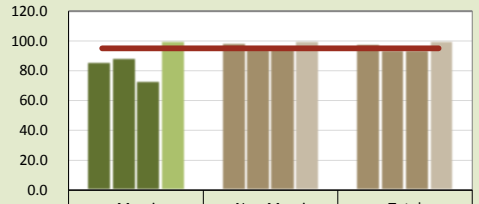
2007/08	97.5	103.5	102.8
2008/09	82.0	98.0	96.3
2009/10	78.4	106.0	102.3
National Average	100.0	100.0	100.0
Target	95		

[6] *The Canterbury Clinical Network (CCN) is an alliance of health professionals from across the Canterbury health system, including the DHB. Together, we are implementing our 'Better, Sooner, More Convenient' business case.*

[7] *Avoidable or 'ambulatory sensitive' hospital admissions are based on admissions for 26 conditions including: asthma, diabetes, angina and chest pain, vaccine-preventable diseases, dental conditions and gastroenteritis. The expected ambulatory sensitive admission rate is the age-group specific national average admission rate, and a ratio greater than 100 indicates performance worse than the national average. Data is dependent upon availability from MoH and may not exactly match financial years (e.g. 09/10 figures are for the year to September 2010).*

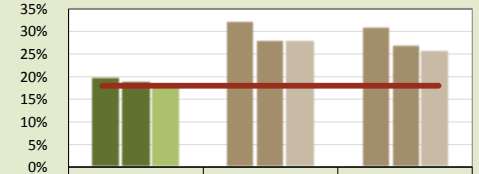
Objective	Planned Actions & Activity 2011/12	Indicator
		Ratio of ASH admissions for those aged 45-64.[7]



	Maori	Non-Maori	Total
2007/08	86.1	98.8	97.7
2008/09	88.6	94.7	94.2
2009/10	73.6	96.1	93.8
National Average	100.0	100.0	100.0
Target	95		

3.3 Maternal health

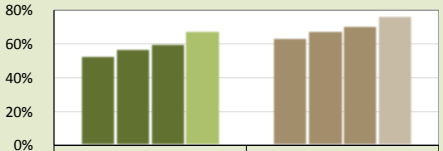
Objective	Planned Actions & Activity 2011/12	Indicator
Promote breastfeeding to give tamariki a healthy start to life. High quality maternity services provide a key foundation for ensuring healthy families and children. In particular, ensuring new mothers can establish breastfeeding and increasing confidence levels in their ability to parent provides a positive start to life for tamariki. Breastfeeding also contributes positively to infant health and wellbeing.	▪ Monitor breastfeeding rates against the national DHB performance targets, and identify areas of significance for Māori to support future service planning and delivery. ▪ Continue to achieve 'Baby Friendly Hospital' accreditation across al CDHB maternity facilities. ▪ Work with Tamariki Ora providers to identify strategies to support mothers to continue breastfeeding to six months. ▪ Invest in training volunteer mothers to provide Mum 4 Mum breastfeeding peer support in communities and workplaces. ▪ Implement the Canterbury DHB Breastfeeding Action Plan.	The percentage of infants exclusively and fully breastfed at 6 months.[8]



	Maori	Non-Maori	Total
2008	19.9%	32.4%	31.3%
2009	19.1%	28.2%	27.3%
National Average	18.6%	28.3%	26.0%
Target	18%		

[8] *Breastfeeding data for the national SI7 measure is received annually from the Ministry. It is reported for calendar years, rather than financial years, and is from Plunket only.*

3.4 Cardiovascular disease (CVD)

Objective	Planned Actions & Activity 2011/12	Indicator
Improve early detection and reduce the burden of cardiovascular disease amongst Māori. CVD includes coronary heart disease, circulation, stroke and other diseases of the heart. Māori have higher rates of CVD hospitalisations and mortality, and CVD is the leading cause of death for Canterbury Māori. CVD is strongly influenced by risk behaviours such as poor nutrition, lack of physical activity and tobacco smoking. Through prevention, early intervention and management support, we can reduce inequalities and the burden of CVD amongst Māori. *Note: Prevention initiatives supporting nutrition, physical activity and smoking cessation are covered in sections 3.2 and 3.7.*	▪ Monitor CVD risk assessment rates against the national health target, and identify areas of significance for Māori to support future service planning and delivery. ▪ Canterbury's PHOs, participate in the CVD risk assessment component of the PHO Performance Programme, with special focus on Māori as a high need group.[9] ▪ Support the implementation of the CCN Māori Health work stream actions including delivery of the Māori Diabetes/CVD Screening Programme to improve CVD detection and management. ▪ Continue to improve engagement and outcomes for the Māori adult population with heart disease, via the Māori mobile nursing disease state management service. ▪ Develop a new cardiology pathway (through our Canterbury Initiative Programme) to ensure consistent and seamless CVD care across community and hospital-based settings. ▪ Continue to support cardiac and stroke rehabilitation to support people to recover and regain independence following an acute event.	The percentage of the eligible population who have had a fasting lipid/glucose test (indicating CVD risk assessment) in the past five years.[10]  The number of tertiary cardiac interventions (no target, information only).

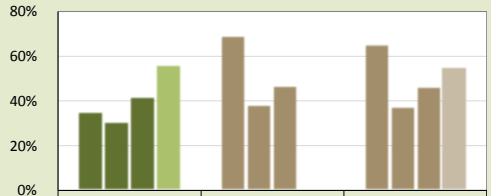
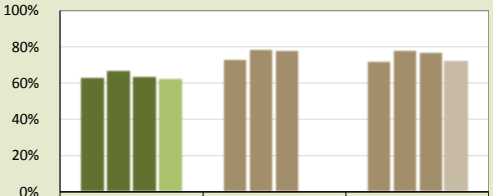
	Maori	Total
2007/08	53.2%	63.9%
2008/09	57.0%	67.6%
2009/10	60.4%	70.9%
National Average	68.0%	76.5%

	Māori	Non-Māori	Total
08/09	10	232	242
09/10	9	266	275

[9] *The PHO Performance Programme (PPP) is a national programme designed to improve the health of enrolled populations and reduce inequalities in health outcomes by supporting clinical governance and rewarding quality improvement within PHOs. Improvements in performance against a range of nationally consistent indicators result in incentive payments to PHOs.*

[10] *Following the February earthquake, a significant number of people are displaced from their homes and workplaces. While this group is being supported to attend primary care, this may not be at their usual general practice – disrupting normal recall systems and processes. Hence, explicit targets have not been set for 2011/12 against the national immunisation, diabetes or CVD health targets. The DHB will continue to work towards regaining prior performance levels and will monitor and report performance against these indicators.*

3.5 Diabetes

Objective	Planned Actions & Activity 2011/12	Indicator
Improve early detection and support good diabetes management amongst Māori. Diabetes can lead to amputation, blindness, heart disease and kidney failure – presenting both a significant disease burden for patients and a large cost to the health sector. Rates of diabetes are increasing, particularly for Māori, with rates about three times higher than other New Zealanders. Canterbury Māori are over five times more likely to die from Type II diabetes than non-Māori. Type II diabetes is strongly linked to poor nutrition and other lifestyle factors and is therefore amenable to prevention. Through prevention, early intervention and management support, we can reduce inequalities and the disease burden of diabetes amongst Māori. *Note: Prevention initiatives supporting nutrition, physical activity and smoking cessation are covered in sections 3.2 and 3.7.*	▪ Monitor diabetes review and management rates against the national health target, and identify areas of significance for Māori to support future service planning and delivery. ▪ Canterbury's PHOs, participate in the diabetes component of the PPP, with special focus on Māori as a high need group. ▪ Support the implementation of the CCN Māori Health work stream actions including delivery of the Māori Diabetes/CVD Screening Programme to improve CVD detection and management. ▪ Invest in an Integrated Diabetes Service, modelled on the successful Integrated Respiratory Service and promote diabetes management guidelines and referral pathways via the HealthPathways website.[11] ▪ Provide education to those newly diagnosed with Type II diabetes and to those starting insulin in general practice. ▪ Continue to work to engage and improve outcomes for the Māori adult population with diabetes, via the Māori mobile nursing disease state management service.	The percentage of the population expected to have diabetes who have had a diabetes annual review.[12]  The percentage of those having a DAR who have satisfactory diabetes management (HbA1c ≤ 8%)[12] 

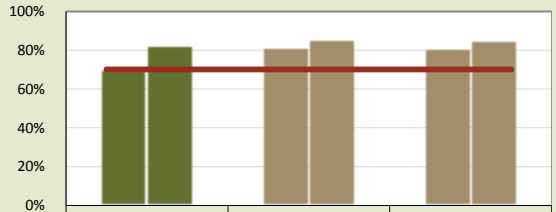
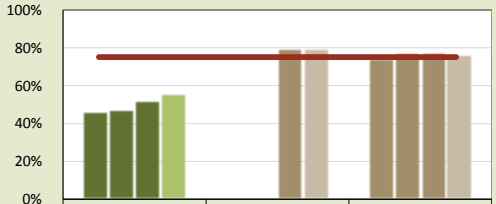
	Maori	Non-Maori	Total
2007/08	35.1%	69.0%	65.4%
2008/09	30.7%	38.2%	37.7%
2009/10	41.8%	46.7%	46.4%
National Average	55.8%		55.0%

	Maori	Non-Maori	Total
2007/08	63.5%	73.4%	72.8%
2008/09	67.3%	78.9%	78.3%
2009/10	64.2%	78.2%	77.4%
National Average	62.8%		72.8%

[11] *The HealthPathways website www.healthpathways.org.nz contains clinically developed information and resources specifically to help Canterbury general practice through consistent pathways across the primary/secondary sectors, including information on referrals, specialist advice, diagnostic tools, GP to GP referral and GP procedure subsidies. The pathways inform patient-centred models of care and remove traditional boundaries by ensuring services are delivered in the most appropriate and convenient settings.*

[12] *Refer to footnote 10 for explanation about the absence of targets. Diabetes data is reported one quarter in arrears. In December 2010 the Ministry revised its estimate of diabetes prevalence for the 2010/11 year. This lower prevalence is only used in the calculation of the 2010/11 figures, as corresponding revised estimates for prior years were not available.*

3.6 Cancer

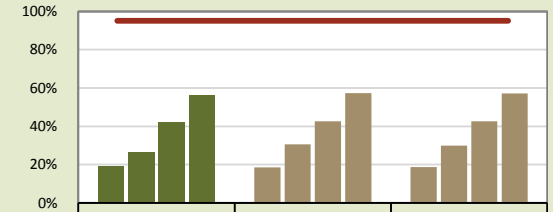
Objective	Planned Actions & Activity 2011/12	Indicator
Improve early detection and reduce the disease burden of cancer amongst Māori. Cancer is the second highest cause of death for Māori in Canterbury and a major cause of hospitalisation. At least one third of cancers are preventable, and the impact and death rate of cancer can be reduced through early detection and treatment. Māori in Canterbury are one and a third times more likely to die from cancer than non-Māori, even though incidence of cancer overall is lower for Māori than non-Māori. This suggests an area of unmet need for Māori and highlights the importance of cancer screening to ensure early detection and treatment. *Note: Prevention initiatives supporting nutrition, physical activity and smoking cessation are covered in sections 3.2 and 3.7.*	▪ Monitor Cancer screening rates for the national programmes, and identify areas of significance for Māori to support future service planning and delivery. ▪ Canterbury's PHOs, participate in the cervical and breast screening components of the PPP, with special focus on Māori as a high need group. ▪ Support interaction between PHOs and organisations such as He Waka Tapu and screening providers to encourage the participation of Māori women in screening programmes. ▪ Invest in community-based promotion to educate, recruit and retain women into the cervical screening programme and overcome barriers such as embarrassment, finances and transport.	The percentage of women aged 45-69 screened under the BreastScreen Aotearoa (BSA) programme.[13]  The percentage of women aged 20-69 screened under the National Cervical Screening Programme (NCSP).[13] 

	Maori	Non-Maori	Total
2008/09	69.9%	81.4%	81.0%
2009/10	82.3%	85.2%	85.0%
Target	70%		

	Maori	Non-Maori	Total
2007/08	46.0%		74.4%
2008/09	47.0%		77.1%
2009/10	51.7%	79.6%	77.8%
National Average	55.5%	79.6%	76.2%
Target	75%		

[13] *Breast and cervical screening data is reported one quarter in arrears.*

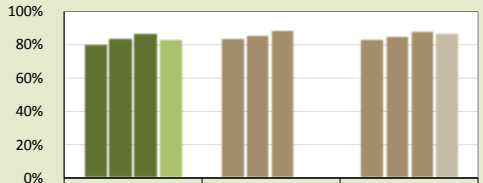
3.7 Smoking

Objective	Planned Actions & Activity 2011/12	Indicator
Reduce the prevalence of smoking and smoking-related harm amongst Māori. Tobacco smoking contributes to a number of preventable illnesses and long-term conditions, resulting in a large burden of disease. In addition to the high public cost of treating tobacco-related disease, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Tobacco control remains the foremost opportunity to rapidly reduce inequalities and improve Māori health.	▪ Monitor smoking advice rates against the national health targets, and identify areas of significance for Māori to support future service planning and delivery. ▪ Continue to implement the ABC Strategy[14] in all Canterbury DHB hospitals, including offering smokers support such as NRT, Quitpacks and referrals to Quitline and Aukati Kaipaipa smoking cessation services. ▪ Continue to work collaboratively with Canterbury PHOs to take a consistent approach to implementing the PPP smoking cessation national goal. (All three PHOs also maintain evidence-based smoking cessation programmes.) ▪ Support Auahi Kore (Smokefree) public places, such as schools, early childhood centres, Kohanga Reo and marae. ▪ Carry out controlled purchase operations to identify retailers selling tobacco products to minors and provide education to retailers to increase compliance rates.	The percentage of hospitalised smokers who are provided with advice and help to quit.[15]  The percentage of current smokers enrolled in a PHO who are provided with advice and help to quit.[16] *Data to be provided by MoH annually.* ***Target: 90%***

	Maori	Non-Maori	Total
Q1 09/10	19%	19%	19%
Q2 09/10	27%	31%	30%
Q3 09/10	42%	43%	43%
Q4 09/10	56%	57%	57%
Target	95%		

[14] *The ABC Strategy for Smoking Cessation involves staff Asking whether the patient smokes (A), offering Brief advice to quit (B) and referring the patient to Cessation support (C).*
[15] *The hospital programme for the smoking cessation health target began in 2009. Baseline data prior to the 2009/10 year is therefore not available.*
[16] *At the time of writing, no data was available to the DHB for this measure while the Ministry reviewed the PPP data submitted by PHOs.*

3.8 Immunisation

Objective	Planned Actions & Activity 2011/12	Indicator
Increase immunisation amongst vulnerable Māori population groups to reduce the prevalence and impact of vaccine-preventable diseases. Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups. While Canterbury has high immunisation rates for both Māori and non-Māori, these high rates must be maintained or improved in order to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough). *Note: Prior to the 22 February earthquake, immunisation of Māori two year olds had reached 90%. However, the earthquake has displaced many people from their homes and workplaces. While this group is being supported to attend primary care, this may not be at their usual general practice – disrupting normal recall systems and processes and impacting immunisation rates.*	▪ Monitor immunisation rates against the national health target, and identify areas of significance for Māori to support future service planning and delivery. ▪ Canterbury's PHOs, participate in the childhood immunisation and 65+ flu vaccination components of the PPP, with special focus on Māori as a high need group. ▪ Support the Immunisation Service Level Alliance to develop new promotion strategies, monitor key performance indicators for service providers and improve the quality of immunisation services in Canterbury. ▪ Temporarily expand missed events administration and outreach services to track, find, recall and immunise 'hard to reach' referrals and children dislocated from their usual general practice. ▪ Expand access to immunisation for children in secondary health care settings. ▪ Ensure the seasonal influenza campaign is widely promoted.	The percentage of two year olds who are fully immunised.[10]  |	Maori	Non-Maori	Total
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2007/08	81%	84%	84%
2008/09	84%	86%	86%
2009/10	87%	89%	89%
National Average	83%		87%	 The percentage of the eligible population (aged 65+) who have had a seasonal influenza vaccination. *Data to be provided by MoH six-monthly.* ***Target: 75%***

3.9 Workforce

Objective	Planned Actions & Activity 2011/12	Indicator
Strengthen and develop our Māori health workforce. Māori health workforce development aims to build a competent, capable, skilled and experienced Māori health and disability workforce which contributes to the improvement of health of our community. Increasing the number of Māori in the health and disability workforce will lead to greater understanding of Māori health needs, and by osmosis, improved culturally responsive services by other staff. Māori health workforce development will also expand the skill base of the Māori health and disability workforce and enable equitable access for Māori to training opportunities.	▪ Encourage staff to identify ethnicity on employment. ▪ Support the delivery of the national Kia Ora Hauora Māori Health workforce development programme, aimed at increasing the overall number of Māori working in the health and disability sector by promoting health as a career choice for Māori and recruiting Māori into health career pathways. ▪ Provide up to 10 local scholarships to Māori and Pacific students who wish to undertake health-related study, targeting in particular those wishing to work in primary care.	The percentage of Māori staff employed by the DHB by occupation class: management, clinical and administrative. (No target, information only.)[17]

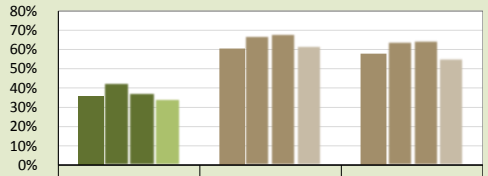
	Manage	Clinical	Admin
Māori	2.8%	2.0%	2.0%
Not stated	5.2%	5.4%	8.7%

[17] *Historical data is not available for this measure; the figures shown were extracted in February 2011. Ethnicity is captured at employee start up; however, it is not a mandatory field and there is a high proportion of 'Not Stated'. Only one ethnicity is recorded, but some staff may identify as more than one ethnicity. There are issues around 'occupational type', as an employee can have more than one role (e.g. a doctor who is a manager).*

4 REGIONAL MĀORI HEALTH PRIORITIES

Working collaboratively, the five South Island DHBs have identified the following priorities for Māori health in the South Island region, in addition to those identified nationally. Identified alongside each is a list of the key actions and activity Canterbury is undertaking over the coming year to address the priority area and reach the targets set.

4.1 Oral health

Objective	Planned Actions & Activity 2011/12	Indicator
Improve oral health for tamariki. Regular dental care has lifelong health benefits. As less than 5% of children in Canterbury have access to fluoridated water, prevention and education initiatives are essential to good oral health. Good oral health also indicates early contact with effective health promotion and reduced risk factors, such as poor diet. Māori children are three times more likely to have decayed, missing or filled teeth. Oral health therefore presents an opportunity to reduce inequalities and improve the targeting of those most in need.	▪ Monitor oral health rates against the national DHB performance targets, and identify areas of significance for Māori to support future service planning and delivery. ▪ Implement the Canterbury DHB Oral Health Business Case with a focus on engagement Māori children in DHB-funded dental health services. ▪ Work with the other South Island DHBs to investigate regional options for oral health promotion targeting Māori whānau. ▪ Work with Well Child/Tamariki Ora providers and general practice to implement a risk-based, targeted oral health preventive care programme for children up to 12 years.	The percentage of children caries-free (no holes or fillings) at age 5.[18] 

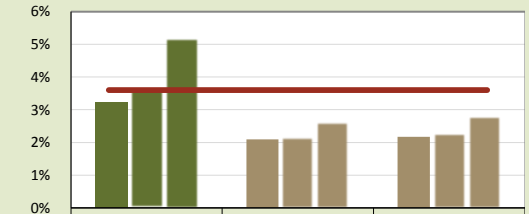
	Maori	Non-Maori	Total
2007	35.6%	60.5%	57.8%
2008	42.8%	67.0%	64.3%
2009	37.6%	68.4%	65.0%
National Average	34.6%	61.8%	55.6%

[18] *Oral health data for the national PP11 measure is collected against school year data and reported annually on calendar years.*

4.2 Elective surgery

Objective	Planned Actions & Activity 2011/12	Indicator
Ensure Māori receive equitable access to elective surgery. Elective services are non-urgent procedures and operations that improve people's quality of life. In delivering elective surgical services to our population, we need to ensure equitable access to these services across the Te Waipounamu and also in comparison with the South Island non-Māori populations and the national Māori population.	▪ Working with the other South Island DHBs, review elective surgical data (including cardiology and dental) to determine whether Māori have equitable access to elective services. ▪ Collectively establish baseline data and definitions for future monitoring and determine future regional priorities.	The percentage of the population accessing elective surgery (including cardiology and dental). ***Baselines and targets to be established.***

4.3 Mental health

Objective	Planned Actions & Activity 2011/12	Indicator
Improve mental health status and care for Māori. Mental illness significantly affects a person's quality of life, and mental health access rates in Canterbury suggest a higher burden of mental illness amongst Māori. Our system of mental health is based on a recovery approach for people with serious mental illness. We aim to provide a balance of specialist hospital services and community-based care, with increased collaboration between providers, service users and their families/whānau.	▪ Monitor access rates against the national DHB performance targets, and identify areas of significance for Māori to support future service planning and delivery. ▪ Support the Canterbury Māori and Pacific provider forum, to raise awareness among mainstream providers of the capacity and capability of Māori mental health providers. Develop patient pathways that support access to tailored, culturally appropriate mental health options for Māori. ▪ Ensure long term mental health clients have current relapse prevention plans in place to support recovery. ▪ Invest in earthquake-related mental health services that support people in more vulnerable situations during Canterbury's recovery period.	The percentage of adults (20-64) accessing specialist mental health services in hospital or community settings.[19]  |	Maori	Non-Maori	Total
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2007/08	3.2%	2.1%	2.2%
2008/09	3.6%	2.2%	2.3%
2009/10	5.2%	2.6%	2.8%
Target	3.6%		

[19] *The reporting period for this measure is lagged three months (i.e. each year's figures are for the 12 months to 31 March). This measure includes both our DHB Specialist Mental Health Services, and also specialist mental health services provided by NGOs. This data covers only those Canterbury specialist mental health NGOs that are submitting NHI additional reporting. The number of providers submitting this reporting is gradually increasing; therefore, previous years' data is directly comparable as it includes fewer providers. Non-specialist mental health services, such as brief intervention counselling in primary care, are not included.*

4.4 Whānau ora

Objective	Planned Actions & Activity 2011/12	Indicator
Ensure that Māori and their whānau are supported to achieve Whānau Ora. Whānau Ora is an inclusive approach to providing services and opportunities that empowers whānau as a whole, rather than focusing separately on individual whānau members and their problems. Services should have a positive impact on the holistic health and wellbeing of the person and their family/whānau, and transitions between services should ensure seamless and consistent care. This requires multiple agencies to work together with whānau, rather than separately with individual whānau members.	▪ Work with the other South Island DHBs to develop a process that better supports patients and whānau when they are transferring between DHB services and assists people and their whānau to access Māori health support services when transferring to another DHB.	Establish a documented process for connecting whānau into support services at other DHBs when whānau are transferring between DHB services.

4.5 Workforce development

Objective	Planned Actions & Activity 2011/12	Indicator
Ensure that Māori service providers have strong management and governance. It is important to support Māori service providers to develop and maintain a high and current skill base, including strong management and governance skills. This ensures that they are best able to provide quality health and disability services to Māori.	▪ Work with the other South Island DHBs to develop a network of courses and development programmes for Māori service providers' management staff and a governance programme for Māori service providers' trustees/directors. ▪ Support Canterbury's Māori and Pacific Provider forum to develop a clinical leadership team as a collaborative partnership across all services. This team will seek to develop organisational support networks, supervision of non-clinical staff and planning development opportunities.	Establish a provider development programme for Māori service providers to support strong management and governance.

5 LOCAL MĀORI HEALTH PRIORITIES

In addition to those priorities already identified at a national and regional level, Canterbury has identified the following local priorities for Māori health in Canterbury. Identified alongside each is a list of the key actions and activity Canterbury is undertaking over the coming year to address the priority area and reach the targets set.

5.1 Respiratory health

Objective	Planned Actions & Activity 2011/12	Indicator
Improve early detection and promote respiratory health amongst Māori in Canterbury. Respiratory diseases, including chronic obstructive pulmonary disease (COPD), asthma and sleep disorders, are the fourth leading cause of death for Māori in Canterbury, and Māori have disproportionately higher rates of respiratory disease. Many of the risk factors associated with respiratory disease, such as smoking, poor nutrition and poor housing, heating and air quality, are preventable. Improved respiratory services present a major opportunity to improve Māori health outcomes. *Note: Prevention initiatives supporting respiratory health such as healthy housing, nutrition and smoking cessation are covered in sections 3.2 and 3.7.*	▪ Monitor uptake of respiratory programmes and identify areas of significance for Māori to support future service planning and delivery. ▪ Support the Integrated Respiratory Services to collaborate with Māori Health providers and deliver tailored respiratory programmes for Māori within the resources available. ▪ Continue to work to improve outcomes for the Māori adult population with lung disease, via the Māori mobile nursing disease state management service. The service will work collaboratively with the Canterbury Initiative and Integrated Respiratory Service and adopt the same integrated model of care.	The rate per 10,000 of people receiving a sleep assessment in the community.[20] **Māori** | **Non-Māori** | **Total** 09/10 | 6.27 | 10.96 | 10.59 ***Target*** | ***>6.27*** | - | - The rate per 10,000 of people attending a community pulmonary rehabilitation programme.[20] **Māori** | **Non-Māori** | **Total** 09/10 | 0.75 | 1.78 | 1.70 ***Target*** | ***>0.75*** | - | -

[20] *These measures only count delivery by community providers, excluding delivery by CDHB's Hospital and Specialist Services. Ethnicity recording was patchy during the first year (2009/10) of the programme.*

5.2 Tamariki ora

Objective	Planned Actions & Activity 2011/12	Indicator
Ensure tamariki in Canterbury get a healthy start. The B4 School Check is the final core Tamariki Ora check, which children receive at age four. It is free, and includes vision, hearing, oral health, height and weight. The check allows health concerns to be addressed early in a child's development, giving him/her the best possible start for school and later life. B4 School Check uptake is lower amongst Māori in Canterbury, so it also presents an opportunity to reduce inequalities.	▪ Monitor B4 Schools Check rates against the national DHB performance targets, and identify areas of significance for Māori to support future service planning and delivery. ▪ Support the PHO mobile engagement team, which will target Māori, Pacific and Quintile 5 children to improve B4 School Check rates and focus on 'hard to reach' children.	The percentage of children (aged four) receiving B4 Schools Checks. [21] Māori: 09/10: 51.2%; *Target*: *80%* Non-Māori: 09/10: 77.1%; *Target*: - Total: 09/10: 74.5%; *Target*: -

5.3 Cultural responsiveness of mainstream services

Objective	Planned Actions & Activity 2011/12	Indicator
Improve the cultural responsiveness of mainstream services in Canterbury. We aim to demonstrate a commitment to the Treaty of Waitangi by better understanding Māori values and culture to improve the effectiveness of services, and thus health outcomes. Improving cultural responsiveness enables our workforce to relate positively to Māori patients and whānau, and supports the provision of services that meet the needs of Māori communities.	▪ Deliver Treaty of Waitangi and Tikanga Māori training programmes and Te Reo Māori courses to CDHB staff. ▪ Support the CCN Māori Health work stream to develop workshops for primary healthcare teams to provide competent care to Māori whānau in a manner that is consistent with the emerging direction on whānau ora. ▪ Through the Māori and Pacific Provider Forum, develop provider profile packs to raise awareness in the community and across the health system of the service options available for Māori.	The number of Treaty of Waitangi and Tikanga Māori training programmes delivered across the DHB and PHOs in Canterbury.[22] ***Target: >50***

[21] *The B4SC Programme began in Canterbury in March 2009; therefore, full years' data is available only for 2009/10.*

[22] *Indicator includes Treaty of Waitangi and Māori cultural competency training programmes delivered by the Canterbury DHB, Rural Canterbury PHO, Partnership Health PHO and Pegasus Health. CDHB figures will include cultural training programmes for the Learning and Development unit and workshops organised by some DHB service units, but not the various one-off workshops given by other DHB Māori Health staff.*

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