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2 DISABILITY SUPPORT ADVISORY COMMITTEE MEMBERS' DISCLOSURES OF INTERESTS

Member	Disclosure of Interest
CHAIR John Vaile WCDHB Member	<ul style="list-style-type: none"> • Member - CCS Westport Branch • Director - Vaile Hardware Ltd • Wife no longer works for DHB as unresolved employment issues
DEPUTY CHAIR Mohammed Shahadat WCDHB Member	<ul style="list-style-type: none"> • Member of the New Zealand Law Society • President of the Hokitika Lions Club 2001-2002 • Principal Partner, Murdoch James and Roper
Professor Gregor Coster Chairman WCDHB <i>Appointed February 2003</i>	<ul style="list-style-type: none"> • Director – PHARMAC • Director - Cornwall Management Limited • Director - Cornwall Nominees Limited • Trustee - The University of Auckland Primary Health Care Trust • Chairman - Institute of Rural Health • Trustee - Goodfellow Foundation
Gloria Hammond	<ul style="list-style-type: none"> • Co-ordinator - New Zealand CCS, West Coast • Field Worker / Regional Co-ordinator - CCS West Coast • Member – Early Intervention Team • Member – Maori Women Welfare League • Chairperson C.O.G.S
Maureen Frankpitt	<ul style="list-style-type: none"> • Manager Kowhai Manor and Richard Seddon Hospital
Elinor Stratford	<ul style="list-style-type: none"> • Manager - Disability Information Service • Vice Chairperson - GDCVH Inc (Grey District Council Volunteer Helpers Inc) • Member - NZCCS Greymouth Branch • Chairperson - West Coast Sub branch - Canterbury Neonatal Trust • Trustee - Canterbury Neonatal Trust • Project Co-ordinator – West Coast District Health Board • Vice-Chair Victim Support, Greymouth • Grey District Councillor • Member of Executive Federation of Disability Information Centres
Dianne Lewis	<ul style="list-style-type: none"> • No points to disclose

3 AGENDA

FOR THE WEST COAST DISTRICT HEALTH BOARD DISABILITY SUPPORT ADVISORY COMMITTEE MEETING TO BE HELD IN THE BOARD ROOM, CORPORATE OFFICE, GREYMOUTH ON WEDNESDAY 16 FEBRUARY 2005, COMMENCING AT 8.30 AM

1. Welcome / Apologies
2. Disclosure of Advisory Committee Members' Interests
3. Agenda Check
4. Minutes of Last Meeting - Held 15 December 2004
5. Matters Arising from Last Meeting
6. Correspondence
7. Action and Responsibility List
8. Quality & Safety Project – Final report
9. Dementia Unit update
10. Inclusion of Mental Health issues into Disability Support Advisory Committee
11. District Strategic Plan
12. Regional Land Transport – feedback from meeting
13. Water Fluoridation - Melanie Penny
14. General Business
15. Next Meeting – To be advised
16. Attendance and Administration Form

4. DRAFT MINUTES OF THE DISABILITY SERVICES ADVISORY COMMITTEE MEETING

HELD ON WEDNESDAY 15 DECEMBER 2004 IN THE BOARD ROOM, CORPORATE OFFICE
COMMENCING AT 8.33 AM

PRESENT: John Vaile, Chairman, WCDHB member
Elinor Stratford
Maureen Frankpitt
Gloria Hammond
Dianne Lewis

IN ATTENDANCE: John Luhrs, CEO
Kevin Hague, General Manager Planning & Funding
Hecta Williams, General Manager Mental Health joined at 8.40am
Melanie Penny, Research & Planning Analyst
Bianca Kramer, Minute Recorder

APOLOGIES: Gregor Coster, Chair WCDHB

1. WELCOME / APOLOGIES

The Chairman welcomed everyone to the meeting. Apologies were received from Gregor Coster, Chair WCDHB

2. DISCLOSURE OF INTEREST

John Vaile add Wife no longer works for DHB as unresolved employment issues
Gloria Hammond add Chairperson C.O.G.S
Elinor Stratford change to Vice Chairperson GDCVH
Elinor Stratford add Grey District Councillor
Elinor Stratford add member of Executive Federation of Disability Information Centres
Dianne Lewis needs to be added to the "Disclosure of Interest", currently no known points

3. AGENDA CHECK

Add Dementia Unit Update as 9a

4. MINUTES OF LAST MEETING

Page 1 Dianne Lewis not listed as being present

Page 4 Under the heading "Report on Disability Awareness Workshop", change "some speakers" to "a speaker".

Moved: Maureen Frankpitt, Seconded: Elinor Stratford

It was RESOLVED that the Minutes of the Disability Services Advisory Committee meeting held 13 October 2004 were a true and correct record following the amendments listed as above.

5 MATTERS ARISING FROM LAST MEETING

- The Chair requested the Agenda be placed on a separate page.
- The “Terms of Reference” will be provided to the in coming Disability Services Advisory Committee and discussed at a later date.
- **Item 13** - A committee member explained that a child she knew of was unable to continue with her choice of activity because of the associated costs etc. The CEO mentioned, as the child discussed was a single child, not a member of a group, it might be more appropriate to find a sponsor who would be in a position to help. If the gym equipment was supplied the membership cost could possibly be reduced. Maybe approach service clubs etc where funding is required – Blackadder Trust – Tony Kokshoorn and David Carruthers

The Helberg Trust pays for a limited time, it has been found the child becomes highly motivated and the funding stops and the cost falls back onto the family. There are more and more rules and regulations associated with the Helberg Trust now, it is generally felt it is made very difficult to obtain funding, unless you are a top end athlete. Lobbying at a political level has started for access to more funding.

Active West Coast administer a fund for children and teenagers who need financial help to access physical activity. If it is based around need, those with a disability should get access to funds without jeopardising those without a disability but still needing help.

- **Item 15** - Further to the discussion at the last meeting, Alpine Coaches Ltd has been advertising for a co driver for their services to Christchurch. Possibility of an AM service, but no confirmation at this stage. There is a husband & wife team, from Reefton, providing a service to Christchurch, but this service goes through the Lewis Pass. The current timetables for bus services travelling to Christchurch is also effecting rest homes. They are incurring extra costs paying fees higher than own when residents have to attend appointments away from the Coast, this ends up incurring the cost of two nights accommodation.

Buller residents are able to utilise subsidised taxis to attend local appointments, currently the running of the same subsidy scheme in Hokitika is being looked at.

The DHB has been invited to join Regional Land Transport Committee. General Manager Planning & Funding to report back regarding the committees Regional Transport Strategy, then this committee can look at it from there.

As the committee is now looking at the situation from a different angle, the motion recorded in the minutes from the previous meeting, to write to Alpine Coaches Ltd, can be removed.

6. CORRESPONDENCE

Quality & Safety Project – Final report

- Put on agenda for next months meeting.

7. ACTION AND RESPONSIBILITY LIST

General Manager Planning & Funding to report back from the Regional Land Transport Committee meeting – re transport for clients attending appointments

General Manager Planning & Funding to distribute to the committee copies of

8. ACCESS TO SECONDARY SERVICES FOR PEOPLE WITH INTELLECTUAL DISABILITIES

General Manager Mental Health read the letter from the previous meeting papers to refresh the memories of the committee, a number of issues were identified to be discussed at the next meeting.

General Manager Planning & Funding to provide copies of the National Health Committee publication “To Have An Ordinary Life”.

9 HEALTH NEEDS ASSESSMENT

A copy of the Draft Health Needs Assessment (HNA) was incorporated in the papers for the meeting held on Wednesday 13 October 2004. The committee has been asked to identify any areas in the HNA that they would like to see addressed in the District Strategic Plan (DSP). Go away and have a think, so they can be brought forward and incorporated into the first draft. This is the opportunity to bring forward those areas that have been in the background.

Information to General Manager Planning & Funding by the end of January/early February to enable the first draft to be available for the April meeting. Points can be as general or specific at you like. “oral health for those with disability”. A chance to bring forward those things that have been in the background.

9a DEMENTIA UNIT UPDATE

The submission provided by the provider arm of the DHB was successful. The new Dementia Unit will be located at Grey Base Hospital, the exact location is being reviewed by the Executive Management Team (EMT). There will be a further update at the next meeting in February.

10 REVIEW OTHER BOARDS DSAC AGENDAS

- CDHB – Blind & Deaf foundation – like to meet with the committees to see what their views are on access and associated problems they have.
- Most still have monthly meetings – maybe this could happen to accommodate speakers. The Chair will bring this point up at the next Board meeting

15. GENERAL BUSINESS

Nil

16. NEXT MEETING

To be advised

17. **ATTENDANCE AND ADMINISTRATION FORM**

The Chairman asked the committee to fill in the attendance and administration forms and return them today.

There being no further business the meeting closed at 10.09am

Action and Responsibility List – Disability Support Advisory Committee Meeting

Item No.	Meeting Date	Action Item	Action Responsibility	Due By
9	15 December 2004	Provide committee members with copies of “To Have An Ordinary Life”	General Manager Planning & Funding	16 February 2005
	15 December 2004	Write to the West Coast PHO and invite them to the April meeting of the Disability Services Advisory Committee	General Manager Planning & Funding	

5 DISTRICT STRATEGIC PLAN

The paper is not available at this time and will be distributed at the meeting

6 WATER FLUORIDATION



West Coast District Health Board

**Background Paper on Water Fluoridation
September 2003**

1. CPHAC RECOMMENDATION

“That the West Coast District Health Board endorse fluoridation as a safe and effective measure, and as part of an overall strategy, to improve the oral health of West Coast residents”

2. EXECUTIVE SUMMARY

Compared to other parts of New Zealand, the oral health of West Coast children is poor – with decay rates similar to those found in Northland, Tairāwhiti, Lakes, and Bay of Plenty DHB areas. Less than a third of Maori five-year-olds are free of decay on the West Coast, compared to 45 percent of non-Maori.

While no communities on the West Coast receive fluoridated water, 62 percent of New Zealand’s population on reticulated water supplies does, and worldwide about 300 million people drink fluoridated water. Water fluoridation is a very well-researched public health measure, and despite the presence of other forms of fluoridation supplementation, such as fluoridated toothpaste, water fluoridation reduces decay rates by a considerable amount; a recent New Zealand study shows children receiving fluoridated water to have 30 percent fewer cavities than those in unfluoridated areas. In a community the size of Greymouth, \$1 spent on fluoridation could save \$10 in dental treatment costs.

Despite claims to the contrary, water fluoridation is safe – with a very large amount of research having been carried out since the introduction of the first fluoridation schemes over 50 years ago, and many reviews of this research, no claims of adverse health effects (except for mild dental fluorosis) have ever been substantiated. While there are vocal and well-organised opponents to fluoridation, there is no scientific controversy, and the activities of antifuoridationists are increasingly coming to be regarded as ‘quackery’.

Fluoridation of water is a responsibility of Territorial Local Authorities, and the costs are also borne by them, although the Ministry of Health may subsidise the installation of fluoridation equipment.

3. BACKGROUND

3.1. What is fluoride?

Fluoride is the ionised form of the element fluorine, and is the 13th most common element in the Earth's crust. It is present in seawater at between 0.8 and 1.4 parts per million (ppm), soils from 300 ppm, and in most unadjusted water supplies in New Zealand at a background concentration of less than 0.3 ppm. Community water fluoridation adjusts the fluoride level to between 0.7 and 1ppm. Because of its widespread presence in the biosphere, fluoride finds its way into the food chain and is found in many foods.

3.2. How does fluoride prevent tooth decay?

Tooth decay begins as a very small “etching” of the enamel, whereby calcium and phosphate ions are lost from the hydroxyapatite crystals which make up the inorganic part of the enamel (Figure 1). This occurs when bacteria in the dental plaque convert sugars to acids. The fluoride ion works to reverse the very early lesions by:

1. Reducing demineralisation (by reducing the critical pH for crystal dissolution from about pH 5.5 to 4.5), and
2. Promoting remineralisation – the process by which calcium and phosphate are reincorporated into the enamel as the pH rises following an acid challenge.

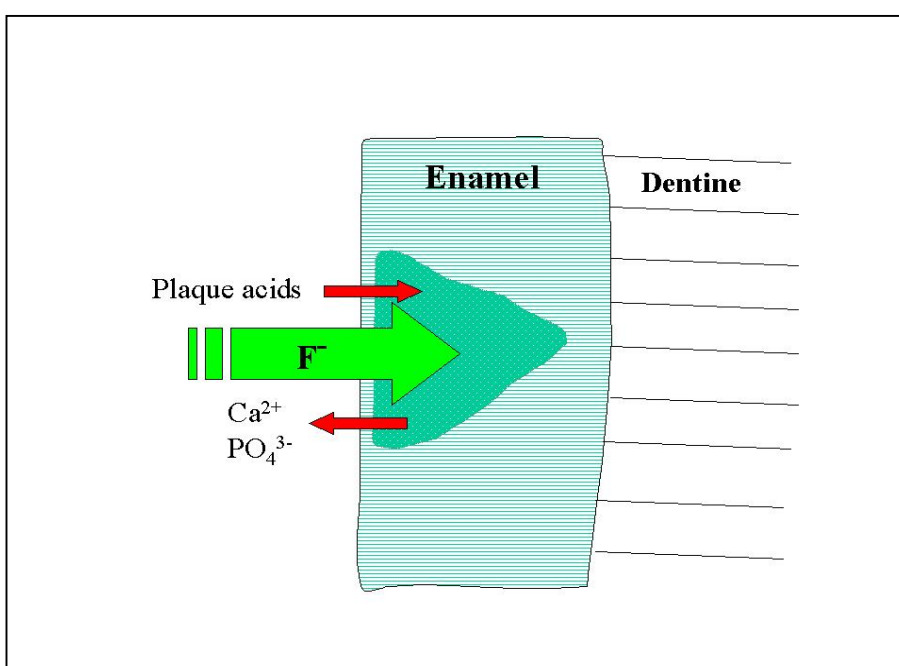


Figure 1.

Fluoride also acts on dental plaque to change the composition of bacteria within it, and reduce acid production.

Early understanding of fluoride's mode of action assumed that the major effect was pre-eruptive – through the incorporation of fluoride into developing tooth enamel. We now know that this is not so, and that the post-eruptive, topical mode of action of fluoride is the important one, and that low concentration/high frequency applications are the most effective – as occurs when drinking water that contains fluoride.

3.3. A short history of water fluoridation.

The history of water fluoridation goes back to the early part of last century when dental researchers, and the United States Public Health Service (USPHS) carried out a number of studies investigating brown staining on teeth. The cause was eventually identified as high levels of fluoride in water supplies. A parallel discovery of great public health importance was that the presence of fluoride was also associated with reduced levels of tooth decay. Further research – on US cities with varying natural levels of fluoride in their water supplies – determined that at a fluoride concentration in drinking water of one part per million, the adverse effect – fluorosis – was minimal, and there were substantial reductions in decay. Community water fluoridation schemes commenced in the USA in the 1940s, and the first New Zealand scheme began in Hastings in 1954. By the beginning of the 21st century, the USPHS was able to include water fluoridation as one of the ten great public health achievements of the 20th Century.¹

Over 300 million people in 39 countries have artificially fluoridated water. These include Australia, Canada, Ireland, Israel, Singapore, Spain, the United Kingdom, and the United States. Currently, approximately 62 percent of New Zealand's population on reticulated water supplies receives fluoridated water. No water supplies on the West Coast are fluoridated, although Hokitika's was until 1975.

¹ CDC (1999): Achievements in public health, 1990-1999: fluoridation of drinking water to prevent dental caries. M.M.W.R. 48, 933-940.

4. Recent studies of water fluoridation.

A considerable body of research regarding the benefits and risks of water fluoridation has accumulated, and this has been subjected to systematic review – most recently by the UK National Health Service.² This review concluded:

“The evidence of a beneficial reduction in cavities should be considered together with the increased prevalence of dental fluorosis. There was no clear evidence of other potential adverse effects.”

The Irish Government has also recently reviewed water fluoridation (75% of Ireland’s population drink fluoridated water), and the conclusions of this review were:

- “Water fluoridation has been very effective in improving the oral health of the Irish population, especially of children, but also of adults and the elderly.
- The best available and most reliable scientific evidence indicates, that at the maximum permitted level of fluoride in drinking water at 1 part per million, human health is not adversely affected.
- Dental fluorosis (a form of discolouration of the tooth enamel) is a well-recognised condition and an indicator of overall fluoride absorption, whether from natural sources, fluoridated water or the inappropriate use of fluoride toothpaste at a young age. “

A recent comparison of the oral health of children from Canterbury and Wellington (almost all of Wellington receives fluoridated water, whereas very few Canterbury children do so) showed that decay levels were 30 percent lower in the fluoridated areas. The differences for Maori children were considerable – only 29 percent of Canterbury’s Maori five-year-olds, had no tooth decay, compared to 40 percent in Wellington.³

² McDonagh,MS; Whiting,PF; Wilson,PM; Sutton,AJ; Chestnutt,I; Cooper,J; Misso,K; Bradley,M; Treasure,E; Kleijnen,J (2000): Systematic review of water fluoridation. *BMJ* 321, 855-859.

³ Lee, M, Dennison, PJ (2003) Water fluoridation and dental caries in five and 12 year old children from Canterbury and Wellington. Submitted for publication.

Other New Zealand research indicates fluoridated water supplies are effective in reducing the inequalities observed among children of different socio-economic status.⁴

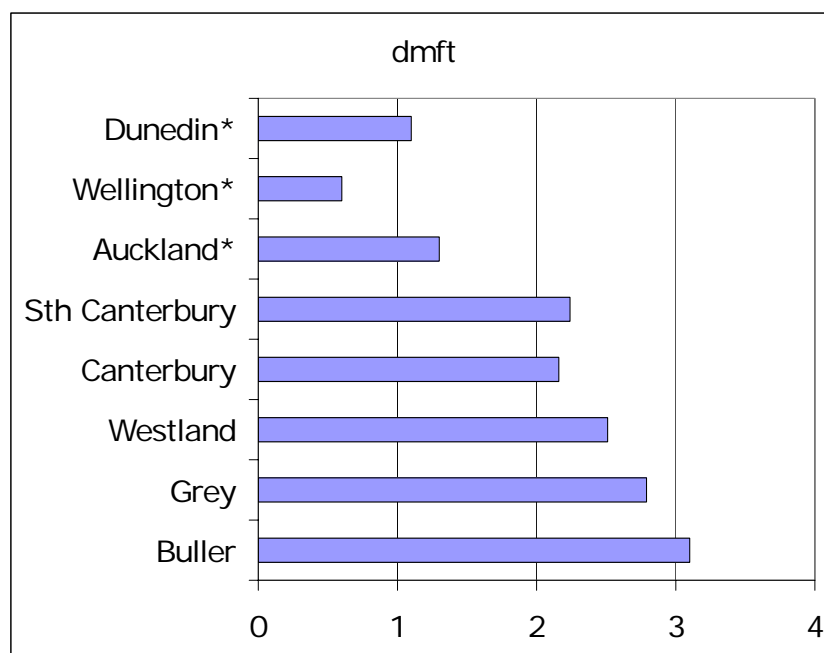
The Ministry of Health's National Health Committee recently released a report titled *Improving Child Oral Health and Reducing Child Oral Health Inequalities*⁵. This report recommends that District Health Boards

“Actively encourage non-fluoridated communities to make applications to the Sanitary Works Subsidy Scheme”, and

“Requests District Health Boards and local authorities to work collaboratively to promote fluoridation of community water supplies”.

5. THE WEST COAST SITUATION

West Coast children have poor oral health by New Zealand standards, overall being on a par with children in the Bay of Plenty and Lakes District Health Board areas. Children in the Buller district have the worst oral health in the region – similar to those in the Tairāwhiti, Northland, and Whanganui DHB areas. The following chart shows data for five year old children in 2002; dmft is the index used for calculating the severity of tooth decay, and is the average number of teeth, per individual, affected by tooth decay.



⁴ Treasure ET, Deaver JG (1992) Relationship of caries with socio-economic status in 14-year old children from communities with different fluoride histories. *Community Dentistry and Oral Epidemiology* 1994; 22:226-230

⁵ National Health Committee, *Improving Child Oral Health and Reducing Oral Health Inequalities*. 2003. Wellington., pp 18

*Dunedin, Wellington, and Auckland are fluoridated

Children of different ethnic groups also experience significant inequalities in oral health outcomes on the West Coast. In particular, Maori children have much higher frequency of decay compared to non-Maori, as the table below indicates.

5-Year-old West Coast children	dmft Score	Caries Free
Non-Maori	2.68	44.8%
Maori	3.15	29.2%

6. INTRODUCING WATER FLUORIDATION

6.1. Health costs of water fluoridation.

In 1994 the Public Health Commission (PHC) published a report on water fluoridation in New Zealand, which, in part, dealt with the evidence of possible adverse effects.⁶ The report found that evidence for adverse health effects such as bone fracture and cancer was inconclusive, and recommended that more research be carried out. The Ministry of Health commissioned a further review of studies on the potential adverse effects of fluoridation, and this was published in 2000.⁷ The report stated:

“No persuasive evidence of harmful effects of optimal water fluoridation was revealed, and, generally, the evidence has strengthened that there are no serious health risks associated with the practice. That was particularly the case for bone fracture risk.

A suggestion arising from this report was that dental fluorosis in New Zealand be further investigated, as no studies on this topic had been carried out in New Zealand since the 1980s. There is new evidence on this topic, from a study carried out in Southland in 2002 (Invercargill city is fluoridated), which suggests that the prevalence of fluorosis has not increased.⁸

6.2. Cost benefit analysis.

⁶ Public Health Commission (1994): Water Fluoridation in New Zealand. Public Health Commission, Wellington.

⁷ Bates, M (2000): Fluoridation of water supplies – an evaluation of the recent epidemiological evidence. ESR, Porirua.

⁸ Mackay, TD (2003), Enamel defects among Southland 9-year-olds. Thesis submitted for the degree of Master of Community Dentistry, University of Otago, Dunedin.

The PHC's 1994 report mentioned that water fluoridation was a highly cost-effective public health strategy,⁵ and this issue was followed up by the Ministry of Health, which commissioned a study on the cost-effectiveness of water fluoridation.⁹ This study found that water fluoridation, in New Zealand, was cost-effective for communities of over 1000 people and concluded that:

“Fluoridation remains very cost-effective, and is particularly so for communities with high proportions of children, Maori, or people of low socio-economic status.”

Within the New Zealand context, fluoridation of water supplies is seen as a territorial local authority cost – although the Ministry of Health has recently announced a subsidy scheme for the introduction of water fluoridation

Wright et al (1999)⁸ show that for a community of 10,000 people (a little larger than Greymouth), over a 30 year time-span, fluoridation of the water supply would cost \$183,000, however it would return \$1,740,000 to the community in averted dental treatment costs. Nearly \$10 dollars saved for every \$1 spent.

6.3. PUBLIC PERCEPTION

Overall, the evidence for fluoridation as a safe and effective public health intervention is very strong. Despite this, water fluoridation continues to be debated vigorously between vocal lobby groups. The element of controversy is an important issue, however, because, as the PHC said:⁵

“Aspects of the controversy over water fluoridation have probably led to some loss of public trust in public health authorities and dental professionals. This could have possible adverse effects on public trust and participation in other health related programs that require complex risk/benefit analysis.”

A further consideration is that water fluoridation does impinge, to some extent, on individual freedom. This does not appear to extend as far as a denial of human rights, and the 1994 PHC report⁵ cites a 1980 New Zealand Human Rights Commission report which stated:

⁹ Wright,JC; Bates,NM; Cutress,T; Lee,M (2001): The cost-effectiveness of fluoridating water supplies in New Zealand. Australian and New Zealand Journal of Public Health 25, 170-178.

“...it is considered that the question of fluoridation of water supplies by public authorities does not constitute a denial of human rights.”

The PHC felt that:⁵

“The proportion of the population concerned with the inconvenience and cost of avoided fluoridated tapwater is unknown but is probably very small.”

An individual’s freedom of choice must also be weighed against the right of the public, especially the most vulnerable people, to benefit from scientific discoveries in preventative medicine. Children of all social classes, and other vulnerable sections of society, readily reap the benefit of fluoridation, without being required to make difficult behavioural changes.

Almost since the start of the first fluoridation trials in the United States in the 1940s, there have been individuals and groups opposed to community water fluoridation; arguments relating to associations between fluoridation and serious health problems such as bone fracture and cancer. These issues have been endlessly relitigated over the last half a century, with many critical reviews and reports published. Recent years have seen anti-fluoridationists asserting that certain countries have "banned" water fluoridation for health and safety reasons. This far from the truth, as the actual reasons for not adopting water fluoridation have been political, legal, or technological. For example, the city of Basle, Switzerland has recently ceased fluoridation – not, as has been claimed, because of health concerns, but because salt fluoridation is so widespread in Switzerland it had become logistically impossible to keep Basle free of fluoridated salt.¹⁰ Fluoride is also recognised as a toxin, and antifluoridationists play on this fact to promote their cause. However, most beneficial medicines are also toxic at higher concentrations, as is oxygen. Nevertheless, the aura of controversy continues to haunt efforts to both implement and retain community water fluoridations schemes. Newbrun and Horowitz put it simply:¹¹

“The simple truth is that there is no 'scientific controversy' over the safety of fluoridation. The practice is safe, economical, and beneficial. The survival of

¹⁰ Meyer T, Marthaler, TM, Burgi H. *Fluoridation in Basle, Switzerland: switch from water to salt as carrier for supplemental fluoride*. Swiss Academy of Medical Sciences, Commission for Fluoride and Iodine, 2003

¹¹ Newbrun E, Horowitz H. *Why we have not changed our minds about the safety and efficacy of water fluoridation: a response to John Colquhoun*. *Perspectives in Biology and Medicine*; 42: 526-541. 1999

this fake controversy represents, in our opinion, one of the major triumphs of quackery over science in our generation.”

The tactics of antifluoridationists has, and continues to be largely one of guilt by association, as Jarvis says: ¹²

“To influence public opinion, antifluoridationists do not have to prove that fluoridation is unsafe, ineffective, or undesirable in some other way. They merely have to create *doubts*. Many who express their concerns over fluoridation have been duped by antifluoridationist's propaganda. Antifluoridationists work to create doubt through *confusion*. Their favourite tactic is to create the *illusion* that a *scientific* controversy exists of the safety of fluoridation.”

6.4. OTHER OPTIONS

Focussing on water fluoridation can have the effect of losing sight of the goal – improving oral health, and reducing health inequalities, and while water fluoridation is currently the best-proved method of accomplishing this goal, it is not the only potential solution. Other solutions include:

Fluoridated Milk. The annual cost of supplying fluoridated milk to a child at school is estimated at \$73 per child. It would cost over \$300,000 annually to provide fluoridated milk to the roughly 5,000 school-aged children on the West Coast – compared to around \$5,000 as this group's annual “share” of the costs of a fluoridated water scheme.

Toothpaste. Fluoride toothpaste and toothbrushes could be distributed to low-income children, however behaviour changes from children and parents are required to see the toothpaste used. The UK Health Education Authority reviewed the effectiveness of oral health promotion and found that neither school-based toothbrushing campaigns nor mass-media campaigns are effective in changing behaviour.¹³

Examination of other options is important, as fluoridation is only possible where there is a reticulated water scheme.

¹² Jarvis, WT *Fluoridation*. National Council Against Health Fraud. 2001

¹³ Kay,E; Locker,D (1997): Effectiveness of oral health promotion: a review. Health Education Authority, London

7. SUMMARY

The weight of scientific evidence supports water fluoridation as a safe and cost-effective method of improving oral health. It benefits individuals throughout their lifespan, and has been shown to reduce health inequalities. There are currently no other options which can compete with fluoridation in terms of population coverage, clinical effectiveness, or cost-effectiveness.

7 MEETING DATES FOR 2005

attached

DATE	MEETING	TIME	VENUE
Wednesday 16 February	DSAC CPHAC	8.30 am – 10.30 am 10.30 am – 1.30 pm	Board Room, Corporate Office, West Coast DHB
Friday 4 March	Board	9.15am	Board Room, Corporate Office, West Coast DHB
Friday 1 April	HAC	8.00 am – 10.00 am	Board Room, Corporate Office, West Coast DHB
	Board	10.45 am	
Wednesday 4 May	DSAC CPHAC	8.30 am – 10.30 am 10.30 am – 1.30 pm	Board Room, Corporate Office, West Coast DHB
Friday 6 May	Board	9.15am	Hokitika (venue to be advised)
Friday 3 June	HAC	8.00 am – 10.00 am	Board Room, Corporate Office, West Coast DHB
	Board	10.45 am	
Wednesday 15 June	DSAC CPHAC	8.30 am – 10.30 am 10.30 am – 1.30 pm	Board Room, Corporate Office, West Coast DHB
Friday 1 July	Board	9.15am	Board Room, Corporate Office, West Coast DHB
Friday 5 August	HAC	8.00 am – 10.00 am	Board Room, Corporate Office, West Coast DHB
	Board	10.45 am	
Wednesday 17 August	DSAC CPHAC	8.30 am – 10.30 am 10.30 am – 1.30 pm	Board Room, Corporate Office, West Coast DHB
Friday 2 September	Board	9.15am	Westport (venue to be advised)
Friday 7 October	HAC	8.00 am – 10.00 am	Board Room, Corporate Office, West Coast DHB
	Board	10.45 am	
Wednesday 12 October	DSAC CPHAC	8.30 am – 10.30 am 10.30 am – 1.30 pm	Board Room, Corporate Office, West Coast DHB
Friday 4 November	Board	9.15am	Board Room, Corporate Office, West Coast DHB
Friday 2 December	HAC	8.00 am – 10.00 am	Board Room, Corporate Office, West Coast DHB
	Board	10.45 am	

<i>DATE</i>	<i>MEETING</i>	<i>TIME</i>	<i>VENUE</i>
Wednesday 14 December	DSAC CPHAC	8.30 am – 10.30 am 10.30 am – 1.30 pm	Board Room, Corporate Office, West Coast DHB



West Coast District Health Board

DSAC MEMBERS' REIMBURSEMENT CLAIM FORM

NAME: _____ (Please Print)

DATE:	DETAILS OF MEETING FEES CLAIMED:	FEE CLAIMED: (Attach Invoice if GST inclusive)
MILEAGE REIMBURSEMENT		
Date	Journey (Please include reason for journey)	Mileage Claimed
OTHER EXPENSES CLAIMED		
Date	Details of Expenses (Please attach GST Documentation supporting your claim)	Amount
TOTAL REIMBURSEMENT		

The details above are true and correct, signed:

Disability Services Advisory Committee Member

Signed and approved:

Disability Services Advisory Committee Chair



West Coast District Health Board

**DSAC MEMBERS' REIMBURSEMENT
CLAIM FORM**