

## AUCKLAND DISTRICT HEALTH BOARD

### COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE

**Minutes of the Community and Public Health Advisory Committee  
meeting held on Wednesday 5 March 2008 in the  
Rangitoto Room, Level 3, LabPlus, Auckland City Hospital, Grafton  
commencing at 9:00 am**

#### 1. ATTENDANCE AND APOLOGIES, CONFLICTS OF INTEREST

##### **Committee Members**

Rob Cooper (Chair)	Jo Agnew
Susan Buckland	Harry Burkhardt
Dr Chris Chambers	Brian Fergus
Dr Ian Scott	Pat Snedden
Bob Tizard	Seiuli Dr Juliet Walter
Ian Ward	

##### **In Attendance**

Rev Alfred Ngaro

##### **Management in Attendance**

Garry Smith – Chief Executive  
Dr Denis Jury – Chief Planning & Funding Officer  
Dr David Sage – Chief Medical Officer  
Naida Glavish – Chief Advisory Tikanga, GM Maori Health  
Janice Mueller – Director Allied Health  
Aseta Redican – GM Pacific Health  
Ian Bell - Board Administrator

##### **Apologies**

The Chair declared the meeting open at 9.08 am and Naida Glavish commenced the meeting with a karakia.

An apology had been received from Taima Campbell, Executive Director Nursing. There were no notifications of conflicts of interest for any items on the agenda.

#### 2. CONFIRMATION OF MINUTES 4 FEBRUARY 2008

Moved Pat Snedden, seconded Chris Chambers

*That the minutes of the Community and Public Health Advisory Committee meeting held on 4 February 2008 be confirmed as a true and correct record.*

Carried

### 3. ACTION TABLE 4 FEBRUARY 2008

#### **Child and Adolescent Oral Health Services**

The question raised relating to improving services were in regard to Maori and Pacific.

### 4. LONG TERM CONDITION MANAGEMENT

Dr Celia Palmer was in attendance and presented to the Committee on the ADHB Approach to Supporting People Living with a Long Term Condition and the draft framework February 2008. Long term conditions were the leading cause of illness accounting for more than 80% of deaths and 70% of health funding. Of the ten National Health Targets six were aimed at long term conditions. The definition from the National Health Committee was “an ongoing long term or recurring condition that can have a significant impact on people’s lives”. Long term conditions were more common among poor people as well as those from Maori, Pacific and South Asian backgrounds and counted for most of the difference in life expectancy between Maori and non Maori. They have a huge impact on peoples lives and those with whom they lived or cared for them. People living with long term conditions experienced the deficiencies of the health system repeatedly and often knew a great deal about their conditions, symptoms and what help they required. One of the challenges was shifting to a comprehensive self management approach although it was noted that within some cultures management required a whole of family rather than self management approach. A proposed care pathway for people with long term conditions was outlined in the context of a proposed long term conditions framework. The next step would be consultation on the framework.

It was suggested that there needed to be clearer identification of who provided the care being nurses, health workers and primary care in the community rather than doctors. This would require a breakdown of the health workforce sector traditional boundaries and it was important not to medicalise normal living.

A Primary Care Plan was being developed and should be available for consultation in approximately 8 weeks. A number of practices had been involved in the Primary Care Plan development and there may be possible funding from the MoH for that involvement.

Moved Ian Scott, seconded Seiuli Dr Juliet Walter

*That the Community and Public Health Advisory Committee endorses the approach being taken for supporting people living with a long term condition.*

Carried

### 5. HEALTH NEEDS ASSESSMENT

Paul Bohmer, Manager Population Health and Mazin Ghafel, Population Health Analyst presented to the Committee. The Health Needs Assessment was required by legislation and a summarised version had been provided in hard copy to Board members. To overcome problems of comparison between different populations which had different age structures the common approach was to standardise the rates using either a standardised ratio comparing the number of events with those expected in a standard population or an aged standardised rate expressed per 100,000 compared with a

standard population. Statistical confidence levels were used to assess whether the result was statistically significant. Data was based on a census area unit was an aggregation of meshblocks which was the smallest geographic unit on which statistical data was collected. Auckland was composed of 3,252 meshblocks (New Zealand 41,392) which aggregated in Auckland to 113 census area units (New Zealand 1,926).

The New Zealand Deprivation Index was applied to each meshblock and ranged from 1 (least deprived) to 10 (most deprived). The dimensions of the deprivation included income, qualifications, living space, communication, transport, etc. Further definitions included Years of Life Lost (YLL) which was an estimate of the years that people would have lived if they had not died prematurely, life expectancy (male 78-79.5 and female 82-83.5) and avoidable hospitalisations where occurrences of severe illness that theoretically could have been avoided which for Auckland were estimated at 32 per 1000 of population or 20% of total hospitalisations. Avoidable mortality was unnecessary death from diseases for which effective public health and medical intervention are available. The Committee was informed on some hospital jargon which included admission, length of stay, day case, acute and elective as well as DRG and WIES.

## **COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE, HOSPITAL ADVISORY COMMITTEE COMBINED MEETING**

### **1. TRAVEL PLAN**

Bill Smith of Ecological Associates and Melanie Alexander of the Auckland City Council were in attendance and presented to the Committee on the Auckland District Health Board Travel Plan. With increasing travel time and cost, the City Council and ARTA were promoting travel plans for large employers for both employees and patients working together with the institution. A whole of journey approach is taken looking at all transport options from an institutional as well as specific site approach. Overseas examples were quoted as well as a plan being developed by the Capital & Coast District Health Board. The ADHB travel planning was a partnership approach between ADHB, Auckland City Council and the Auckland Regional Transport Authority firstly scoping the issues including in and out patient and visitor travel and access as well as staff travel and access. Auckland City Council initiatives were the central connector and the Greenlane project and the ARTA's planned improvements were the moving of Boston Road station to Park Road, upgrading the Newmarket and Greenlane stations and ongoing service improvements.

Reviews included pedestrian mobility and cycling, parking management, information and marketing and passenger transports including subsidies. A survey would be undertaken of travel behaviour of patients, visitors and staff in March to April to come up with a series of recommended actions by June 2008.

The meeting adjourned at 10:45 am and reconvened at 11:04 am.

## COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (continued)

### 6. PROVISIONAL FUNDING ALLOCATION FOR 2008 - 2009

Denis Jury spoke to the report and while Auckland's population was approximately 9.6% of the New Zealand population funding was 9.3% of the Population Based Funding formula due to assessment of need in the population. The 2006 census also had a variation from the previous projections used based on the 2001 census. Further income was through Inter District Flows (IDFs) being the interaction with other District Health Boards and some top sliced funding for national contracts which generally were buying capacity for smaller specialised services. There was ring fenced funding for electives however the need may not be there and as payment was on performance this funding could be at risk.

Overall funding for ADHB for 2008 - 2009 compared with 2007 - 2008 was an increase of 6%. The paper contained further analysis using pie charts showing NGO funding for both ADHB and other DHBs and for ADHB's population NGO spending further analysis including \$61.1m to GPs/PHOs. This was an increase over the last 3 years from \$28m. The hospital and specialist services were analysed for ADHB's population and other DHBs and then further broken down for ADHB's population into the specialist services. Between years overall there had been a 1% or approximately \$14m shift from hospital and specialist services to the primary sector.

Chart 7 detailing ADHB's population funding allocations needed to be revised and reproduced.

Moved Seiuli Dr Juliet Walter, seconded Jo Agnew

*That the Community and Public Health Advisory Committee endorses the provisional funding allocations to support the 2008 - 2009 District Annual Plan.*

Carried

### 7. PLANNING AND FUNDING MONTHLY REPORT

Points noted from the report, which was taken as read, included changes in legislation to place subsidised residents in license to occupy facilities which had blurred the boundaries between Aged Care facilities which were DHB managed and retirement villages. These guidelines were being agreed regionally.

There were illustrations of analysis being done mapping acute utilisation trends and elective utilisation trends against deprivation quintiles. Did Not Attend (DNA) were also being mapped, with these tools being used to try and develop trends across time and to be more scientific in allocation of funding.

The previous under spending of ring fenced Mental Health funding had been used and was being reviewed by the MoH. The budget for Mental Health in 2008-2009 would continue to be ring fenced.



**Maori Health**

Kerry Hiini was in attendance and advised that some of the focus was on long term condition management particularly in what support was required for Maori when they went home and, with Health Eating Healthy Action (HEHA) identifying the priority areas for Maori. The impact of provision of care for Maori was captured in the Maori Health Strategic Plan with better reporting and outcome measures being developed to show health trends over time.

**Pacific**

Health Village Action Zones had been nominated for a Health Innovation Award and was in the final 21 and had been presented to the MoH Fono. A team planning day had been held to consider the top ten priorities and objectives for 2008-2009. There had been a meeting with Adult Health to try and identify support within the provider arm, rather than from the Pacific team, to relate to Pacific patients. It was noted that grants related to HEHA were very detailed and difficult to obtain. This raised the question of the role of specialists such as nutritionists to support front line in the community. The Pacific Health Advisory Group would be nominating representatives to the CPHAC Committee.

The Committee noted the Planning and Funding Monthly Report.

**8. GENERAL BUSINESS**

There were no items of general business.

**9. NEXT MEETING**

The meeting closed at 12:03 pm

The next meeting is scheduled for  
9:00 am, Wednesday 2 April 2008  
Rangitoto Room  
Level 3, LabPlus  
Auckland City Hospital  
Grafton

**CONFIRMED**

**CHAIR:** .....**DATE:** .....