

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini



**COMMUNITY AND PUBLIC
HEALTH ADVISORY
COMMITTEE MEETING**

30 SEPTEMBER 2005

**AGENDA
AND
MEETING PAPERS**

EMBARGOED UNTIL CONSIDERED BY THE COMMITTEE

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Referred Services Reports

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- C & PH West Coast Breast Feeding Promotion
- Plunket Breast Feeding Statistics
- Submission by A Wallace to WCDHBs District Strategic Plan

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AGENDA

FOR THE WEST COAST DHB COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING TO BE HELD IN THE BOARD ROOM, CORPORATE OFFICE, GREYMOOUTH ON FRIDAY 30 SEPTEMBER 2005 COMMENCING 10.30 AM

1. Welcome / Introductions/Apologies
2. Standing Orders / Disclosure of Advisory Committee Members' Interests
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 - 5.1 Draft District Strategic Plan – any comments on the draft DSP (already distributed) to be submitted to General Manager Planning & Funding by Friday 7th October 2005.
 - 5.2 Primary Mental Health Plan – 1st quarterly report
 - 5.3 Referred Services Reports (Labs and Pharms)
 - 5.4 Time line for Rural GP Training
 - 5.5 Mobile Breast Screening issues: continued discussion on access and equity issues for screening and diagnostic mammography
 - 5.6 Breast Feeding Statistics
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8. **IN COMMITTEE**
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 - 8.2 Matters Arising
 - 8.3 **PHO Review**
OIA 1982 5.9(2)(l) Commercial NZPHDA Sch 3 Cl 32(a)
9. **NEXT MEETING – as per WCDHB timetable**

Morning tea at approximately 10.15am

KARAKIA

E Te Atua i runga rawa kia tau te rangimarie, te aroha, ki a matou i tenei wa
Manaaki mai, awhina mai, ki te mahitahi matou, i roto, i te wairua o
kotahitanga, mo nga tangata e noho ana, i roto i tenei rohe o Te Tai Poutini
mai i Karamea tae noa atu ki Awarua.

That which is above all else let your peace and love descend on us at this
time so that we may work together in the spirit of oneness on behalf of the
people of the West Coast.

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE DISCLOSURES OF INTERESTS

Member	Disclosure of Interest
CHAIR Julie Kilkelly <i>WCDHB Member</i>	<ul style="list-style-type: none"> • Member - NZ College of Pharmacists • Director - Kilkelly Kartage Ltd • Director - Olsen's Pharmacy 2002 Limited
DEPUTY CHAIR Dr Carol Atmore <i>WCDHB Member</i>	<ul style="list-style-type: none"> • Member, South Link Health • General Practitioner - Employed by WCDHB at Grey Medical Centre and GP Liaison Officer
Professor Gregor Coster Chairman WCDHB <i>Appointed February 2003</i>	<ul style="list-style-type: none"> • Director - PHARMAC • Director - Cornwall Management Limited
Robyne Bryant WCDHB Member	<ul style="list-style-type: none"> • Trustee - Board of Coast Care Trust • Employed by WCDHB as a midwife on a casual basis
Cheryl Brunton	<ul style="list-style-type: none"> • Medical Officer of Health for West Coast - employed by Community and Public • Health - Canterbury District Health Board • Senior Lecturer in Public Health - Christchurch School of Medicine and Health • Sciences (University of Otago) • Fellow - Australasian Faculty of Public Health Medicine • Member - Public Health Association of NZ • Member - Association of Salaried Medical Specialists
Greville Wood	<ul style="list-style-type: none"> • General Practitioner – West Coast DHB • Fellow – Royal New Zealand College of General Practitioners • Regional coordinator for University of Otago Under Graduate Medical Student Training Programme • Executive Committee of South Link Health • WCPHO Board
Barbara Greer	<ul style="list-style-type: none"> • Member - Rata Branch Maori Women's Welfare League • Member - Runanga O Makaawhio • Shareholder - Mawhera Corporation • Tumuaki Rata Te Awhina Trust • Member – NHO Consumer Advisory Group • Colorectal Cancer Advisory Group
Sharon Ransom	<ul style="list-style-type: none"> • Member – New Zealand Nurses' Organisation • Member – West Coast Primary Health Nurses Network • Member – Child and Youth Advisory Committee • Clinical Leader – Nelson Marlborough West Coast Royal New Zealand Plunket Society • Member - Well Child Network • Aunt employed by WCDHB
Barbara Beckford	<ul style="list-style-type: none"> • Member - Medical Radiation Technologists Board (Responsibility for registration and disciplinary matters) • Member - NZ Medical Council Professional Standards Competence Review Committee

	<ul style="list-style-type: none">• Co-Convenor - Federation of Women's Health Councils Aotearoa (Consumer advocacy interests)• Co-Chair - National Screening Unit Consumer Reference Group• Member - BreastScreen Aotearoa Advisory Group• Member – Public Health Association of NZ• Member – Well Women’s Centre• Member – National Ethics Advisory Committee• Member – NZ Guidelines Development Team (reviewing the management of women with abnormal smears)
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DRAFT MINUTES OF THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING HELD 19 AUGUST 2005 AT 10.36 IN THE BOARDROOM, CORPORATE OFFICE, GREYMOUTH

PRESENT	Julie Kilkelly, Chair Carol Atmore, Deputy Chair Robyne Bryant Cheryl Brunton Greville Wood Barbara Greer Sharon Ransom Barbara Beckford
IN ATTENDANCE	Gerri van der Zanden Melanie Penny, Planning & Funding Analyst Shona McLeod, Planning & Funding Analyst Bianca Kramer, Minute Secretary
APOLOGIES	Gregor Coster, WCDHB Chair Christine Robertson, WCDHB Deputy Chair Kevin Hague, CEO Hecta Williams, General Manager Mental Health Gary Coghlan, General Manager Maori Health

1. APOLOGIES, WELCOME

The Chair welcomed everyone to the meeting. The Chair waived standing orders.

2. DISCLOSURES OF INTEREST

The following amendments were made to Board Members' disclosures of interest.

Carol Atmore

- Remove, Contracted by WCDHB and South Link Health as GP Liaison

Robyne Bryant

- Remove, Member – Mawhera Maori Women's Welfare League
- Remove, Employed by Westland R.E.A.P, Team Leader Early Childhood Education
- Add, Casual call on for McBrearty Ward

3. AGENDA CHECK

No changes

4. MINUTES OF THE PREVIOUS MEETING HELD 16 JUNE 2005

- Item 5.5, amend line six to read (amounts up to \$1,000 per grant)
- Item 7.3, line three, correct spelling of feedback

Moved: Carol Atmore Seconded: Barbara Beckford

It was RESOLVED that the Minutes of the Community and Public Health Advisory Committee meeting held 16 June 2005 were a true and accurate record subject to the amendments above.

5. MATTERS ARISING / ACTION AND RESPONSIBILITY LIST

Write to PHO regarding low uptake of Green Prescription

The Chair had spoken to the Green Prescription Coordinator. The WCPHO does not have a contract to provide Green Prescriptions but is funded to promote them. SPARC fund the Green Prescription through Sport West Coast in Westland and Sport Buller in the Buller region. The WCDHB has no formal contract with the regional sports trusts..

Green Prescription uptake in the Westland region was increasing. Uptake in the Buller area did not seem to be as high, and issues identified included low GP numbers, personnel at Sport Buller and a limited number of options that were available in Buller to offer participants on the program. It was noted that a new green prescription co-ordinator was being appointed for Buller. It was noted that a General Practitioner needed to prescribe a Green Prescription, to ensure that the person's health condition was stable before starting on the program.

Healthy Lifestyles, a WCPHO funding stream, was different to the Green Prescription. A healthy lifestyles facilitator was employed by the WCPHO's Management Services organisation. She was based in Dunedin, and is due to visit the West Coast in the next few months. Part of her role may include promotion of Green Prescriptions to practice teams.

It was suggested that all funding for healthy lifestyle type activity could be coordinated on the Coast by a central body, to maximise benefit for the West Coast. It was noted that the West Coast based organisations that deal with health promotion on the West Coast have an informal grouping with regular contact,. It was acknowledged that before changes could occur clarification needed to be provided on contractual links and funding for Green Prescriptions between the WCDHB, the WCPHO, SPARC and the regional sports trusts.

A committee member expressed concern about specific GPs being named in the discussion paper included in the CPHAC papers, given the public nature of the documents.

It was decided that CPHAC will receive an annual report on Green Prescriptions. It was agreed that the Planning and Funding Analyst should continue to monitor uptake of the Green Prescription programme in the interim, and inform the Committee if any significant concerns arise in the meantime.

Action: Planning & Funding Analyst

Further analysis/breakdown of cervical screen figures

The Health Promoter, Cervical Screening had informed the Chair that changes in staff at the NSU has delayed progress. A report would be made to CPHAC as soon as further analysis was available.

The Chair had spoken to the Manager of Cervical Screening / Sexual Health, and was informed that there were some specific practice related issues that needed addressing, and a number of different approaches were being considered.

Write to WCPHO highlight poor and falling rates of cervical screening and asking them to address any best practice issues

New Ministry of Health targets set for PHO regarding cervical screening are now 85% of eligible women and a re screening target of 75%

This item is to remain on the agenda for further updates

Investigation of most efficient use of direct financial incentives & scholarships to recruit and retain health professionals

Paper provided by Recruitment Co-ordinator

Distribute copies of Primary Care Plan to CPHAC member

Actioned

Distribute to CPHAC members draft DSP

Actioned

C&PH West Coast Public Health Plan Quarterly Report

Carried over. Timeframes need to be clarified. Action Chair.

Distribute Primary Mental Health Plan

Actioned

Primary Mental Health Plan 1st Quarterly Report

Due September meeting

Follow up time frames for MoH consultation document on Suicide Prevention

The time frame didn't allow for any action by this committee

Update on WCDHB Nutrition and Physical Activity Policy

Paper provided by Planning & Funding Analyst

5.1 RURAL GP TRAINING PROGRAMME

The GM Primary Care was not available to provide an update, but Greville Wood was able to provide an update. Interviews for the Co-ordinator position had taken place, and an appointment was in the process of being made. The high calibre of applicants was noted. Details of the two paediatric six month RMO positions in Christchurch are currently still being negotiated between the WCDHB and CDHB. The committee was informed that the Board would be asking management for timelines for implementation of the program. The Chair, CPHAC would request an update on the progress at the next WCDHB meeting.

Action: Chair

5.2 SCHOLARSHIPS

A paper provided by the Recruitment Co-ordinator outlined recruitment and retention problems being experienced.

The reason for the Committee's interest in scholarships was to encourage young West Coast people to go into health related career areas. Investigation of scholarships should be kept as an action point of its own in the recruitment and retention strategies being considered.

The recommendation, in the paper for a committee to look at overall recruitment strategies for the health sector on the West Coast was supported. It was felt that the Working Party would benefit from having WCPHO representation.

Action: Chair

5.3 CHILD & YOUTH HEALTH STRATEGY

Planning & Funding Analyst, S M, gave a brief update on the progress of the Child & Youth Health Strategy. The aim is to have draft strategy ready in November 2005. The first Hui is due to take place next week. Groups will be established to feed information back to the working party.

The MenzB project has dominated the work plans of the Planning and Funding staff at WCDHB over recent months. To offer assistance, C & PH has taken over responsibility for the Youth Health Plan. The Planning & Funding Analyst will give regular updates on progress.

5.4 PROVIDER KPIS/MONITORING

The PHOs quarterly report has been provided to WCDHB Planning and Funding. A report will be provided to the next CPHAC meeting.

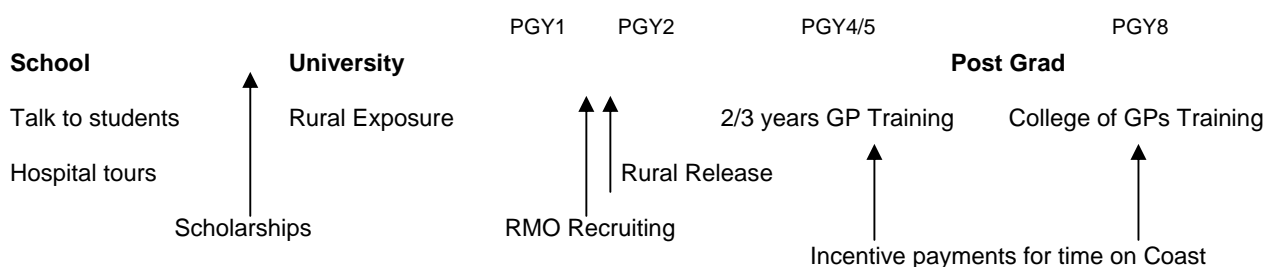
Action: GM Planning and Funding

5.5 PRIMARY HEALTH CARE PLAN

Some committee members have provided feedback to GM Planning and Funding individually. The following general points were made by the committee

- Elder care – the central coordination centre could be extended into other service areas if it proved successful
- Emphasis on collaboration was good to see
- Transport issues are important in providing high quality primary care
- Linkages to disability support services need to be considered
- '5.9 increasing community participation' It was noted that NGOs provide well care, not sick care, in our community and linkages with groups such as SPARC, Plunket and other NGO's need to be strengthened.
- The Draft Plan was obviously authored by a number of others, and needed a coherent style

- We need to maximise achieving a sustainable workforce and opportunities in recruiting and retaining health professionals – as follows



- The final plan should have a succinct summary around the following key strategic areas
 - To develop the West Coast as a Centre of Rural Excellence
 - To achieve an overall continuum of care, through the WISE Elder Care project, and Chronic Disease Management projects
 - To achieve a sustainable workforce
 - To increase/foster community participation/partnerships

6. CORRESPONDENCE

Nil received, nil sent

7. GENERAL BUSINESS

7.1 PHO PROGRESS

There is currently a review document being drafted by the Planning and Funding team, regarding the meeting of contractual obligations. Further discussion between the Chair, CPHAC and the WCDHB CEO/GM Planning & Funding will occur prior to the next CPHAC meeting regarding review of progress towards meeting aims of the Primary Care Strategy. It makes sense to tie this review work in with Ministry of Health work on PHO performance currently being done.

Action: Chair/WCDHB CEO

This items will come back to the next meeting

7.2 REFERRED SERVICES (LABS/PHARMS)

The proposed strategy for the future provision of laboratory services – West Coast District Health Board, is currently out for consultation. The time frame for comment on the proposal ends on Wednesday 31st August 2005.

Referred services constitutes a portion of the new PHO Performance Management Programme that the Ministry of Health is developing for PHO's. Participation in this programme will be mandatory for all PHOs by 2007

All at once dispensing – The paper provided indicated that the West Coast has one of the higher rates of close control prescribing, along with other rural areas of New Zealand. Committee members were cautious of comments made in the paper regarding the possible need to introduce compliance initiatives to control the level of close control prescribing.

Evidence of patient benefit without patient and community harm would need to be produced before this would be recommended.

This item, in its entirety, requires further work by management and will be brought back to the next meeting.

Action: Planning and Funding Team

7.3 PRISM PROJECT UPDATE

This particular topic has been presented through HAC. Prism has been rolled out in both the Grey Medical Centre and Dobson Clinic. Both clinics are finding it useful, although with the expected teething problems.. Concerns regarding confidentiality were raised, It was considered that there is a need for public consultation (which could also double as education), in this area.

Recommendation to WCDHB:CPHAC recommends that in the development of an electronic health record across the Primary/Secondary interface that public consultation occurs regarding confidentiality, privacy and access issues (if this has not already occurred)

Moved: Barbara Beckford Seconded: Robyne Bryant

7.4 MOBILE BREAST SCREENING SERVICES – ACCESS ISSUES

A paper discussing the inequality of access that rural women at high risk of breast cancer have to breast screening services was discussed

545 West Coast women are estimated as being at high risk of developing breast cancer, with 109 women in the highest risk group. These women should all have a mammogram every year.

If they are in the eligible age range, they receive a mammogram on the West Coast every two years from the mobile service. These women currently have to travel to Christchurch every second year for their 'interval' mammogram, as these are not preformed by the mobile service. The high risk women who are not in the eligible age range for a free mammogram every two years need to travel to Christchurch annually.

Other issues were discussed around access and equity of services, both for screening and diagnostic mammography. These will be further discussed at the next CPHAC meeting.

Action: Chair and Barbara Beckford

Recommendation to WCDHB: CPHAC recommends that Management investigate the feasibility of providing travel assistance for high risk women accessing interval screening mammography services

Moved: Barbara Beckford Seconded: Robyne Bryant

7.5 BREASTFEEDING RATES

The West Coast figures for exclusive breast feeding after six weeks are lower than optimal. The collection of breast feeding statistics may not capture all the information., Once we

have more accurate figures and further information to CPHAC, we can then consider whether any further action is necessary.

Action: Barbara to get more details on statistics for next meeting

Action: Shar to bring data collected via Plunket

Action: C&PH to rewrite paper originally written by Nicky McCathy

Action: Paper submitted to DSP consultation round to be supplied – minute secretary

7.6 HEALTHY EATING HEALTHY ACTION PLAN – FIRST QUARTERLY REPORT

Planning & Funding Analyst, Melanie Penny updated the committee on the consultation feedback provided by DHB employees and the actions to date. It was acknowledged that there had not been a great response, with only 12 employees responding, however feedback was not intended to be representative. The feedback as a whole supported the HEHA Plan. The issue of fundraising was mentioned in the feedback, this has not been ruled out completely but needs approval from the relevant GM to ensure that the fundraising activity complies with the HEHA principles.

12. IN COMMITTEE

Pursuant to Clause 32a, Schedule 3 of the New Zealand Public Health & Disability Act 2000 members of the public are to be excluded from the portion of the 19 August 2005 meeting of the Community & Public Health Advisory Committee that relates to the following items on the grounds that the public conduct and discussion of the following items would enable the WCDHB to carry out, without prejudice or disadvantage, commercial activities granted by Section 9(2)i of the Official Information Act 1982.

Moved: Julie Kilkelly Seconded: Cheryl Brunton

It was RESOLVED to move into In Committee at 1.15

13. MOVING OUT OF IN COMMITTEE

Moved: Julie Kilkelly Seconded: Cheryl Brunton

It was RESOLVED to move out of In Committee at 1.34pm

14. NEXT MEETING

Friday, 30th September, 10.30am, Boardroom, Corporate Office Greymouth

15. ATTENDANCE AND ADMINISTRATION FORMS

Actioned.

There being no further business to discuss the meeting concluded at 1.36 pm

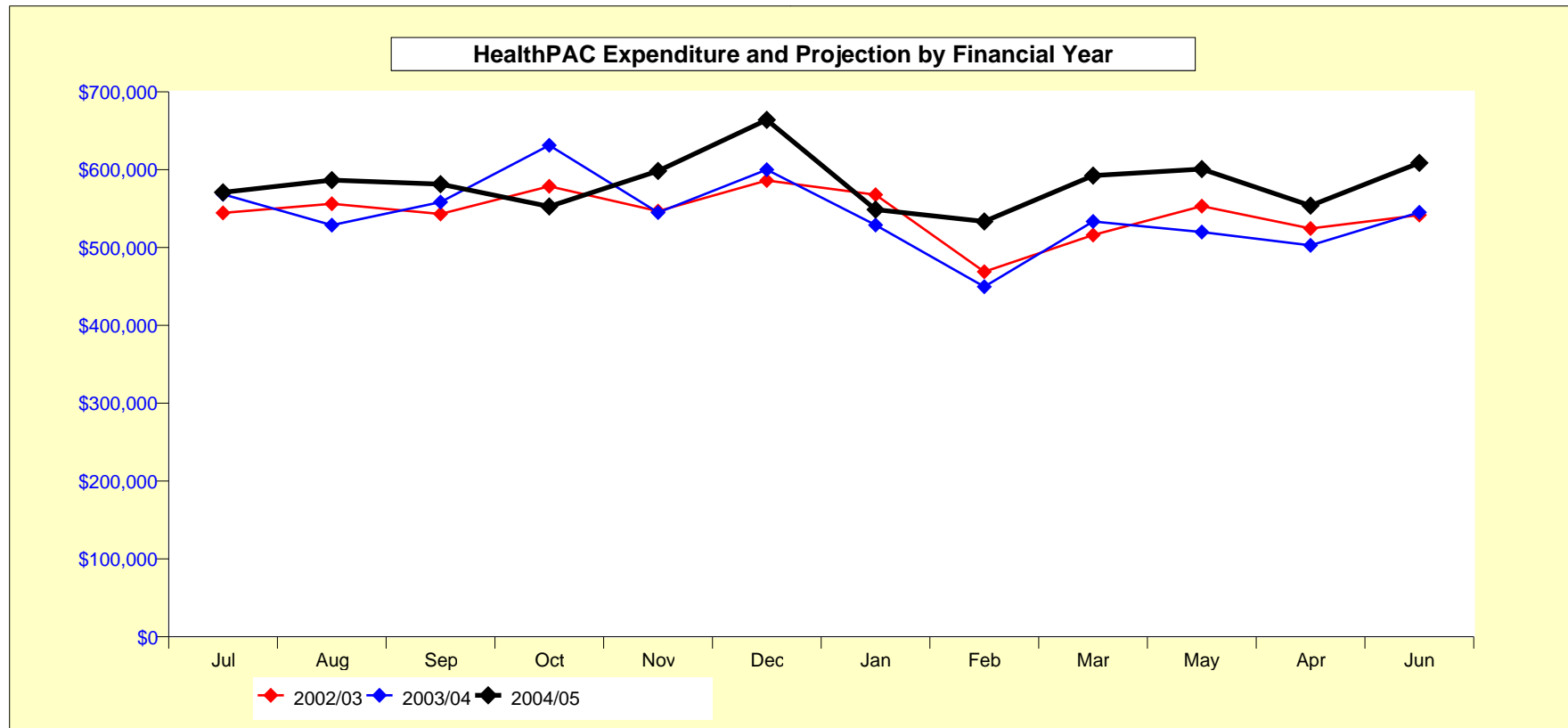
Action and Responsibility List – Community and Public Health Advisory Committee Meeting

Item No.	Meeting Date	Action Item	Action Responsibility	Due By
	15 June 2005	Write to WCPHO regarding low uptake of Green Prescription	Chair	Aug 05
	15 June 2005	Further analysis/breakdown of cervical screen figures	Chair & Health Promoter / Cervical Screening	As available
	15 June 2005	Write to WCPHO highlight poor and falling rates of cervical screening and asking them to address any best practice issues		
	15 June 2005	Investigation of most efficient use of direct financial incentives & scholarships to recruit and retain health professionals	Recruitment Co-ordinator & General Manager Operations	
	15 June 2005	Distribute to CPHAC members draft DSP	General Manager Planning & Funding	
	15 June 2005	C&PH West Coast Public Health Plan Quarterly Report	Cheryl Brunton	September 2005
	15 June 2005	Primary Mental Health Plan 1 st Quarterly Report	General Manager Mental Health	September 2005
	15 June 2005	Collate reports and figures for referred services (Labs & Pharmacy)	General Manager Planning & Funding	September 2005
	19 August 2005	Request update from Board regarding time line for Rural GP Training	Chair CPHAC	September 2005
	19 August 2005	Establish committee to look at overall recruitment strategies for the health sector	??	
	19 August 2005	Regular updates on the Child & Youth Health Strategy	Planning & Funding Team / C&PH	
	19 August 2005	PHO quarterly report	Minute Secretary	September 2005
	19 August 2005	PHO review document	CEO	September 2005
	19 August 2005	Referred Services Reports – Labs and Pharmacy	Planning & Funding Team	September 2005
	19 August 2005	Mobile Breast Screening issues: continued discussion on access and equity issues for screening and diagnostic Mammography	Barbara Beckford	September 2005
	19 August 2005	Details of Breast Feeding statistics	Barbara Beckford	September 2005
	19 August 2005	Plunket Data for Breast Feeding	Shar Ransom	September 2005
	19 August 2005	C&PH to rewrite West Coast Breastfeeding paper originally submitted by C&PH Greymouth	C & PH	September 2005
	19 August 2005	DSP consultation paper on Breast Feeding to be supplied in papers	Minute Secretary	September 2005

REFERRED SERVICES REPORT

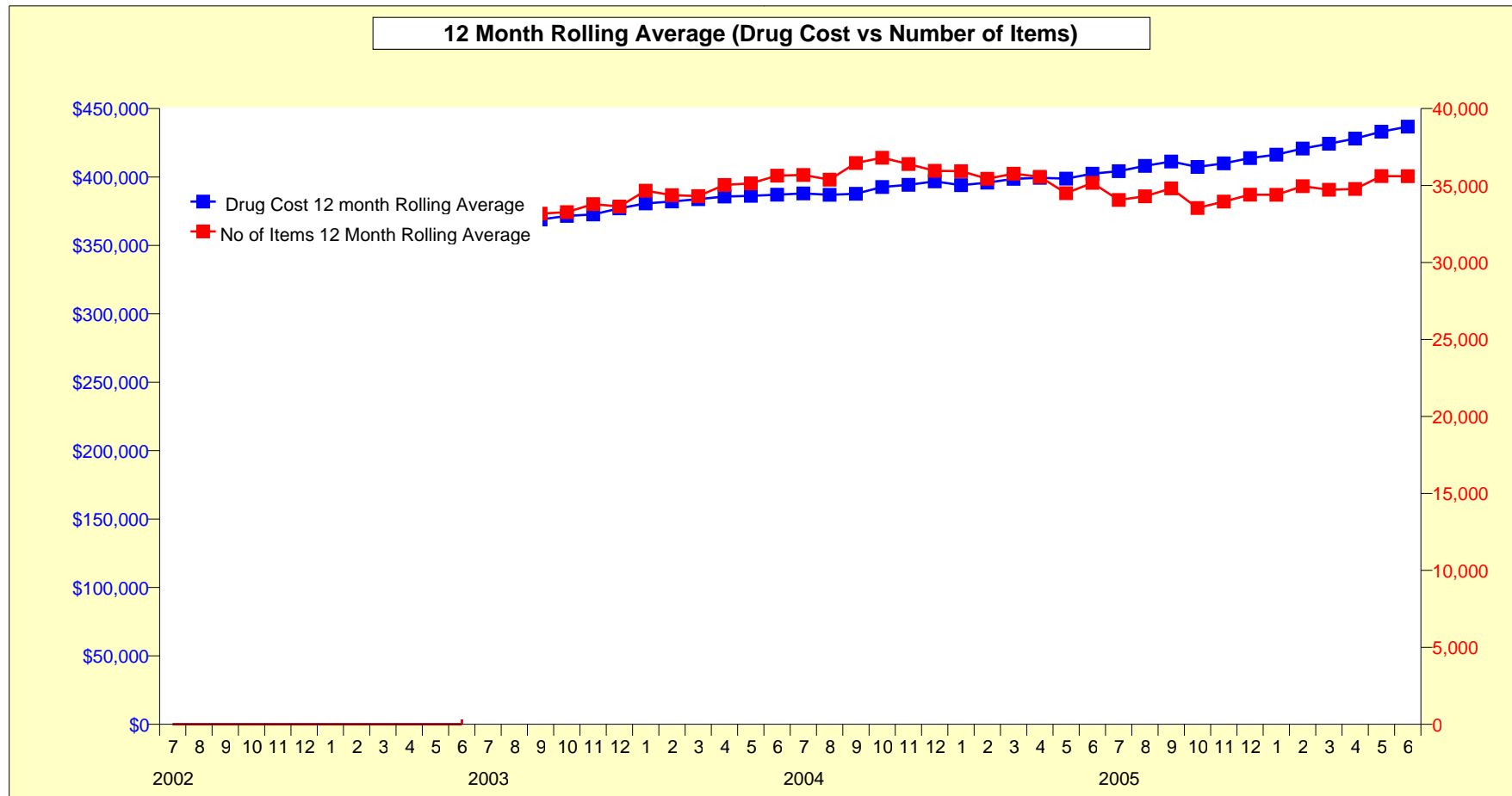
Referred Services Reports (Pharmacy) - West Coast

Part One - Expenditure Trends



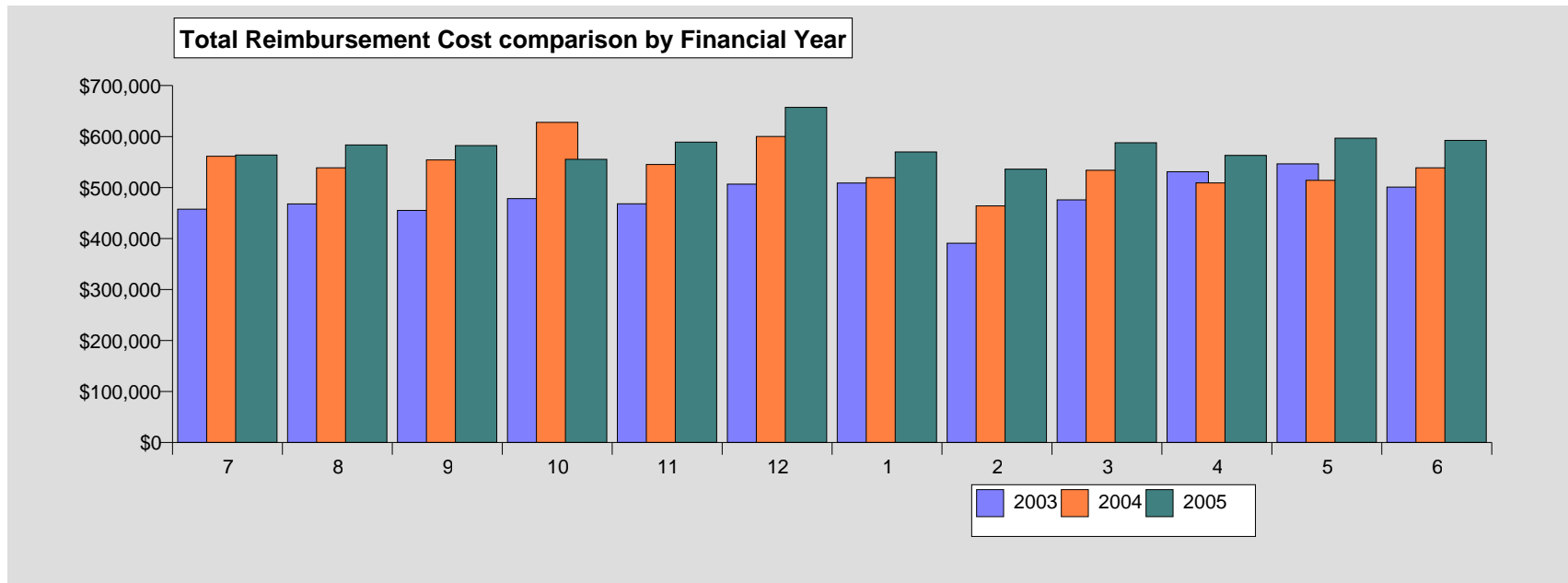
Graphic Notes & Assumptions - Monthly expenditure for pharmacy is supplied by HealthPAC. The data points showing costs are based on "Date of Service". The period covers actual expenditure for 2002/03 and 2003/04 financial years. A combination of actual expenditure and estimates (SISSAL developed "demand driven services forecast model") have been used for the 2004/05 projection. Important to note, the Pharmac rebate is not included in these results.

Referred Services Reports (Pharmacy) - West Coast



Graphic Notes & Assumptions - Monthly drug expenditure and volumes have been extracted from the NZHIS Pharmacy Warehouse. The graphic shows the rolling twelve month average for drug costs (blue line and axis) and number of items (red line and axis). The data extract goes back to Jul 2001 and is based on "Date of Claim". The X-axis is in numeric format because the software does not recognise any of the dates as text formats (2002 = 2001/02 financial year and 7 = July).

Referred Services Reports (Pharmacy) - West Coast

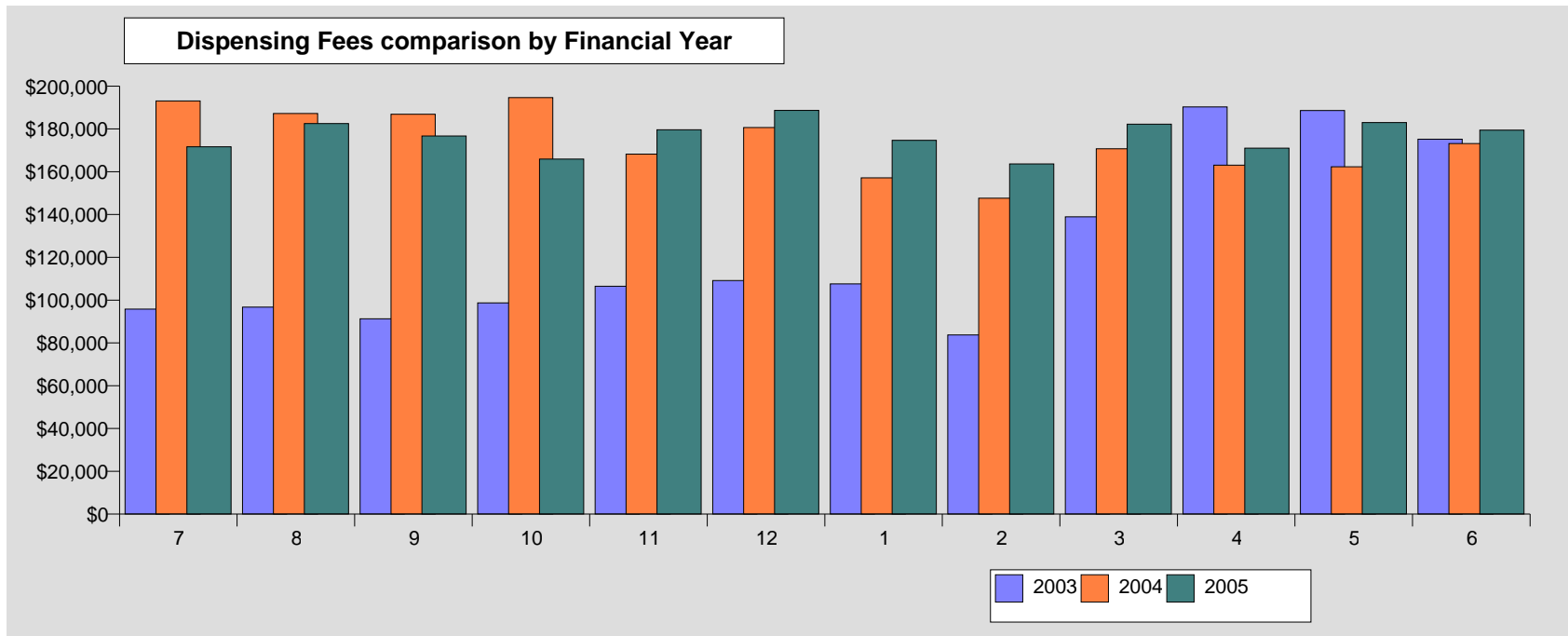


Cross Tab Table Showing Costs by Financial Year (7=July)

	7	8	9	10	11	12	1	2	3	4	5	6
2003	\$457,661	\$467,947	\$455,091	\$478,249	\$468,065	\$506,617	\$508,848	\$390,817	\$475,969	\$531,121	\$546,547	\$500,878
2004	\$561,468	\$538,736	\$554,107	\$627,791	\$545,158	\$600,120	\$519,572	\$464,002	\$533,799	\$509,015	\$514,252	\$538,767
2005	\$563,847	\$583,528	\$582,355	\$555,362	\$589,085	\$657,352	\$569,690	\$536,001	\$587,931	\$563,010	\$596,677	\$592,435

Graphic Notes & Assumptions - Monthly expenditure has been extracted from the NZHIS Pharmacy Warehouse. The graphic shows a comparison between financial years for reimbursement costs paid to Pharmacies (domicile of the Pharmacy equals Funding DHB). The data extract goes back to Jul 2002 and is based on "Date of Claim". Please note, southern management fees paid to Pharmacies are not included in this data. The payment of this fee ceased in the latter half of 2002/03. The X-axis is in numeric format because the software does not recognise the dates as text formats (2002 = 2002/03 financial year and 7 = July). Also important to note, due to the time lag in updating the data warehouse, the results shown for the last quarter may not be complete.

Referred Services Reports (Pharmacy) - West Coast

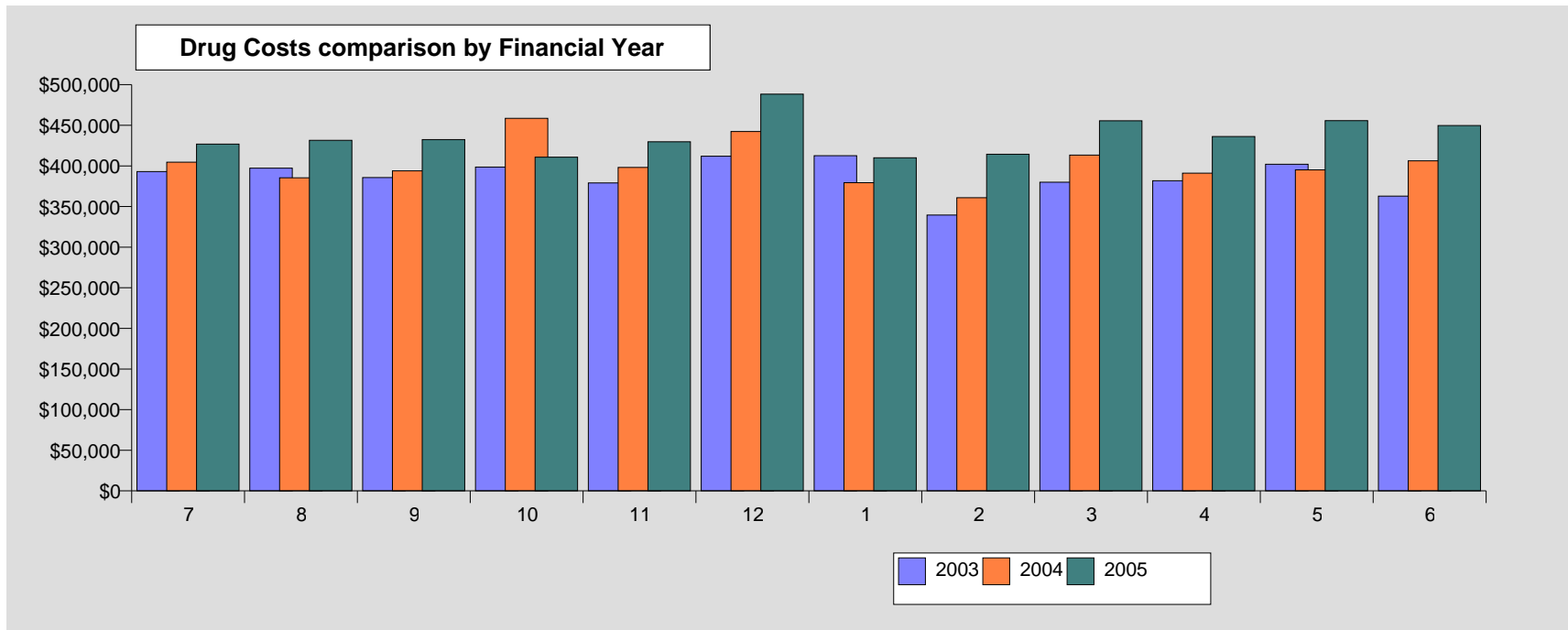


Cross Tab Table Showing Dispensing Fees by Financial Year (7=July)

	7	8	9	10	11	12	1	2	3	4	5	6
2003	\$95,816	\$96,711	\$91,267	\$98,697	\$106,487	\$109,120	\$107,554	\$83,701	\$138,893	\$190,292	\$188,609	\$175,168
2004	\$193,067	\$187,192	\$186,881	\$194,617	\$168,218	\$180,646	\$157,135	\$147,641	\$170,695	\$163,048	\$162,279	\$173,149
2005	\$171,677	\$182,527	\$176,676	\$165,901	\$179,586	\$188,657	\$174,659	\$163,632	\$182,223	\$170,990	\$182,970	\$179,414

Graphic Notes & Assumptions - Monthly expenditure has been extracted from the NZHIS Pharmacy Warehouse. The graphic shows a comparison between financial years for dispensing fees paid to Pharmacies (domicile of the Pharmacy equals Funding DHB). The data extract goes back to Jul 2002 and is based on "Date of Claim". Please note, southern management fees paid to Pharmacies are not included in this data. The payment of this fee ceased in the latter half of 2002/03. The X-axis is in numeric format because the software does not recognise the dates as text formats (2002 = 2002/03 financial year and 7 = July). Also important to note, due to the time lag in updating the data warehouse, the results shown for the last quarter may not be complete.

Referred Services Reports (Pharmacy) - West Coast

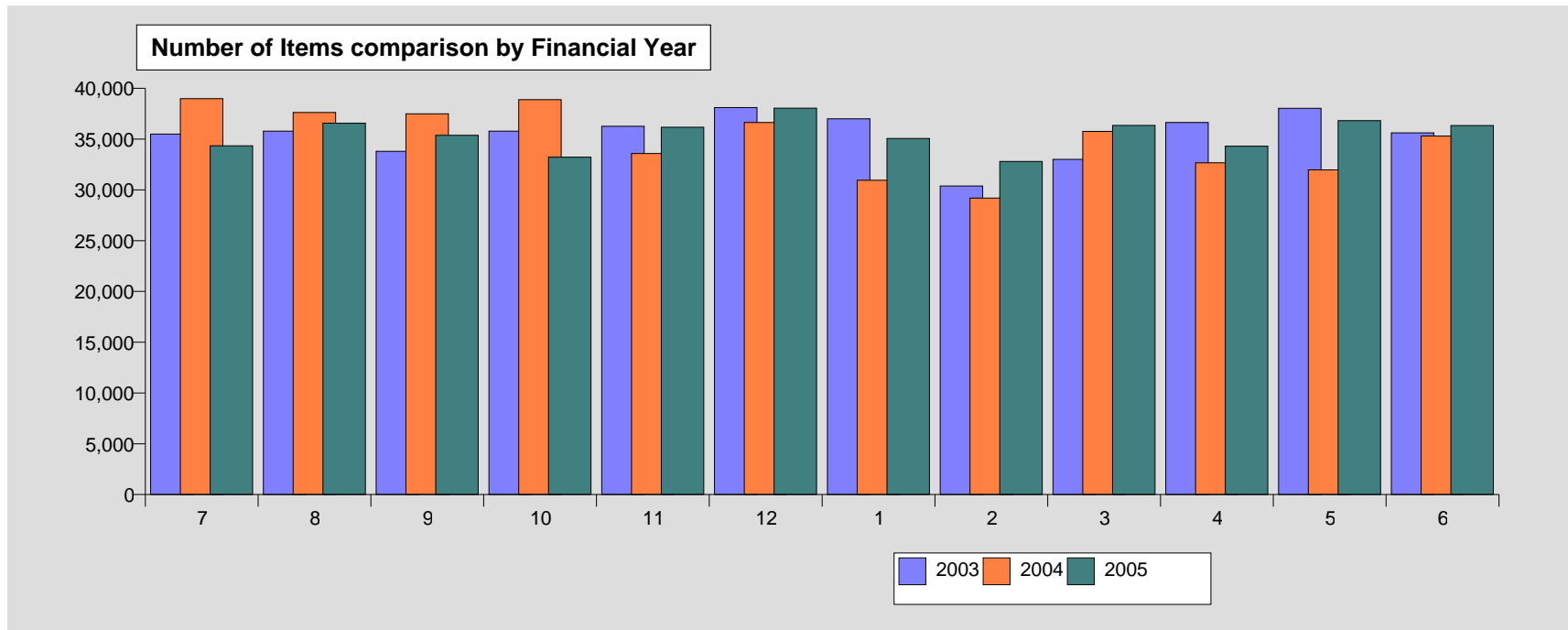


Cross Tab Table Showing Drug Costs by Financial Year (7=July)

	7	8	9	10	11	12	1	2	3	4	5	6
2003	\$392,967	\$397,284	\$385,644	\$398,619	\$379,027	\$411,922	\$412,587	\$339,571	\$379,988	\$381,748	\$402,051	\$362,772
2004	\$404,592	\$385,405	\$393,891	\$458,638	\$398,146	\$442,412	\$379,400	\$360,821	\$413,312	\$391,015	\$395,117	\$406,205
2005	\$426,799	\$431,479	\$432,370	\$410,726	\$429,743	\$488,290	\$410,090	\$414,360	\$455,541	\$436,215	\$455,695	\$449,744

Graphic Notes & Assumptions - Monthly expenditure has been extracted from the NZHIS Pharmacy Warehouse. The graphic shows a comparison between financial years for drug costs paid to Pharmacies (domicile of the Pharmacy equals Funding DHB). The data extract goes back to Jul 2002 and is based on "Date of Claim". The X-axis is in numeric format because the software does not recognise the dates as text formats (2002 = 2002/03 financial year and 7 = July). Also important to note, due to the time lag in updating the data warehouse, the results shown for the last quarter may not be complete.

Referred Services Reports (Pharmacy) - West Coast

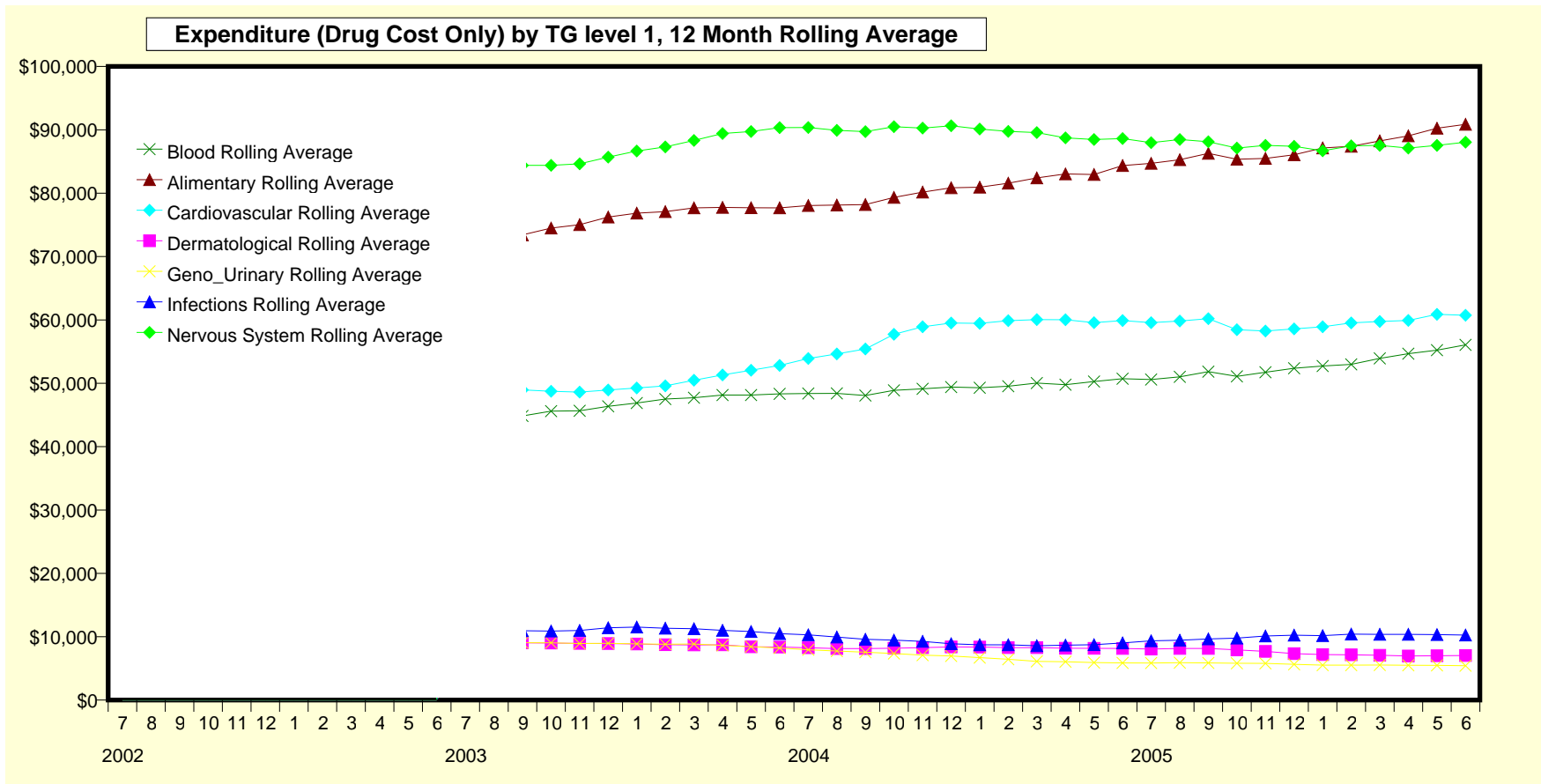


Cross Tab Table Showing Number of Items by Financial Year (7=July)

	7	8	9	10	11	12	1	2	3	4	5	6
2003	35,502	35,783	33,796	35,782	36,263	38,102	36,995	30,379	33,008	36,644	38,037	35,617
2004	38,978	37,621	37,493	38,884	33,578	36,641	30,945	29,189	35,762	32,668	31,971	35,301
2005	34,347	36,570	35,381	33,220	36,164	38,042	35,069	32,798	36,350	34,309	36,815	36,338

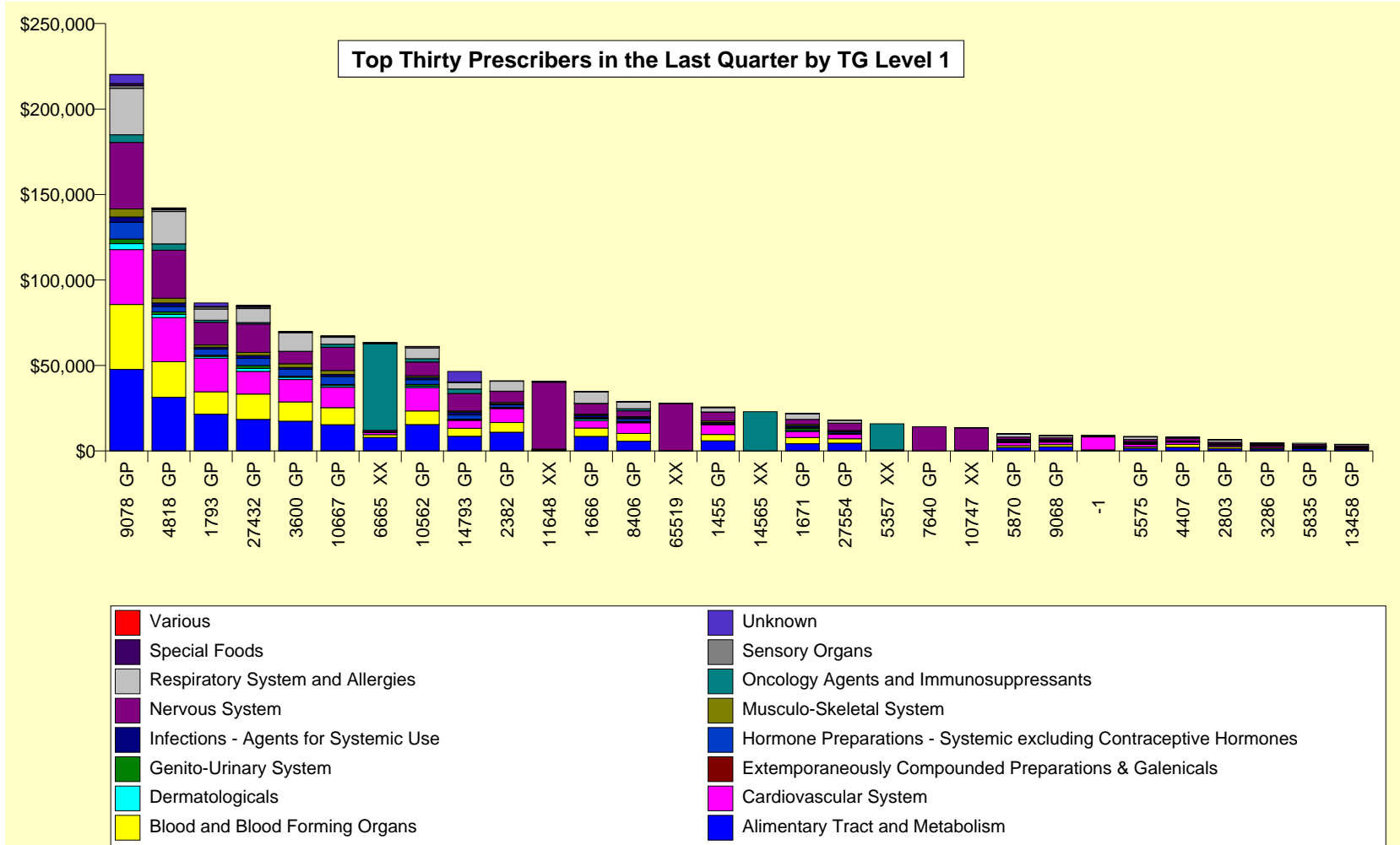
Graphic Notes & Assumptions - Monthly volumes have been extracted from the NZHIS Pharmacy Warehouse. The graphic shows a comparison between financial years for the number of items dispensed by Pharmacies (domicile of the Pharmacy equals Funding DHB). The data extract goes back to Jul 2002 and is based on "Date of Claim". The X-axis is in numeric format because the software does not recognise the dates as text formats (2002 = 2002/03 financial year and 7 = July). Also important to note, due to the time lag in updating the data warehouse, the results shown for the last quarter may not be complete.

Referred Services Reports (Pharmacy) - West Coast



Graphic Notes & Assumptions - Monthly drug expenditure and volumes have been extracted from the NZHIS Pharmacy Warehouse. The graphic shows the rolling twelve month average of drug costs broken down into therapeutic group level 1. Only the 7 major groups are shown. The data extract goes back to Jul 2001 and is based on "Date of Claim". The X-axis is in numeric format because the software does not recognise the dates as text formats (2002 = 2001/02 financial year and 7 = July).

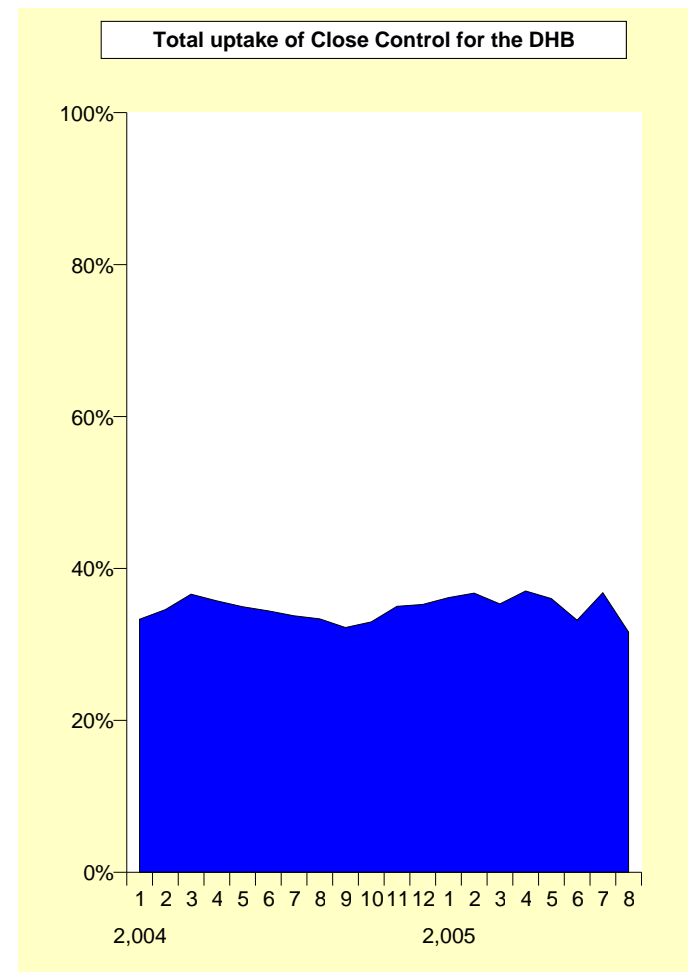
Referred Services Reports (Pharmacy) - West Coast



Graphic Notes & Assumptions - Quarterly expenditure for prescribers has been supplied from the NZHIS Pharmacy Warehouse. The costs have been broken down into therapeutic group level 1 detail and are based on "Date of Service". Total reimbursement costs has been used to rank the top thirty prescribers.

Part Two - Close Control and NHI Uptake

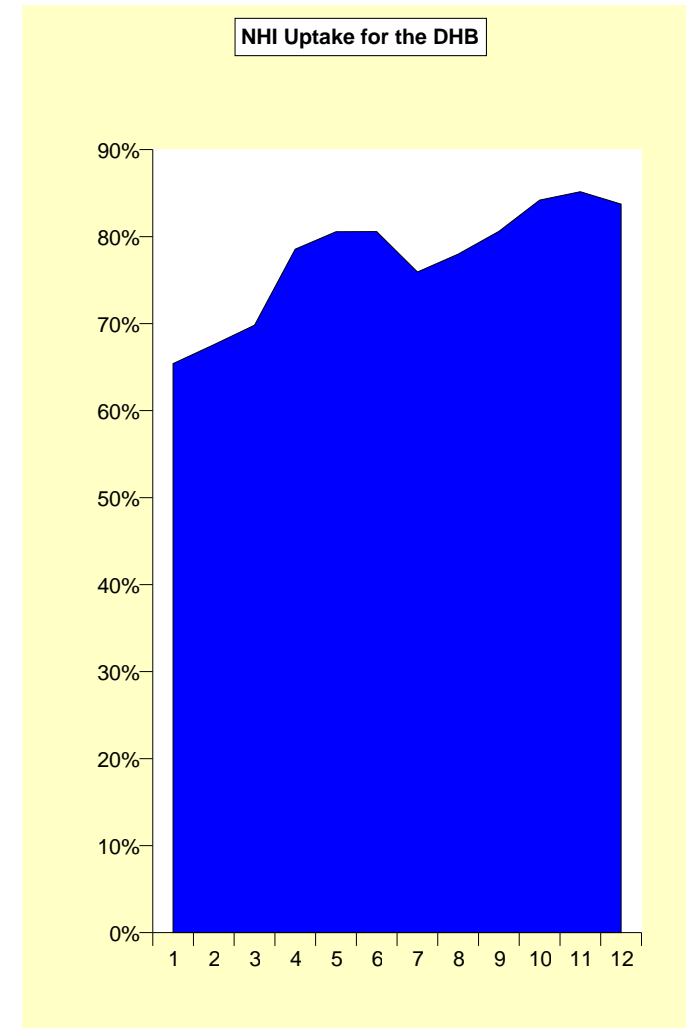
Close Control - Top 20 prescribers of repeat items (No of Items only for the latest quarter)					
Full Name	Ranking Order	Occupation Code	Total Possible Stat Dispensings (Repeat Seq = 0 or 1)	No of Items dispensed as Close Control	% Close Control
	Doctor No 1	GP	3,048	2,230	73%
	Doctor No 2	GP	2,271	948	42%
	Doctor No 3	GP	2,914	840	29%
	Doctor No 4	GP	1,536	523	34%
	Doctor No 5	GP	1,948	513	26%
	Doctor No 6	GP	1,364	425	31%
	Doctor No 7	GP	1,286	325	25%
	Doctor No 8	GP	710	319	45%
	Doctor No 9	GP	625	304	49%
	Doctor No 10	GP	244	165	68%
	Doctor No 11	GP	621	165	27%
	Doctor No 12	GP	494	157	32%
	Doctor No 13	GP	659	136	21%
	Doctor No 14	GP	875	120	14%
	Doctor No 15	GP	263	113	43%
	Doctor No 16	XX	79	67	85%
	Doctor No 17	GP	170	58	34%
	Doctor No 18	GP	240	45	19%
	Doctor No 19	GP	95	44	46%
	Doctor No 20	GP	93	42	45%



Notes for Part Two - The data for this section was supplied from the NZHIS Pharmacy Warehouse. Close Control Table and Graphic - The method used to calculate the uptake of close control is consistent with Pharmac. Assumptions 1 - Repeat Sequence Number equal to 0 or 1 for all possible items dispensed as All-at-Once; 2 - List of items dispensed as Stat was supplied by Pharmac; Repeat Sequence equal to 0 for items dispensed as All-at-Once. Ranking for the top twenty close control prescribers is determined on the total number of repeat dispensings. The graphic shows the total uptake for all prescribers since Jan 2004. NHI Coverage Table and Graphic - The table and graphic shows by Pharmacy the number of scripts containing patient NHI details.

Referred Services Reports (Pharmacy) - West Coast

Percentage of NHIs recorded by Pharmacy (latest quarter)				
Claimant Name	Ranking Order	No. of Scripts with NHI recorded	Total No. of Scripts	% NHI Coverage
	Pharmacy No 1	10498	13595	77%
	Pharmacy No 2	8221	9477	87%
	Pharmacy No 3	10601	11699	91%
	Pharmacy No 4	4429	5647	78%
	Pharmacy No 5	254	467	54%
	Pharmacy No 6	10349	11689	89%
	Pharmacy No 7	3	4	75%



Notes for Part Two - The data for this section was supplied from the NZHIS Pharmacy Warehouse. Close Control Table and Graphic - The method used to calculate the uptake of close control is consistent with Pharmac. Assumptions 1 - Repeat Sequence Number equal to 0 or 1 for all possible items dispensed as All-at-Once; 2 - List of items dispensed as Stat was supplied by Pharmac; Repeat Sequency equal to 0 for items dispensed as All-at-Once. Ranking for the top twenty close control prescribers is determined on the total number of repeat dispensings. The graphic shows the total uptake for all prescribers since Jan 2004. NHI Coverage Table and Graphic - The table and graphic shows by Pharmacy the number of scripts containing patient NHI details.

BREAST FEEDING STATISTICS

BREAST FEEDING STATISTICS

TO: Chair and Members
Community and Public Health Advisory Committee

FROM: Community and Public Health

DATE: September 2005

WEST COAST BREASTFEEDING PROMOTION

Healthy Eating-Healthy Action identifies breastfeeding promotion as an important area of work. Breastfeeding has obvious benefits for the health of all children and an increase in breastfeeding rates has the potential to reduce health inequalities, as Maori and Pacific babies are less likely to be breastfed at all time points than European and Other babies. There has been little improvement in breastfeeding rates in New Zealand over the past 10 years and the West Coast DHB had the country's lowest 6-week breastfeeding rates in the country in 2001 (Breastfeeding: A guide to action).

In August 2005, McBrearty Ward and Kawatiri Maternity Home received accreditation as 'Baby Friendly' under the Baby Friendly Hospital Initiative. One of the criteria for accreditation is that 75% of women discharged from the ward/unit must be exclusively breastfeeding. McBrearty had a rate of 81.6% of babies exclusively breastfed at discharge during the months of March/April/May 2005, Kawatiri had only two mothers give birth in the month they were assessed, both were exclusively breastfeeding on discharge, giving a rate of 100%. It is vital that rates on discharge are high enough to enable national targets to be met at six weeks and six months. (See attached statistics collated from WCDHB, Plunket and WC Independent midwives)

National definitions and target rates

National definitions for breastfeeding were defined in 1999 and providers have been required to report on breastfeeding rates using these definitions since 2003.

Exclusive: The infant has never, to the mother's knowledge, had any water, formula or other liquid or solid food. Only breast milk, from the breast or expressed, and prescribed medications have been given from birth.

Fully: The infant has taken breast milk only, and no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours.

Partial: The infant has taken some breast milk and some infant formula or other solid food in the past 48 hours.

Artificial: The infant has had no breast milk but has had alternative liquid such as infant formula, with or without solid food, in the past 48 hours.

The national targets for breastfeeding rates are:

Exclusive plus fully breastfeeding rate at 6 weeks: 74% by 2005, 90% by 2010

Exclusive plus fully breastfeeding rate at 6 months: 21% by 2005, 27% by 2010

Breastfeeding promotion

Many of the factors which impact on successful breastfeeding are due to the social environment, so changing the environment to be more supportive should have a positive impact on breastfeeding rates (for more information, see 'Breastfeeding: A guide to action; MOH 2002). Breastfeeding promotion involves creating an environment that supports, promotes and protects breastfeeding, making it the cultural norm in New Zealand. As well as concentrating on promoting breastfeeding in hospitals through the 'Baby Friendly Hospital Initiative', this could involve advocacy for 'Baby Friendly Workplaces' and social environments such as retail and hospitality venues that support breastfeeding mothers. Work on the WC has also aimed at raising the positive profile of breastfeeding by seizing available media opportunities. The NZ Breastfeeding Authority is due to pilot 'Baby Friendly Community Initiative' in 2006, whereby health agencies outside the hospital setting work towards 'baby-friendly' accreditation.

BABES in Arms

Community and Public Health has previously funded a breastfeeding promotion project that included initiatives to promote more supportive environments, plus the contracting of a breastfeeding support coordinator. A lactation consultant/midwife was paid 12 hours per month to coordinate and run breastfeeding support groups in Greymouth and Hokitika, and to pursue opportunities to promote breastfeeding. This was set up in late 2003 to fulfil the needs of the 10th step towards accreditation of WC maternity services with the Baby Friendly Hospital Initiative. The original coordinator resigned from this position in late 2004. At a WC Breastfeeding Interest group meeting (of health professionals) held in October 2004, members of the group stated strongly the need for this paid position to continue. Previous breastfeeding support groups in Hokitika and Greymouth have been unsuccessful long term, due to the difficulty consistently finding volunteer coordinators. A new paid coordinator began in the position in January 2005.

Evaluation of BABES in Arms

The success of the breastfeeding support groups has been mixed, with particularly low levels of attendance in Hokitika. This was acknowledged as an ongoing issue last year, therefore the new coordinator was made aware of this and meetings were promoted more heavily to see if this improved attendance. This involved paid newspaper ads in the Messenger, the Grey Evening Star and the West Coast Times plus free ads in the Community Notices and on community radio. The coordinator also phoned mothers who had previously attended sessions and other mothers who were known to be breastfeeding to inform them of the meetings, and reminded Plunket nurses and WC midwives of the group meeting times. Despite these efforts, attendance has remained variable.

Numbers attending BABES in Arms meetings, 2005

Month	Hokitika	Greymouth
January		8
February	4	5
March	2	7
April	2	2
May	6	3
June	7	

Many of the mothers who attend the BABES in Arms groups already appear to be committed to breastfeeding, with some breastfeeding babies beyond 12 months. It is difficult to know whether attendance at the group is effective at encouraging mothers, who wouldn't have done so otherwise, to breastfeed past the six week and six month milestones, thereby achieving the aim of improving breastfeeding rates.

Feedback taken from mothers who attend the group is generally positive, particularly with regard to guest speakers. Most of these speakers have spoken on topics unrelated to breastfeeding however, and this information may have been available from other parenting groups e.g. PAFT, Parents Centre, ante-natal classes.

Future of BABES in Arms

While there is clearly a role for public health in advocating for environments eg hospitals, workplaces, social settings that are supportive of breastfeeding, it was questioned whether it was the role of public health to be funding a support service for breastfeeding mothers. C&PH believed it would be more appropriate if the service was more closely linked to, and funded by, maternity services. This would allow greater consistency of support and mothers who would benefit most from the support group could be identified and referred by the maternity service providers. Since July 2005, the BABES in Arms coordinator's wage has been funded by WCDHB maternity services. Community and Public Health continues to provide support to the BABES in Arms group by providing a vehicle and covering other miscellaneous expenses, for example in World Breastfeeding Week promotions.

Other WC support groups

In Westport, the breastfeeding support group is run by the Plunket nurse. In Reefton, there is a mothers' support group coordinated by the Public Health Nurse, which is open to breastfeeding and artificially feeding mothers. La Leche League does not have any formal support groups running on the West Coast.

Other possible community initiatives to improve breastfeeding rates

Establishment of a West Coast Breastfeeding Advocate whose role could include:

- implementation of the Baby-Friendly Community Initiative across all WCDHB funded services
- implementation of the breastfeeding section of the WCDHB 'Healthy Eating' policy
- focus on workplaces, using the information on 'Breastfeeding in the Workplace' recently released by the Dept of Labour
- creating 'breastfeeding-friendly' environments across the West Coast, by extending the 'Baby-friendly Cafés' and working in other social settings
- ensuring breastfeeding support groups run across all areas of the WC
- support future national social marketing campaign flagged in HEHA
- continuing to highlight breastfeeding in the media and the community

Anecdotal feedback from new mothers on the WC suggests that difficulty accessing lactation consultants in the community may be one factor contributing to the WC's high drop-off in breastfeeding rates before the 6week milestone. Maternity staff also identify this as a barrier to continued breastfeeding. Alison Wallace, from Hokitika, is a Plunket and maternity nurse as well as an International Board Certified Lactation Consultant (IBCLC). Her submission to the WCDHB Draft strategic annual plan stated: "There is no-one, however, working in a paid position solely in this capacity (*as a lactation consultant*) on the West Coast. There are several IBCLC's, all are employed as maternity unit staff or Plunket Nurses, mostly part-time. These positions do not always allow time or resourcing to attend to all the lactation needs, especially when the client is not the responsibility of that practitioner." There may be a need for IBCLCs to have hours specifically dedicated to breastfeeding support, so they are available to make home visits and hold community clinics.

At the meeting of the Breastfeeding Interest Network October 2004, there was much discussion of a peer support programme developed and run by La Leche League. This programme involves training a peer support leader, who would then train mothers in the community to act as peer

support counsellors for other breastfeeding mothers. It was felt that this system might work well, particularly in the isolated communities on the West Coast. One barrier to implementing this programme is the cost of training and employing the peer support leader, approximately \$5000 for the five days training and ongoing LLL support, plus the cost of the leader's time. There may also be some difficulty in recruiting and training suitable peer support counsellors, who would be unpaid for their time. Their training would take 30 hours each.

WEST COAST BREASTFEEDING STATISTICS

National targets for breastfeeding rates

Exclusive plus fully breastfeeding rate at 6 weeks of 74% by 2005, 90% by 2010
Exclusive plus fully breastfeeding rate at 6 months of 21% by 2005, 27% by 2010

Mothers and babies usually discharged from wards at around 2 days old
Discharged from LMC anywhere between 2weeks and 5weeks+5 days old
Plunket first visit must be by 5weeks+6days old at the latest. This is usually when their '6 week' stats are obtained. Plunket sees approximately 80% of all babies born on the West Coast. The other 20% are mostly seen by Public Health Nurses, Rural nurse specialists and Rata te Awhina. Unsure how these other providers gather infant feeding statistics.

<u>McBrearty Ward (discharge from hosp)</u> 01/01/2004 – 31/12/2004	Number	Percentage
Exclusively BF	155	63.3
Fully BF	8	3.3
Partially BF	42	17.1
Partially BF (medically indicated)	14	5.7
Artificially fed	17	6.9
Not stated	9	3.7
Total	245	100%

<u>Buller (discharge from hosp)</u> 01/01/2004 – 31/12/2004	Number	Percentage
Exclusively BF	13	68.4
Fully BF	1	5.3
Partially BF	1	5.3
Partially BF (medically indicated)	3	15.8
Artificially fed	1	5.3
Not stated	0	0
Total	19	100.1%

<u>WCDHB maternity wards (discharge)</u> 01/01/2004 – 31/12/2004	Total Number	Total Percentage
Exclusively BF	168	63.6
Fully BF	9	3.4
Partially BF	43	16.3
Partially BF (medically indicated)	17	6.4
Artificially fed	18	6.8
Not stated	9	3.4
Total	264	99.9%

EXCLUSIVE BREASTFEEDING PLUS FULLY BREASTFEEDING AT DISCHARGE FROM WARD: 67%

Independent Midwives

CS 01/01/2004 – 31/12/2004	Number	Percentage
Exclusively BF	10	35.7
Fully BF	9	32.1
Partially BF	5	17.9
Artificially fed	4	14.3
Total	28	100%

NE 01/01/2004 – 31/12/2004	Number	Percentage
Exclusively BF	18	56.3
Fully BF	6	18.8
Partially BF	2	6.3
Artificially fed	6	18.8
Total	32	100.2%

Independent Midwives combined 01/01/2004 – 31/12/2004	Number	Percentage
Exclusively BF	28	46.7
Fully BF	15	25.0
Partially BF	7	11.7
Artificially fed	10	16.7
Total	60	100.1%

Exclusive breastfeeding plus fully breastfeeding percentage at discharge from independent LMC: 71.7%

Plunket

Assuming number of enrolments for the time period (Jul 2003-Dec 2004) is equal to number of six week checks

Plunket approx six weeks 01/07/2003 – 31/12/2004	Number	Percentage
Exclusively BF	222	50.5
Fully BF	48	10.9
Partially BF	53	12.0
Artificially fed	117	26.6
Total	440	100.0%

Exclusive breastfeeding plus fully breastfeeding percentage at 6wks: 61.4%

Assuming rate between July-Dec 2004 contributes half as much to the percentage rate as the rate from the previous 12 months

Plunket approx six months 01/07/2003 – 31/12/2004	Percentage
Exclusively BF	9.7
Fully BF	10.0
Partially BF	37.0
Artificially fed	43.3
Total	100.0%

Exclusive breastfeeding plus fully breastfeeding percentage at 6months: 19.7%

Author: Community and Public Health
Approved: General Manager Planning & Funding– Date September 2005
Approved: Chief Executive - Date September 2005

BREAST FEEDING STATISTICS

TO: Chair and Members
Community and Public Health Advisory Committee

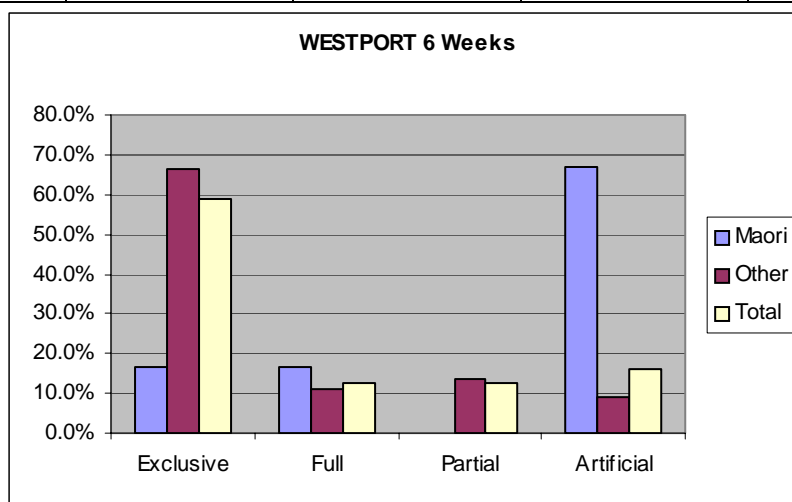
FROM: Shar Ransom

DATE: 14 September 2005

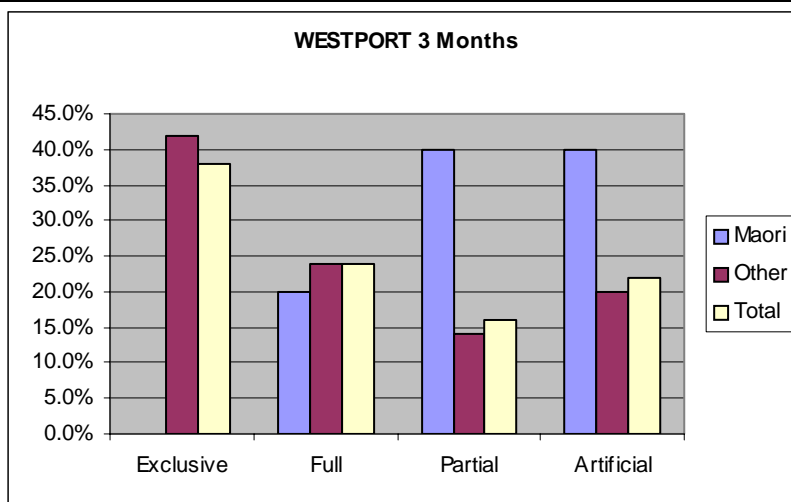
Breast Feeding Stats (enrolled Plunket clients) 1st July 2004 – 30th June 2005

Westport

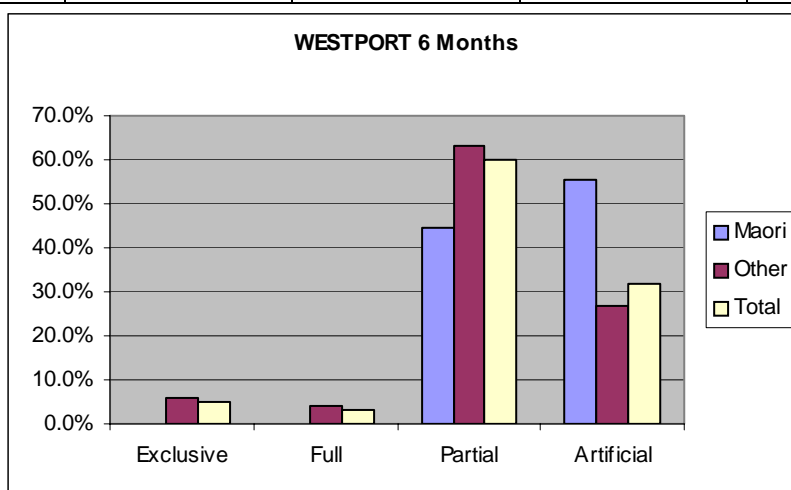
	Exclusive	Full	Partial	Artificial
6 weeks				
Maori (6 babies)	16.5%	16.5%	nil	67%
Other (45 babies)	66.5%	11%	13.5%	9%
Total (51 babies)	59%	12.5%	12.5%	16%



3 months				
Maori (5 babies)	nil	20%	40%	40%
Other (50 babies)	42%	24%	14%	20%
Total (55 babies)	38%	24%	16%	22%



6 months				
Maori (9 babies)	nil	nil	44.5%	55.5%
Other (51 babies)	6%	4%	63%	27%
Total (60 babies)	5%	3%	60%	32%



Definitions and Targets

Exclusive: The infant has never to the mother's knowledge, had any water, formula, or other liquid or solid food. Only breast milk from the breast or expressed and prescribed medicines have been given from birth.

Fully: The infant has taken breast milk only, and no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours. (This matches the WHO exclusive rate indicator). MOH 6 week target exclusive and fully 74% by 2005 90% by 2010, 3 month target 57% by 2005 and 70% by 2010, 6 month target 21% by 2005 and 27% by 2010.

Partial: The infant has taken some breast milk and some infant formula or some other solid food in the past 48 hours.

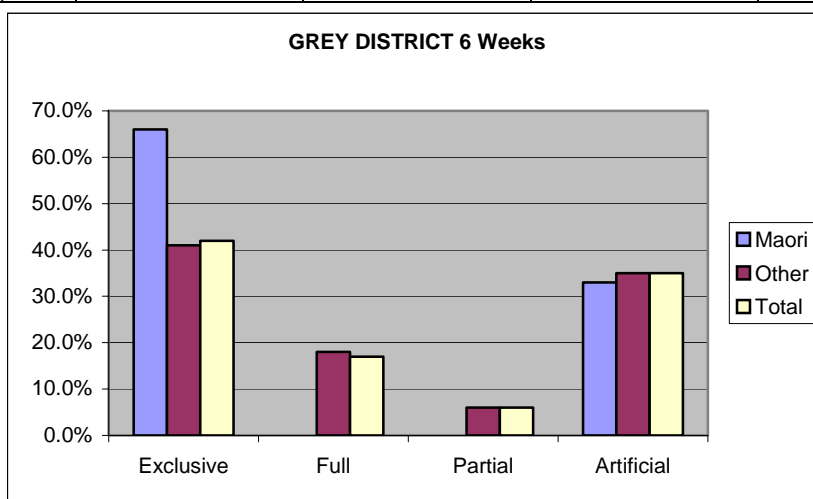
Artificial: The infant has had no breast milk but has had alternative liquid such as infant formula, with or without solid food, in the past 48 hours.

MOH targets set in 2002

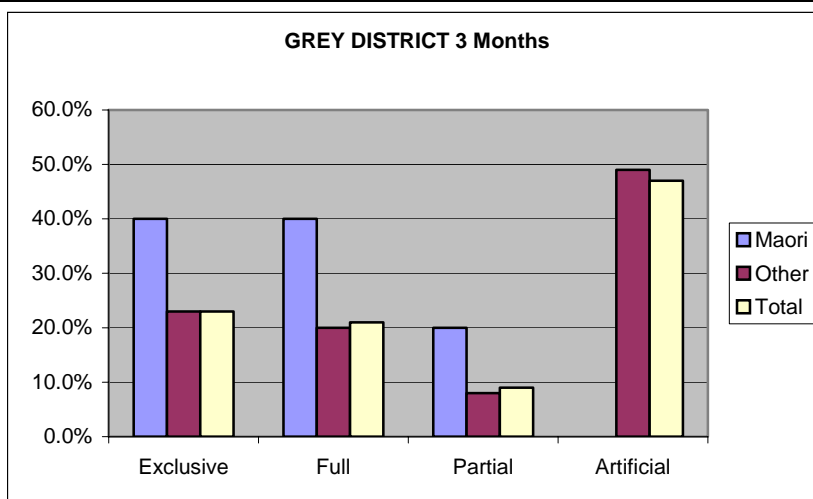
Grey District

(Paroa/Kumara, Greymouth/Blaketown/Boddytown/Karoro, Cobden, Runanga/Rapahoe Taylorville/Coral Creek, Dobson/Kaiata, Grey Valley)

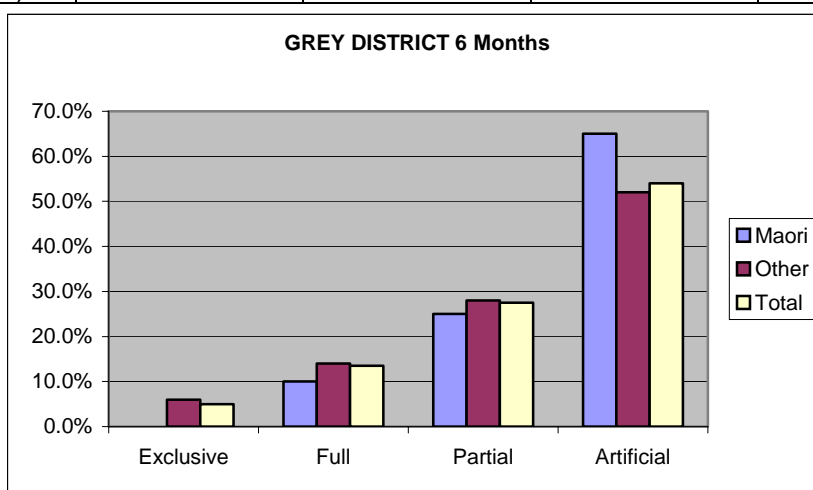
	Exclusive	Full	Partial	Artificial
6 weeks				
Maori (3 babies)	66%	nil	nil	33%
Other (78 babies)	41%	18%	6%	35%
Total (81 babies)	42%	17%	6%	35%



3 months				
Maori (5 babies)	40%	40%	20%	nil
Other (110 babies)	23%	20%	8%	49%
Total (115 babies)	23%	21%	9%	47%



6 months				
Maori (20 babies)	nil	10%	25%	65%
Other (124 babies)	6%	14%	28%	52%
Total (144 babies)	5%	13.5%	27.5%	54%



Definitions and Targets

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Fully: The infant has taken breast milk only, and no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours. (This matches the WHO exclusive rate indicator). MOH 6 week target exclusive and fully 74% by 2005 90% by 2010, 3 month target 57% by 2005 and 70% by 2010, 6 month target 21% by 2005 and 27% by 2010.

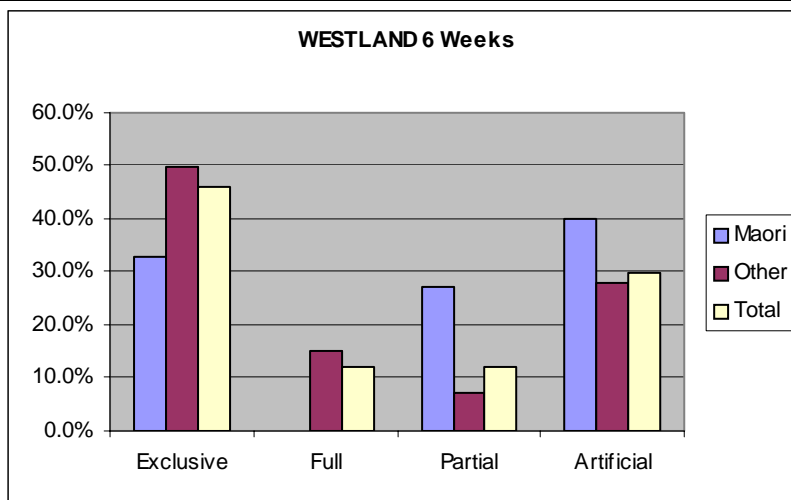
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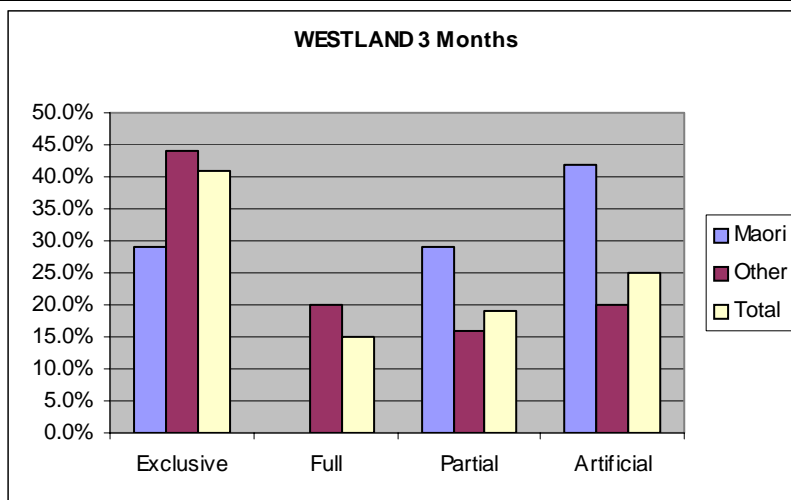
MOH targets set in 2002

Westland (Hokitika) Hokitika, Harihari, Ross, Kokotahi/Kowhitirangi

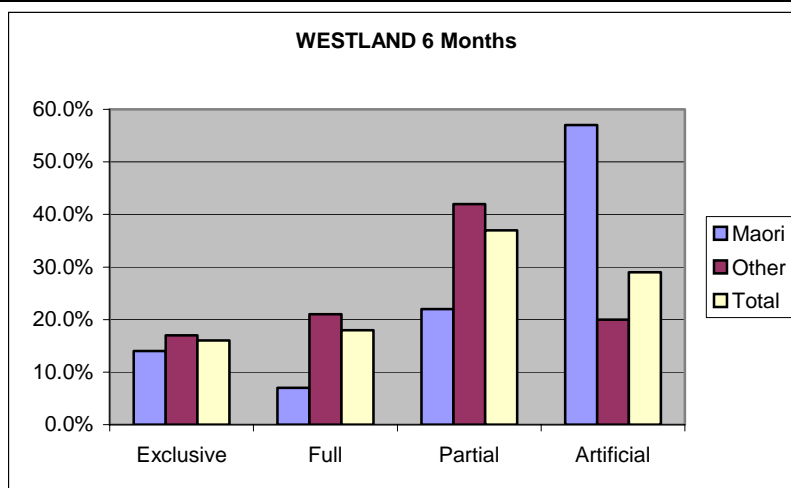
	Exclusive	Full	Partial	Artificial
6 weeks				
Maori (15 babies)	33%	nil	27%	40%
Other (54 babies)	50%	15%	7%	28%
Total (69 babies)	46%	12%	12%	30%



3 months				
Maori (14 babies)	29%	nil	29%	42%
Other (50 babies)	44%	20%	16%	20%
Total (64 babies)	41%	15%	19%	25%



6 months				
Maori (14 babies)	14%	7%	22%	57%
Other (48 babies)	17%	21%	42%	20%
Total (62 babies)	16%	18%	37%	29%



Definitions and Targets

Exclusive: The infant has never to the mother's knowledge, had any water, formula, or other liquid or solid food. Only breast milk from the breast or expressed and prescribed medicines have been given from birth.

Fully: The infant has taken breast milk only, and no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours. (This matches the WHO exclusive rate indicator). MOH 6 week target exclusive and fully 74% by 2005 90% by 2010, 3 month target 57% by 2005 and 70% by 2010, 6 month target 21% by 2005 and 27% by 2010.

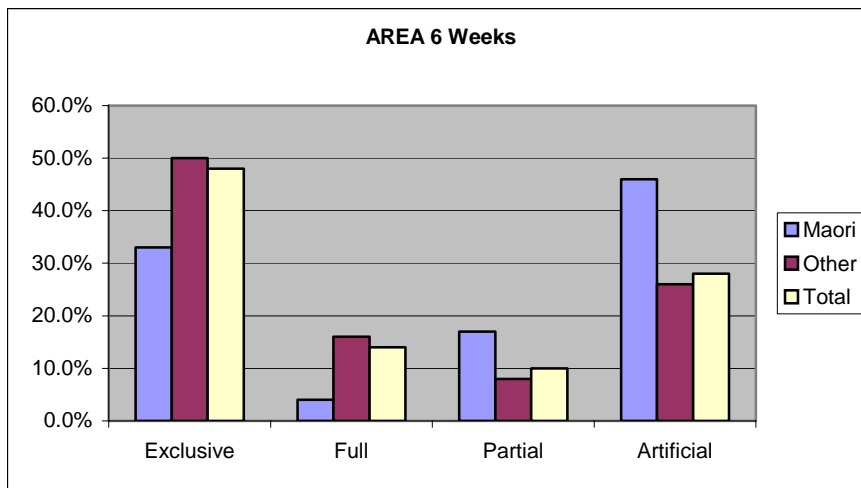
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Artificial: The infant has had no breast milk but has had alternative liquid such as infant formula, with or without solid food, in the past 48 hours.

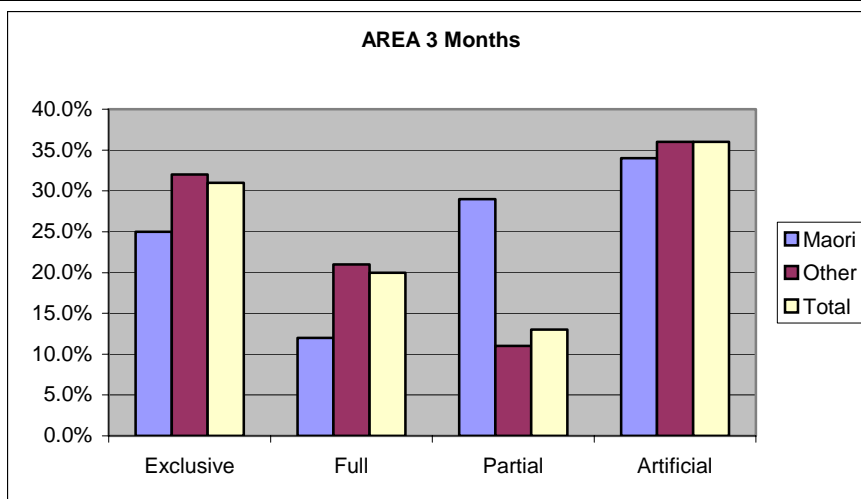
MOH targets set in 2002

Total West Coast Area

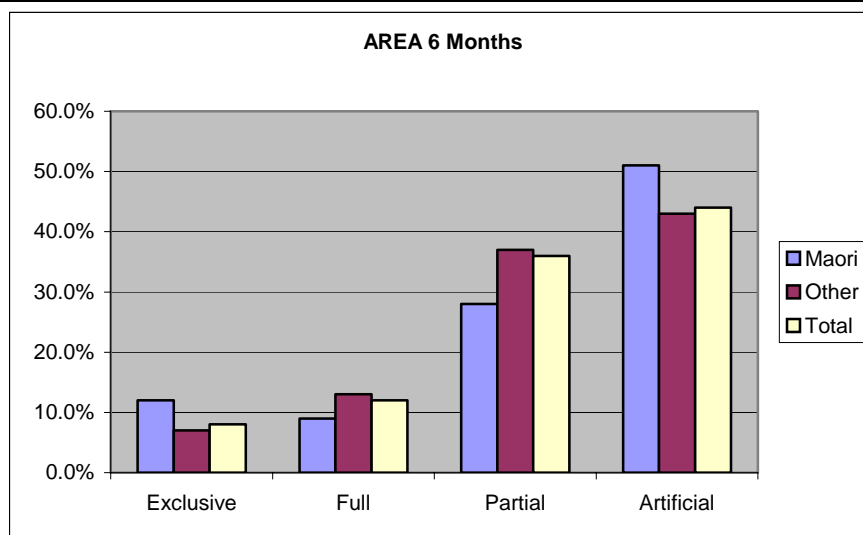
	Exclusive	Full	Partial	Artificial
6 weeks				
Maori (24 babies)	33%	4%	17%	46%
Other (177 babies)	50%	16%	8%	26%
Total (201 babies)	48%	14%	10%	28%



3 months				
Maori (24 babies)	25%	12%	29%	34%
Other (210 babies)	32%	21%	11%	36%
Total (224 babies)	31%	20%	13%	36%



6 months				
Maori (43 babies)	12%	9%	28%	51%
Other (223 babies)	7%	13%	37%	43%
Total (266 babies)	8%	12%	36%	44%



Definitions and Targets

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Artificial: The infant has had no breast milk but has had alternative liquid such as infant formula, with or without solid food, in the past 48 hours.

MOH targets set in 2002

Sources

MOH Breastfeeding: A Guide to Action 2002
Plunket Database

Author:	S Ransom – Date September 2005
Approved:	General Manager Planning & Funding – Date 15 September 2005
Approved:	Chief Executive - Date 15 September 2005

BREAST FEEDING STATISTICS

TO: Chair and Members
Community and Public Health Advisory Committee

FROM: A Wallace

DATE: Submitted to District Strategic Plan – 8 June 2005

SUBMISSION TO THE WEST COAST DISTRICT HEALTH BOARD'S

DRAFT STRATEGIC PLAN, 2005

Executive Summary

Firstly I applaud the inclusion of 'creating a West Coast environment supportive of breastfeeding' in the intended vision of the WCDHB.

The following submission:

- describes why supporting breastfeeding is an important task for the WCDHB
- makes some suggestions on how to begin creating this environment supportive of breastfeeding
- proposes that other measures also need to be implemented to increase the breastfeeding rate here

The strategies I believe can make a difference would be:

- Increased support for breastfeeding mothers where needed e.g. home-help, lactation consultant services, breastpump hire
- Collaboration with Community and Public Health, WCH Providers such as Plunket, and Iwi providers, to implement the La Leche League Peer Counseling Programme.
- Extension of the Baby Friendly Hospital Initiative
 - to the paediatric service
 - other hospital services involving mothers and babies, requiring
 - consultation with the public
 - written policies
 - education of staff involved, to understand the why and how
- DHB services in the community becoming Baby Friendly, with appropriate education, guidance, auditing and accreditation
- Collection of data on the rate of AF/BF of under 2year olds in hospital;
 - to give a local perspective on how important supporting breastfeeding is
 - to give a basis on which to monitor the results of changes in policies
- Creation of a Baby Friendly workplace within the WCDHB

- Support for other workplaces to become Baby Friendly.
- Extensive community, and health professional, education to develop a greater awareness of the impact on children's health of not receiving human milk.
- Creation of a position of 'breastfeeding advocate' within the WCDHB, to co-ordinate the above.

I am making a submission to the WCDHB's Strategic Plan as an individual, however I have been a International Board Certified Lactation Consultant for ten years and have worked in the maternity unit and as a Plunket nurse on Coast for almost all of that time. This gives me a sound knowledge breastfeeding issues, and of how families live and the things that impact on their lives.

WHY SUPPORTING BREASTFEEDING IS AN IMPORTANT TASK FOR THE WCDHB

Research shows us that more babies who are artificially fed are admitted to hospital. It follows then, that increasing the breastfeeding rate will lower the hospital admissions. Less hospital admissions will save the WCDHB money, especially as under two year olds are often admitted with a parent as well. As well as reducing hospital admissions, doctors visits and medication use, increased breastfeeding rates would mean less children would have the discomfort of illness, and fewer parents the stress, and possibly time off work that accompanies sick children. Increased breastfeeding rates would also positively affect women's health.

What is the Impact of Artificial Feeding?

In World Breastfeeding Week last year the Women's Health Action published data on the increased likelihood of illness for artificially fed babies. Their research stated that:

Children who are not exclusively breastfed for 6 months are more at risk of suffering certain illnesses and conditions. The babies are;

- About 250% more likely to be hospitalised for respiratory infections like asthma and pneumonia
- About 100% more likely to suffer from diarrhoea.
- About 60% more likely to suffer from recurrent ear infections.
- About 40% more likely to develop type 1 diabetes.
- About 30% more likely to suffer from leukaemia.
- About 25% more likely to become overweight or obese.

The data from these figures come from: well designed studies, from developed countries, 1990 onward, sample sizes of 100 children or more with a breastfeeding duration of at least 6 months.

World Health Recommendations/NZ/West Coast Comparisons To The Recommendations

'In May 2001 The World Health Assembly meeting adopted a resolution to: 'protect, promote and support exclusive breastfeeding for six months as a global public health recommendation, and to provide safe and appropriate complementary foods, with continued breastfeeding for up to two years of age and beyond'(WHO 2001). In NZ at three months old around 30% of babies have no breastmilk at all (Plunket, 2004). On the West Coast at this age more than 50% are not exclusively breastfed, they have had something other than breastmilk, (Ministry of Health, 2002), therefore are more likely to succumb to illness.

Breastfeeding A Guide to Action (MOH, 2002) says there is a need to 'Identify those DHB's with poor breastfeeding outcomes and discuss strategies to improve outcomes'. The figures cited in this publication point to the West Coast as having the poorest breastfeeding outcomes at 6 weeks

of age, and below the NZ average at 3months of age (2001 figures), signifying we need to discuss strategies!

The DHB has an obligation to use the NZ Health Strategy and publications from MOH to guide planning. Underpinning these NZ publications are the world health documents such as the Ottawa Charter, which calls for action to: build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services, a guide for this submission.

NZ Health Strategy, Important Key Health Objectives, and the Relationship to Breastfeeding.

Of the 13 population health objectives in the NZ Health Strategy, evidence confirms that breastfeeding will contribute positively to five of these, and may affect others also.

Reduce smoking, improve nutrition, reduce obesity

Mothers sometimes reduce their smoking when breastfeeding.

Increasing breastfeeding uptake and duration is improving children's nutrition.

Obesity is more likely to occur if an individual has been artificially fed (MOH 2002).

Reduce the incidence and impact of cancer, cardiovascular disease, and diabetes

Breastfeeding protects women against some breast and ovarian cancers.

Babies who are artificially fed are at greater risk of cardiovascular disease later in life and of contracting juvenile diabetes, when diabetic women breastfeed they often have lower insulin needs

Reduce violence in interpersonal relationships

Breastfeeding allows close emotional bonding between mother and child, this may reduce incidences of violence to the child (Acheson, 1995).

Reduce health disparities by improving health outcomes for Maori

Maori health priority areas include hearing, diabetes and asthma.

Artificially fed babies are at greater risk of glue ear (contributing to hearing loss), diabetes and asthma. Breastfeeding protects against these.

CREATING AN ENVIRONMENT SUPPORTIVE OF BREASTFEEDING

My proposal is for the:

- Extension of the Baby Friendly Hospital Initiative
 - to the paediatric service
 - other hospital services involving mothers and babies, requiring
 - consultation with the public
 - written policies
 - education of staff involved, to understand the why and how
- DHB services in the community becoming Baby Friendly, with appropriate education, guidance, auditing and accreditation

The maternity facilities have almost achieved Baby Friendly Hospital accreditation, however beyond the maternity unit setting, other environments also need to be supportive of breastfeeding (Baby Friendly).

- Creation of a Baby Friendly workplace within the WCDHB

Employers as well as families benefit from supporting their employees to breastfeed. Although mothers who work for the WCDHB often make satisfactory arrangements, these are influenced by the manager, and the employee's awareness of possible breastfeeding/expressing options. There is no formal agreement/policy. Policy could include time away from duties to breastfeed or express, and facilities (e.g. a room, fridge, breastpump) available to use.

- Support for other workplaces to become Baby Friendly

WCDHB, as the main organisation involved in health care on the Coast, would do well to lead others by developing policies which support breastfeeding.

By adopting these policies to create supportive environments the WCDHB will be following the Ottawa Charters call for action to 'build healthy public policy' and 'create supportive environments'.

OTHER MEASURES TO INCREASE THE BREASTFEEDING RATE

Although within the healthcare setting, the environment may be 'Baby Friendly, changing the communities and culture on the West Coast will require a more comprehensive approach, the following measures could be implemented:

- Collaboration with Community and Public Health, WCH Providers such as Plunket, and Iwi providers to implement the La Leche League Peer Counseling Programme.

The WCDHB 'intended vision for the future' states an intention for 'better connection between services'. By linking in with other providers community action is strengthened (Ottawa Charter). By implementing the peer counseling programme, the expertise of an organization that has been active in supporting breastfeeding for more than 40 years, can be utilized.

La Leche League Breastfeeding Peer Counsellor Programme is attached as an appendix.

- Increased support for breastfeeding mothers where needed e.g. home-help, lactation consultant services, breastpump hire.
-

Increased support in a very practical way would make visible the worth of breastfeeding. Home-help, lactation consultant services and breastpump hire are needed in some cases, and families are often not in the financial position to pay for these themselves.

'Breastfeeding A Guide to Action' found that barriers to breastfeeding include 'perceived inadequate milk supply, poor suckling and attachment, use of pacifiers and infant formula.' Milk supply is associated breastfeeding frequently and also mothers getting enough rest, for some mothers this is a struggle because of older children or difficulties. Short term practical help in the home (home-help) for those mothers who are struggling to manage breastfeeding, funded by the DHB would be a preventative action aimed at keeping the breastfeeding relationship intact. There are some situations e.g. when there is poor suckling and attachment, where there is a need for more intensive and expert assistance with breastfeeding in order to develop personal skills (Ottawa Charter) and to 'intervene as early and effectively as possible to deal with any problems that arise' (WCDHB's intended vision for the future). These situations occur in complicated cases and where intensive support is needed, best practice would indicate referral to a International Board Certified Lactation Consultant (IBCLC). There is no-one, however, working in a paid position solely in this capacity on the West Coast. There are several IBCLC's, all are employed as maternity unit staff or Plunket Nurses, mostly part-time. These positions do not always allow time or re-sourcing to attend to all the lactation needs, especially when the client is not the responsibility of that practitioner.

- Extensive community, and health professional, education to develop a greater awareness of the impact on children's health of not receiving human milk.

'Breastfeeding A Guide to Action' cites societal and environmental factors as barriers to successful breastfeeding, amongst which are:

'Societal norms and the values and beliefs of women'

In some West Coast communities the beliefs concerning infant feeding come from generations of artificially feeding infants and are usually not suitable to understand breastfeeding.

'Partner attitudes to breastfeeding'

West Coast men get very little breastfeeding information unless they attend ante-natal classes with their partner, and yet research shows partners are the greatest influence on the breastfeeding mother.

'Socioeconomic status and educational attainment'

'Women with lower educational attainment and socioeconomic status breastfeed for shorter lengths of time....'

Much of the West Coast has a deprivation score of 8, 9 and 10, the lowest education and socioeconomic brackets, therefore are likely to need more strategies to increase their breastfeeding duration. The Peer Counseling Programme La Leche League runs has been successful in similar areas in Britain and the USA..

Education about breastfeeding, especially concerning the use of pacifiers (dummies) and formula, and the negative effect these have on breastfeeding, is needed throughout the community as it is often the partner or grandparents who are influential in breastfeeding management. Discussion on the impact of human babies not receiving human milk might have more impact than 'breast is best' terminology.

Education of the community would serve as 'improved health promotion for children' (WCDHB's intended vision for the future). More specific to breastfeeding the The Innocenti Declaration of 1990, on the Protection, Promotion and Support of Breastfeeding, states that there 'needs to be reinforcement of a 'breastfeeding culture' and defence against incursions of a 'bottle-feeding' culture, and obstacles to breastfeeding within the health system eliminated' (WHO, 1990).

One could draw a parallel to smoking. Smoking is the social norm in some circles although the act of breathing in a foreign substance damages health. Similarly feeding babies a substitute for breastmilk introduces a foreign situation, which then affects the babies and mothers health. Bottle feeding is often the social norm, and is not seen as harmful, even within the health profession, although there is growing evidence that a baby who is artificially feed is likely to be disadvantaged. As with smoking cessation it is not only the individual that action for health needs to target, it is the social milieu in which baby feeding takes place. Just as the WCDHB allocates resources to address smoking, I believe it should also continue to allocate resources to protect, promote and support breastfeeding

To 'reorient health services' (Ottawa Charter) preventative actions such as practical support for breastfeeding, which increases the chance of wellness, could be implemented instead of focusing all resources on illness.

Although many people are familiar with 'best is best', I believe the importance of breastfeeding to babies, women, and families, is not well understood by our community, including those in the health services, as evidenced by the beliefs and actions which result in the prevalent artificial feeding of babies.

- Collection of data on the rate of AF/BF of under 2year olds in hospital;
 - to give a local perspective on how important supporting breastfeeding is
 - to give a basis to monitor any changes resulting from changes in policies

The 'WCDHB intended vision for the future' states an intention 'for better information collection...', collecting breastfeeding data will show more clearly what is happening and where to direct resources.

- Creation of a position of 'breastfeeding advocate' within the WCDHB, to co-ordinate the above.

To implement these strategies employment of a breastfeeding co-coordinator, or similar, would be necessary.

CONCLUSION

To change the culture and the breastfeeding rate on the West Coast a comprehensive approach, such as is outlined in the Ottawa Charter, needs to be taken. Education of community members,

families and health professionals, as well as strategies which directly concern breastfeeding mothers, will be necessary.
The goal for West Coast children should be; to be exclusively breastfed until around six months and to have some breastfeeding until two years of age, as recommended by the World Health Organization.

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Approved:	General Manager Planning & Funding – Date 20 September 2005
Approved:	Chief Executive - Date 20 September 2005

WORK PLAN

Please find work plan attached

CPHAC 2005/06 WORK PLAN

Mission Statement: To fund a continuum of quality health services aimed at providing improved health outcomes and maximise the independence of people with disabilities.

DAP Section, for CPHAC attention	Objective	Responsibility	End Date	Reporting Frequency	Progress			Comment
					Behind	On Target	Complete	
Ensuring Services for the DHB's population	Provide input into							
	1. Health Need Assessment	GM Planning & Funding		Annually				
	2. District Annual Plan	GM Planning & Funding		Annually				
	3. Statement of Intent	GM Planning & Funding		Annually				
	4. Annual Report	Chief Financial Manager		Annually				
Improving Maori Health	To monitor							
	1. Maori Health Plan progress towards aims and objectives	GM Maori Health		Quarterly				
Improving Mental Health	To monitor							
	1. Primary Mental Health Plan progress towards aims and objectives	GM Mental Health		Quarterly				
Reducing the Incidence and Impact of Diabetes	To monitor							
	1. Local Diabetes Team reports	GM Planning & Funding		Annually				
Reducing the Incidence and Impact of Cardiovascular disease and Stroke	To monitor (these apply to other disease areas also)							
	1. Green prescription uptake	GM Planning & Funding		Annually				
	2. Nicotine Replacement	GM Planning & Funding		Annually				

CPHAC 2005/06 WORK PLAN

DAP Section, for CPHAC attention	Objective	Responsibility	End Date	Reporting Frequency	Progress			Comment
					Behind	On Target	Complete	
	Therapy uptake							
Improving Oral Health	To monitor							
	1. School Dental Service	GM Planning & Funding		Annually				
	To investigate/scope							
	1. Feasibility funding for travel assistance to children and adolescents who need to travel for emergency dental care not able to be provided by local dental therapists.	GM Planning & Funding						
	2. West Coast Community Dental Centre	GM Planning & Funding						
Child and Youth Services	To develop							
	1. Youth Health Strategy	GM Planning & Funding						
	To monitor							
	1. Immunisation rates	GM Primary Care		Six monthly				
	2. Sexual Health Services	Janet Hogan		Six monthly, Feb 06				
Progressing the NZ Primary Health Strategy	To develop							
	1. Primary Care Plan	GM Planning & Funding		Each meeting				

CPHAC 2005/06 WORK PLAN

DAP Section, for CPHAC attention	Objective	Responsibility	End Date	Reporting Frequency	Progress			Comment
					Behind	On Target	Complete	
	2. Information Services Strategic Plan (as relevant to Primary Care)	Chief Financial Manager		Quarterly				Clarification sought as to EMT's notions re this
	3. Greymouth Health Centre	GM Planning & Funding/GM Primary Care		Each meeting				
	4. Neighbourhood Nursing Project progress	DON		Quarterly				
	To monitor							
	1. Community Referred Services, including Laboratory and Pharmaceutical spending	GM Planning & Funding		Quarterly				
	2. PHO a) Review criteria being considered towards meeting (i) Aims of Primary Care Strategy (ii) Contractual obligations to the WCDHB	GM Planning & Funding		Quarterly/ ?six monthly				
	3. Healthline usage	GM Planning & Funding		Annually				
Subsection of NZ Primary Care Strategy - Recruitment and Retention Strategies	To develop							
	1. Rural GP Training Program	GM Primary Care		Each meeting				

CPHAC 2005/06 WORK PLAN

DAP Section, for CPHAC attention	Objective	Responsibility	End Date	Reporting Frequency	Progress			Comment
					Behind	On Target	Complete	
	To monitor							
	1. Undergraduate Medical Student training program	Dr Greville Wood		Six monthly				
	To investigate/scope							
	1. The most efficient use of direct financial incentives and scholarships to recruit and retain health professionals.	GM Planning & Funding/Chief Financial Manager						
Implementing the NZ Cancer Control Strategy	To monitor							
	1. National Cervical Screening Program involvement for West Coast women	Cervical Screening Program coordinator		Six monthly				
	2. Breastscreen Aotearoa involvement for West Coast women	? GM Primary Care		Six monthly				
	To investigate/scope							
	1. Engage WCPHO in best practice cervical screening evaluation	GM Planning & Funding						
Implementing Healthy Eating, Healthy Action Plan	To monitor							
	1. HEHA progress towards goals and objectives	GM Planning & Funding		Quarterly from Aug 05				
Public Health	Monitor							

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2005/06 WORK PLAN

DAP Section, for CPHAC attention	Objective	Responsibility	End Date	Reporting Frequency	Progress			Comment
					Behind	On Target	Complete	
	1. West Coast Public Health Plan progress	Medical Officer of Health		Six monthly				