

SECTION IV

PRIORITIES FOR COUNTIES MANUKAU

Chapter 13. Themes and priorities

Introduction

The District Health Board is expected to assess the needs of the populations it serves. Assessing health needs is a complicated process requiring information on current services (including community perceptions), epidemiology and the effectiveness of interventions. The health information presented in this document will be important in contributing to this assessment and the prioritisation of services. More work will be needed to both include community perspectives and incorporate evidence of effectiveness.

The work to date has focused on health services - collating available data from routinely collected population based statistics and health service contacts. The data is heavily weighted to hospital discharge data with information from outpatients and primary care being less prominent. The movement towards District Health Boards responsible for both primary and secondary care is an opportunity to address the difficulties in obtaining this information.

Principles for priority setting for health services

Increasingly health service managers are seeking a principled approach to priority setting that is both relevant and transparent. This approach aims to identify a set of principles on which resources might be allocated. Usually a number of different factors are considered and weighted depending on how much value is placed on them. Some of the factors that have been considered are listed below: -

- **Community priority**

The District Health Boards have a responsibility to involve local communities in discussions about the allocation of resources, and to build an understanding of the decisions made on behalf of these communities.

- **Important health problem**

The criteria for importance include the magnitude of the health problem in the population, the severity for the affected individual and the impact of the health problem (both social and health).

- **Effectiveness of potential interventions**

Measures of effectiveness include efficacy - whether or not an intervention is successful in ideal conditions. Use effectiveness - whether the intervention works in field conditions and in the absence of data on the above historical or programme experience. Cultural factors may also have an impact on effectiveness.

- **Cost**

The cost measures considered vary, but are usually linked to outcomes. They include economic tools such as cost-effectiveness and cost-utility analysis. Another tool that has been recommended is programme budgeting and marginal analysis (PMBA). PMBA involves a two-stage process. Firstly, current expenditure, outputs and outcomes

are identified for a particular service eg mental health. In the second phase, the services which would be purchased if additional funding were made available and the services which would be reduced if less funding was available, are identified. The costs and benefits of each move are identified and linked to outcomes. These tools appear to be more applicable within service priority setting.

- **System capacity**

The success of an intervention will be influenced by the ability of the overall health system to introduce and maintain it. There are four main components of system capacity: human resource management, support and supervision, logistics and financial management.

- **In line with national priorities**

Some priorities will have already been highlighted at a national level. This will influence the priorities for Counties Manukau Health Board. There may however be additional conditions or services that are important to the local community in Counties Manukau and some national priorities may be of lesser concern. National health priorities may affect local ones by, for example, determining the amount of funding available for certain service areas.

Other criteria have been used for priority setting including feasibility (within a time-frame), urgency and avoidance of duplication. In addition to the development of a rational priority setting system, an ethics framework has been developed - an accountability of reasonableness - for legitimate and fair decisions on setting priorities¹. To make legitimate and fair decisions on priorities, organisations must meet four conditions:

- (i) **Publicity** - Decisions and their rationales must be publicly accessible.
- (i) **Relevance** - These rationales must rest on evidence, reasons and principles that fair minded parties (managers, clinicians, patients and consumers in general) can agree are relevant to deciding how to meet diverse needs of a covered population under necessary resource constraints.
- (ii) **Appeals** - there must be a mechanism for challenge and dispute resolution, including the opportunity for revising decisions in light of further evidence or arguments.
- (iii) **Enforcement** - there must be either voluntary or public regulation of the process to ensure that the first three conditions are met.

¹ Singer PA. Medical Ethics. *BMJ* 2000;321:282-5.

New Zealand Health Strategy

The recent publication of the New Zealand Health Strategy² describes the way in which the government is hoping to achieve its goal of improving the health of the population and reducing health inequalities. In the document the government lists 61 objectives that it hopes to achieve and from these highlights 13 priority population health objectives for action for the medium and short term. These represent national priorities and are to:

- reduce smoking
- improve nutrition
- reduce obesity
- increase the level of physical activity
- reduce the rate of suicides and suicide attempts
- minimise harm caused by alcohol, illicit and other drug use to both individuals and communities
- reduce the incidence and impact of cancer
- reduce the incidence and impact of cardiovascular disease
- reduce the incidence and impact of diabetes
- improve oral health
- reduce violence in interpersonal relationships, families, schools and communities
- improve the health status of people with severe mental illness
- ensure access to appropriate child health care services including well child and family health care and immunisation.

To reduce inequalities in health status the strategy will work to ensure accessible and appropriate services for people from lower socio-economic groups, Maori and Pacific peoples.

These objectives could be condensed into 8 priority areas: **health inequalities, cancer** (including reduction in smoking), **diabetes, cardiovascular disease** (incorporating nutrition, smoking and physical activity), **mental health** (incorporating suicide, substance abuse and severe mental illness), **oral health, child health and violence**.

The New Zealand Health Strategy highlights five **service delivery** areas that the health sector should concentrate on in the short to medium term. These are public health, primary care, reducing waiting times for elective surgery, improving the responsiveness of mental health services, accessible and appropriate services for people living in rural areas. There are areas of overlap between these service priority areas and the health goals identified. The Strategy also focuses on key issues concerning quality that are needed to ensure the better performance of services. These include sector-wide continuous improvement mechanisms, individual rights, consultation, co-ordination, information management and technology, workforce development, and the evaluation of the Strategy.

² King A. *The New Zealand Health Strategy*. Wellington: Ministry of Health. December 2000

Counties Manukau health issues

From the data available in this health information document we have asked two questions. First are the national priorities also priorities for Counties Manukau? Secondly are there other priorities not included in the national strategy which are relevant to the local situation in Counties Manukau? We discuss each of these in turn:

Should the national priorities (redefined as eight priority areas) also be contenders as priorities for Counties Manukau in terms of their importance?

- **Health inequalities**

The percentage of people that are living in areas classified as very deprived in Counties Manukau is 34% - that is 117 000 people. For all HFA localities this is the highest absolute number and the highest proportion after Tairāwhiti and Northland. In addition Counties Manukau has a slightly larger proportion of least deprived people than average, it therefore has more than its equitable share of rich and poor people. In Counties Manukau male life expectancy at birth is 1.2 years shorter than the New Zealand average and female life expectancy is 0.8 years shorter. There is a difference of 8 years in life expectancy at birth between men living in Howick and men living in Otara.

Marked health inequalities exist between the least and most deprived people in Counties Manukau, and between ethnic groups. These inequalities have featured throughout the document in almost every area examined. Māori and Pacific people are heavily concentrated in areas of greater relative deprivation, making rather moot as to the relative importance of each factor. There are conditions to which people from particular ethnic groups seem more susceptible, for example diabetes in Māori and Pacific peoples and colo-rectal cancer in Europeans. There are conditions where socio-economic factors seem more important – for example overall hospitalisations. There will also be ethnic and socio-economic differentials in accessing services, especially primary care and diagnostic services, that also need to be addressed to ensure that people of all ethnic groups and all socio-economic backgrounds obtain the health care they need.

This priority area will be fundamental to Counties Manukau District Health Board.

- **Cancer**

Cancer is the second leading cause of death (17%) and a major cause of hospitalisation in New Zealand (7%). There are about 17,000 new registrations of cancer a year. The aetiology and management of cancers however, vary considerably. Genetic predisposition and different life-style factors influence the development of cancer resulting in considerable variation in rates by ethnic group. Lung cancer accounts for 8% of premature avoidable mortality and 5% of potential years of life lost. Health service treatments are of low effectiveness. In Counties Manukau lung cancer is more common among the least deprived populations and among Māori. Smoking is directly related to lung cancer and it is Māori who have the highest smoking rates in Counties Manukau. Colo-rectal and skin cancer are more common among Europeans. High quality services can improve the survival rates for cancer through early detection and appropriate management.

- **Diabetes**

Diabetes is estimated to cause about 1200 deaths per year in New Zealand. Diabetic complications are major contributors to the burden of disability experienced by people from middle age, especially in the Maori and Pacific communities. Predictions are for a significant increase in the next 10 years. In Counties Manukau hospitalisation rates are 116 per 100,000, these are higher than New Zealand hospitalisation rates of 91 per 100,000. There is a strong relationship between socio-economic status and hospitalisation. The least deprived age-standardised rate is 42 per 100,000 whereas the rate for the most deprived reaches 246 per 100,000. These factors make diabetes an important issue for Counties Manukau.

- **Cardiovascular disease**

Cardiovascular disease is the leading cause of death amongst all ethnic groups in Counties Manukau. It accounts for the largest cause of potential years of life lost, the largest cause of disability adjusted like years lost, and the largest cause of potentially avoidable admissions (3,465 Counties Manukau residents in 1999). Multiple interventions with a strong evidence base include four of the national objectives - a reduction in smoking and obesity, an improvement in nutrition, a reduction in diabetes and increase in exercise.

- **Mental health**

Mental illness is the third most common cause of disability in industrialised countries rating after cancer and heart disease, but above respiratory disease in terms of disability adjusted life years. Three percent of the adult New Zealand population have moderate/severe mental health disorders and another 12% have mild disorders³. The Northern Region Health Survey carried out in 1996/97 measured the self-assessed health status of the Auckland population. Along with West Auckland people, Counties Manukau residents had a low mental health score. Counties Manukau residents have a statistically significantly lower than the national average SF-36 mental health score probably due to the lower socio-economic status of Counties Manukau.

- **Oral health**

The number of decayed, missing or filled permanent teeth (dmft) is one indicator used to reflect oral health. The dmft score for New Zealand improved consistently throughout the 1980's but slowed in the early 1990s and has now reversed slightly. In New Zealand and Counties Manukau the prevalence of caries in children is higher among Maori, lower socio-economic groups and those without fluoridated water. Oral health has not previously been identified as a specific priority for Counties Manukau. Less than half of 12 year olds in Counties Manukau have caries free permanent teeth.

- **Child health**

Counties Manukau children have experienced a large increase in their risk of being admitted to hospital over the past two years. An increasing population and the meningitis outbreak account for some of this increase but the rest is due to increases in respiratory infections and infectious diseases. Counties Manukau has high rates of infectious disease in the 0-2 year old population. These diseases account for 870 preventable admissions to hospital in less than one year olds. Respiratory infections in Counties Manukau account for 41% of admissions in the under ones and 8% in the 0-14 year old age groups. Admission rates in the under ones are very high particularly among Pacific people when they reached a rate of 683/1000 in 1999. More than half the

³ *Moving Forward. The mental health plan for more and better services.* Wellington: Ministry of Health. 1997

children born to Pacific mothers will be admitted to hospital in their first year of life. Other concerns in Counties Manukau are the incidence of sudden infant death syndrome (SIDS) which is still high for Maori. Immunisations are one cost-effective intervention and rates in Counties Manukau are low - full immunisation coverage at age two in 1996 was 64%.

- **Violence**

Violence is increasingly being recognised as a health problem with long term health and social impacts. During the period 1993-6 there was an average of just under 9 deaths per annum among children aged 0-14 years from injury purposely inflicted by other persons. There were over 200 cases of physical harm (among the same age group) that resulted in hospitalisation in 1997 (a rate of 25 per 100 000). Hospitalisation is more common in Maori and in males.

Are there other priorities specific to the situation in Counties Manukau?

- **Chronic respiratory disease**

Asthma and chronic obstructive airways disease make up 6% of medical admissions in Counties Manukau. Asthma is the sixth major cause of disability adjusted life years lost. It is a major cause of preventable admission to hospital and is associated with poor use of prophylactic medication in Counties Manukau. In 1999 hospitalisation rates among Counties Manukau residents for both asthma and chronic obstructive airways disease were significantly higher than for New Zealand.

- **Infectious disease**

Communicable diseases were the fourth major cause of death in New Zealand between 1989 and 1993⁴. New Zealand has higher rates of some vaccine preventable diseases than comparable developed countries. Periodic measles and pertussis epidemics are directly attributable to low rates of vaccination. In Counties Manukau rates of admission for measles and whooping cough were higher than for the rest of the country. Non-vaccine preventable diseases that occur in Counties Manukau at high rates compared to the rest of New Zealand include meningococcal disease, cellulitis, acute respiratory infections, rheumatic fever and enteric diseases. Cellulitis alone accounted for 1376 Counties Manukau resident discharges in 1999. This burden of infectious disease is not distributed evenly throughout the community. Maori, Pacific peoples, the poor, the very young and the elderly are disproportionately represented. The national objective to improve access to child care service including immunisation will go some way to addressing this issue. Improved access to treatments (eg Pharmac subsidy policies) may also be required.

- **Adolescent health**

Counties Manukau has a relatively high rate of teenage pregnancy, particularly in Maori, Pacific, and people living in relatively deprived areas. Sexual health was a source of 412 preventable admissions among Counties Manukau residents in 1999. This was mainly due to admissions for pelvic inflammatory disease and ectopic pregnancy, often the results of complications following sexually transmitted infections. The high incidence of sexually transmitted infections, especially chlamydia and

⁴ Christie S, Tobias M. The burden of infectious disease in New Zealand. *Australian & New Zealand Journal Public Health* 1998; 22(2): 257-260

gonococcal disease in New Zealand as a whole has been raised as a concern. Teenage mothers have a higher rate of low birth weight babies. Sexual health is a major cause of infertility. Other risk-taking behaviour, eg motor vehicle speeding, alcohol and other drug misuse have high rates in the adolescent and young adult period. Injury is further discussed below. Many lifestyle choices start in the adolescent period such as smoking, adult diet, and exercise, that have significant impacts on future health status. These behaviours are modifiable, but prevention is dependent on education and an efficient and well-resourced community-based health service infrastructure.

- **Injury prevention**

Globally road traffic injuries are the fifth most important cause of potential years of life lost. Compared to other OECD countries New Zealand has a high child injury death rate (Our Children's Health). In the early 1990's New Zealand's injury death rate for 0-4 year olds ranked worst out of 21 OECD countries for which data were available. In 1999 there were 2070 public hospital discharges to Counties Manukau children as a result of an injury or poisoning. This was 9.9% of all discharges to Counties Manukau children. The rate of 20/1000 children is significantly higher than the national rate of 17. In addition there were 3,292 public hospital discharges to Counties Manukau 15-44 year olds as a result of an injury or poisoning. This was 11% of all public hospital discharges to this group. The rate of 19/1000 population is significantly higher than the national rate of 16. It is clear that injuries are still a major cause of potentially avoidable hospitalisation in Counties Manukau. Injury prevention has been identified as one of the government's objectives but not highlighted as a priority for the short to medium term.

- **Cerebrovascular disease (stroke)**

Cerebro-vascular disease is the third-ranked cause of death in New Zealand after ischaemic heart disease and cancer. The stroke discharge rate in Counties Manukau has remained fairly stable over the last five years, and is very similar to the national rate. In 1999 the hospitalisation rate for stroke among Counties Manukau residents was 174 per 100,000 compared to a national rate of 160 per 100,000. Stroke predominantly affects those aged over 65 years of age. Counties Manukau Pacific stroke discharge rates are higher than the Maori and significantly higher than the Other ethnic group. The development of the planned stroke unit at Middlemore will be one step towards more effective health care in this important area. Effective interventions for the primary and secondary prevention of stroke as well as its management exist and are not universally being implemented. Stroke shares some of the causal factors with cardiovascular disease and will therefore be addressed to some extent by the national priorities.

Next steps

This report has highlighted health inequalities in Counties Manukau – both across socio-economic and ethnic groups. There is much potential to make health gains in those areas where these differences are most marked. Much of the health status of a population is determined by factors that lie outside the health system itself. Inter-sectoral collaboration with other local and central agencies such as housing, education and city councils will be needed to bring about many of the changes needed. Influencing national policies will be important – for example making low cost dentistry available, or reducing cost barriers to primary care and pharmaceuticals.

The data in the report needs to be supplemented with information on community priorities and the effectiveness of interventions in order to inform local strategic plans.

The document highlights some of the information already available and gaps where more is needed (eg. outpatients and primary care). Access to high quality health information will be crucial to supporting the decision-making processes of District Health Boards.

While generally in accord with the New Zealand Health Strategy in terms of priorities, it is apparent from the report that there are clear issues for Counties Manukau that may not always be national priorities and vice versa. Funding for health will always be limited. The establishment of a transparent priority setting process will enable the best use of this data in conjunction with other resources for planning services in Counties Manukau.