MacroAuckland

Health 2

Hauora 2

Life Expectancy and Mortality 2

Health and Poverty 3

Infant Health 3

Children and Young People 3

Substance Abuse 4

Smoking 4

Alcohol Abuse 4

Illegal Drugs 5

Obesity 5

Diabetes 5

Asthma and Respiratory Problems 6

Active Living 6

Nutrition 6

Feeling Healthy 7

Accessing Health Care 7

Mental Health and Illness 8

Suicide and Self-harm 8

Environment and Health 9

References 10

Endnotes 12

Health

Health can considered narrowly, as the absence of disease or frailty as an indication of well-being, or broadly, when referring to total physical, mental and social well-being (MSD, 2008a, p. 33).

Hauora

Hauora is the Maori understanding of health. It is a broad view, including tinana (physical), hinengaro (mental), whanau (family) and wairua (spiritual) aspects. It also incorporates other elements such as the environment, land and language (MSD, 2008a, p. 33). One path to achieving hauora is through whanau ora, i.e. Maori families being supported to achieve their own maximum health and well-being (Mauriora-ki-te-Ao/Living Universe, 2009, p. 6).

These concepts are being included in public health through Ministry of Health key milestones. Currently all three district health boards (DHBs) that operate in wider Auckland (see DHB maps in Appendix) have achieved the latest key milestones. These include practices such as engaging with local iwi, implementing Maori Health Plans, and Treaty of Waitangi training for board members (Ministry of Health, 2010c, p. 4).

Life Expectancy and Mortality

Life expectancy and mortality is a useful measure of health. Average life expectancy in Auckland has been increasing over the past 20 years. In 1990, men were living to an average age of 73.2 years and women to 79.2; by 2007 this had risen to 79.4 for men and 83.2 for women (ARC, 2009, p. 35). (See Appendix table A3).

While Auckland has the highest number of annual deaths nationwide (7430 in the year to September 2010), it has a comparatively low proportion of deaths. This is generally attributed to Auckland having a more youthful population, with only 10% of Aucklanders being aged over 65 compared with 13% of all New Zealand residents (Bascand, 2010, p. 7).

Mortality rates vary across the three DHB areas: Auckland and Counties–Manukau both have rates close to the national average, whereas Waitemata has the lowest age-adjusted mortality rates of any New Zealand DHB (Ministry of Health, 2010b, p. 16).

Health and Poverty

There is a strong relationship between poverty and life expectancy. Those who live in areas of high deprivation are likely to live shorter lives due to lower income, poorer diet and lifestyle, poorer housing and less access to health care (Social and Economic Research and Monitoring Team, 2008, p. 7). They are also less likely to access health care from early in life. For example, children living in areas of high deprivation are less likely to be immunised: only two-thirds of children living in the most deprived areas in Auckland (deciles 9 or 10) are fully immunised by the time they are two, compared with 77% fully immunised in areas of low deprivation (deciles 1 or 2) (MSD, 2008a, p. 42).[i]

Infant Health

More babies are being born in the Auckland region. In 2010, approximately 36% of all New Zealand babies were born in Auckland (Bascand, 2010, p. 6). There are differences in infant death rates between the three DHB areas (Child and Youth Mortality Review Committee, 2009, p. 2): the rate is lowest for Waitemata (4.4 per 1000 die during birth), followed by Auckland (5.2), then Counties–Manukau (7.1) (Ministry of Health, 2007, p. 25).

Not all babies born in Auckland have equal health opportunities. Approximately 10% of Auckland babies are growing up with concerning levels of vitamin deficiencies, levels usually seen in developing countries (St John and Wynd, 2008, p. 92). The vast majority of babies in Auckland are breastfed at some stage during their infancy, but rates differ across the DHB areas: Auckland has the highest breastfeeding levels (90.5%), followed by Waitemata (94.5%), then Counties–Manukau (82.8%) (Ministry of Health, 2008b, pp. 24–25)

Children and Young People

A pressing and ongoing concern for Auckland is the high number of avoidable illnesses and deaths amongst children and young people. New Zealand has one of the highest rates of preventable illness and death in the OECD (St John and Wynd, 2008, p. 13). Despite this, children and young people's overall health has improved in Auckland over the past decade across all areas of Auckland and all ethnic groups. However, these improvements are not affecting young Aucklanders equally: Maori and Pacific young people have significantly worse health outcomes than other ethnic groups (Ministry of Youth Development, 2008, p. 3). This has been seen particularly in relation to rates of meningococcal disease, rheumatic fever and tuberculosis (Children's Commissioner, 2006, p. 9).

Health and physical education are being taught in schools. In 2010, secondary students were learning a range of health and physical education subjects at school, including health, home economics, sports

studies, outdoor education and physical education. The most popular is 'physical education'. Approximately a third students are taking 'health', with similar numbers taking a combined 'health and physical education'. There is a 90% drop-off rate from Year 9 to Year 13 in these subjects (Ministry of Education, 2010).

Auckland's young people are concerned about a lack of mental health support in schools. Some of the problems that young Aucklanders report include mood swings, peer pressure, self-harm, and relationship issues (Children's Commissioner, 2008, p. 25). Although suicide rates amongst young people have decreased since the 1990s, rates are still high, as are rates of self-harm (Ministry of Youth Development, 2008, p. 3) (See the later section *Mental Health – Suicide and Self-harm*).

Substance Abuse

Smoking

Overall, smoking is continuing to decrease, with Auckland DHB having seen one of the highest reductions of regular smoking in New Zealand in the past five years (Paynter, 2010, p. 28). There are different rates of smoking according to area and socio-economic status: more adults smoke in the Counties–Manukau DHB area (21%) than in Auckland (17.2) and Waitemata (15.3%) (Ministry of Health, 2008b, p. 65); those who live centrally or rurally are less likely to smoke than those who live within 20–40 kilometres of the CBD (see Appendix table A3); and smoking rates continue to be higher in areas of higher deprivation (Ministry of Health, 2010f, p. xii).

In the past decade the number of 14–15 year-olds reporting that their parents never smoke has increased by around 30% across all DHB areas (Paynter, 2010, pp. 31–32). Teenagers with parents who do not smoke are more likely not to smoke. As adult rates of smoking are continuing to decline, rates of smoking amongst 14–15 year-olds are also declining. This is true across all ethnicities, including a strong downward trend amongst Maori and Pacific teenage girls (Paynter, 2010, p. 29).

Alcohol Abuse

Alcohol abuse affects Aucklanders from all areas of Auckland, but is a greater problem for those in the Auckland DHB area. Around 22% of adult drinkers in the Auckland DHB area engage in hazardous drinking, compared with 19.4% in the Waitemata DHB area and 18.5% in Counties–Manukau (Ministry of Health, 2008b, p. 73). For all DHB areas, these figures are higher now than in 2002/03 (Ministry of Health, 2007, p. 23).

Under-age drinking in Auckland has received much media attention. There is concern about the ease with which young people are able to access alcohol. In a recent study of 1179 young Auckland drinkers aged 12–17, approximately 20% were able to purchase their own alcohol (James, 2010, p. 22).

Alcohol abuse is strongly associated with other social problems, such as drink-driving, violence (see the *Safety* section) and other drug addictions. Approximately 86% of frequent drug users in Auckland reported alcohol as their most frequently used drug alongside the other substances they were using (Wilkins et al., 2008, p. 14).

Illegal Drugs

Substance abuse impacts on the health of the user, and there are also social and safety issues which arise with substance abuse (see the Safety section). While legal drugs (such as alcohol) remain the most commonly used drugs in Auckland, there are also a range of illegal drugs which are popular in Auckland. People aged 18-24 generally have the highest rate of illicit drug use at about three in ten people (Ministry of Health, 2010). Cannabis is consumed by 1.9% of adults daily and 7.8% of adults at least monthly. The most commonly used by frequent drug users in Auckland are cannabis (84%), methamphetamine or ‘P’ (74%), ecstasy (65%) and crystal methamphetamine (48%) (Wilkins et al., 2008, p. 14).

Obesity

Obesity measures a person’s BMI (Body Mass Index) and uses this to determine their health. The BMI is calculated by taking into account a person’s height in relation to their weight (Ministry of Health, 2007, p. 63). While this is a widely accepted measure of health, it is problematic as it attempts to determine health based only on weight and height. For example, the BMI does not distinguish between muscle weight and fat weight. This means someone with high blood pressure, diabetes or heart problems would get the same rating as a person of the same weight and height with none of these issues. In Auckland, 9.7% of children are classified as obese. This is slightly higher than the national average. Prevalence of obesity for adults is 21.4%. This is 5% less than the national average (Ministry of Health, 2008b, pp. 104, 114).

Diabetes

The adult diabetes rate (5%) is similar across the whole of New Zealand. The one DBH area in the country in which this rate is dramatically higher is Counties–Manukau, where 8.2% of all adults are diagnosed with diabetes. It has also been noted that there is a strong relationship between deprivation and diabetes (Ministry of Health, 2008b, pp. 139–140).

Asthma and Respiratory Problems

Asthma is more prominent in children than in adults in the Auckland region. For children, asthma prevalence is consistent across the DHBs (13–14% for all three areas). There is greater disparity amongst adults, ranging from 7.7% in Auckland, to 9.7% in Waitemata, and up to 12.4% in Counties–Manukau. There is evidence that deprivation, in particular poor housing, increases asthma and respiratory problems for Aucklanders. This has a disproportionate impact on Maori and Pacific Aucklanders (Gravitas Research and Strategy Ltd, 2009, p. 52).

Active Living

Living more actively is widely accepted as a way of increasing health and well-being. Aucklanders are living more actively than in previous years. From 2009/10 there was a 27% increase in cyclist movements in Auckland (Gravitas Research and Strategy Limited, 2010, p. 1). However, many Aucklanders are still choosing cars or public transport over walking: approximately 60% of the short journeys that could be made by foot, are not (Auckland Regional Transport Authority, 2007, p. 9).

Physical activity levels differ across the Auckland region. The least active DHB area is Auckland, where only 40.3% of adults engage in regular physical activity. This rate increases for Waitemata (46.7%) and is highest for Counties–Manukau (53%) (Ministry of Health, 2008b, p. 96). However, while those in Counties–Manukau live more actively, they are more likely to have poor nutrition (see *Nutrition* section following).

Decreasing numbers of children walking or biking to school. The number of students travelling by car has doubled in the last decade (Auckland Regional Council, 2010, p. 37). Most children aged 5–14 years are watching two hours or more of television every day, with the numbers highest in the Auckland DHB area (62.3%), followed by Waitemata (59.6%) and then Counties–Manukau (57.6%) (Ministry of Health, 2008b, p. 48).

Nutrition

High costs of nutritious foods and comparatively low costs of fast foods add additional health challenges for low-income individuals and families. It is not surprising that children living in areas of higher deprivation are around 10% more likely to eat fast food three or more times in a week than children in areas of low deprivation (Ministry of Health, 2008b, p. 40).

There is significant disparity with regard to nutrition across the region. For example, fizzy drink consumption (3+ per week) for 2-14 year-olds varies from 15.1% in the Waitemata DHB area to 25.5% in

Counties–Manukau. Once again, there is a clear association between fizzy drink consumption and higher deprivation, and this association is stronger for girls than boys (Ministry of Health, 2008b, p. 36). It appears that inadequate vegetable consumption is a challenge across all DHB areas in the region: Waitemata, Auckland and Counties–Manukau are all well under the national average for adequate intake of vegetables in adults' diets (Ministry of Health, 2008b, p. 86). This gap has grown slightly since 2002/03 (Ministry of Health, 2007, p. 23).

Feeling Healthy

Health is something Aucklanders rate as important, but not necessarily over other concerns. In the 2008 New Zealand Election Study, only 18.3% of Aucklanders felt health was one of the most important issues facing them personally (NZES, 2008). In the General Social Survey, only 2.9% of Aucklanders rated their health as 'poor', and 9% as 'fair' (see Appendix table A1). It is possible that this accounts for the relatively low priority given to health. Aucklanders who feel healthy may not rate their health is a main concern. This attitude makes it challenging to promote preventative health measures and maintain long-term health.

Despite significant differences in many of the measures of health across the different DHB areas, the perception of having excellent health is relatively consistent. More than 60% of parents in all three DHBs rate the health of themselves and their children as excellent or very good (Ministry of Health, 2008b, p. 188). These rates were similar in the BCQL survey, in which it was found that age and income played the greatest role in determining whether someone identified themselves as having excellent health (14–25 years, household income over $100,000) or poor health (65+ years, household income under $20,000) (Reid, 2009, p. 8).

Accessing Health Care

Some Aucklanders are struggling to access the health care they need. In the Counties–Manukau DHB area, 2.3% of parents felt their children were unable to get GP services when they needed them; this rose to 3.9% in Auckland and 4.4% in Waitemata. The figures for adults were higher, with 7.4% in Waitemata feeling they were unable to access GP services, 7.0% in Auckland and 4.5% in Counties–Manukau (Ministry of Health, 2008b, p. 271).

Not all Aucklanders are taking full advantage of the health care available to them. For example, in 2009/10 fewer than 50% of people with diabetes in the Waitemata and Auckland DHB areas attended their free annual diabetes check, although in Counties–Manukau approximately 70% of people with diabetes attended their free check. Reported diabetes management also varies across the three DHBs: close to 80% of those in the Waitemata and Auckland reported satisfactory or better diabetes

management, compared with less than 60% for Counties–Manukau (Ministry of Health, 2010a, pp. 123–4).

Mental Health and Illness

Mental health and well-being is an important aspect of health and hauora. Conservative estimates suggest that 40% of New Zealanders will experience a mental illness at some stage in their life (Oakley Browne et al., 2006, p. 26). This equates to well over 500,000 Aucklanders experiencing mental illness at some stage in their life.

Auckland has a comparatively high rate of childhood adversity when compared with other OECD cities. New Zealand has high rates of abuse, neglect, domestic violence and other adverse behaviours towards children. There is a strong relationship between childhood adversity and developing mental illness (Barnett and Barnes, 2010, p. 18).

There are many challenges that come with mental illness. Some of these include 'self-stigma', feeling isolated, negative impacts on relationships, self-doubt and feeling suicidal (Peterson et al., 2008, pp. 27–33). Families play a significant role in supporting or discriminating against those with mental illness. Recent New Zealand research has found families themselves can often be subject to discrimination (Barnett and Barnes, 2010, p. 10).

Suicide and Self-harm

From 2003–2007 Auckland had a suicide rate of 10.1 deaths per 100,000 people, slightly lower than the national rate of 11.9 (MSD, 2010, p. 5). There is variation across the different DHB areas, with Counties–Manukau and Auckland DHB areas having lower rates of hospitalisations for intentional self-harm than Waitemata (Ministry of Health, 2010e, p. 62). Waitemata had 329 admissions, almost double the number of either Auckland or Counties–Manukau (Ministry of Health, 2010d).

There is a strong association between mental illness, self-harm and suicide. The presence of a mental disorder is the biggest risk factor for suicidal behaviour (Ministry of Health, 2008a, p. 2). Ethnicity is also a risk factor for self-harm and suicide, with Maori being overrepresented in these statistics (Ministry of Health, 2010d). Despite significant decreases in youth suicide rates over the past 25 years, age also continues to be a strong risk factor (Ministry of Youth Development, 2008, p. 3), as does deprivation (Ministry of Health, 2008a, p. 2).

Environment and Health

Auckland's natural environment plays a significant role in the health of Aucklanders. Auckland's range of parks, beaches and outdoor spaces provide opportunities for recreation and physical activity. However, there are a range of environmental factors interfering with the health of Aucklanders.

Auckland is not meeting the national standards for air quality (ARC, 2010a, p. 45). The main causes of this are transport pollution and domestic fires during winter months (ARC, 2010b, p. 32). Reducing air pollution is not just an environmental issue, it is a health issue as well. It is estimated that air pollution is leading to around 500 premature deaths in Auckland each year (MSD, 2008b, p. 6). (For more information see the *Environment* section.)

References

Auckland Regional Council (ARC) (2009). *A Report on Progress Towards Auckland Regional Community Outcomes.* Auckland: ARC.

Auckland Regional Council (2010a). *Auckland Regional Land Transport Strategy 2010–2040*. Auckland: ARC.

Auckland Regional Council (2010b). *State of the Auckland Region Report 2010*. Auckland: ARC.

Auckland Regional Transport Authority (ARTA) (2007). *Sustainable Transport Plan 2006–2016*. Auckland: ARTA.

Barnett, H. and Barnes, A. (2010). *Walk a Mile in Our Shoes/He tuara, ngā tapuwae tuku iho ō ngā Mātua Tūpuna:Exploring Discrimination Within and Towards Families and Whānau of People Diagnosed with 'Mental Illness'.* Auckland: Mental Health Foundation of New Zealand.

Bascand, G. (2010). Births and Deaths: September 2010 Quarter. *Hot Off the Press*. Wellington: Statistics New Zealand.

Child and Youth Mortality Review Committee (2009). *Fifth Report to the Minister of Health: Reporting mortality 2002–2008.* Wellington: Child and Youth Mortality Review Committee, Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi.

Children's Commissioner (2006). *More than an Apple a Day: Children's Right to Good Health*. Wellington: Office of the Children's Commissioner.

Children's Commissioner (2008). *Briefing for Incoming Minister: Office of the Children's Commissioner*. Office of the Children's Commissioner. Retrieved 27 December 2010 from http://www.occ.org.nz/__data/assets/pdf_file/0010/5797/OCC_BIM_2008.pdf

Gravitas Research and Strategy Limited (2010). *Manual Cycle Monitoring in the Auckland Region March 2010 Regional Summary.* Auckland: Regional Cycle Monitoring Working Group, Auckland Regional Transport Authority.

Gravitas Research and Strategy Limited (2009). *A Review of the New Zealand Housing Sector.* Auckland: ASB Community Trust.

James, B. (2010). *Under the Influence. Reshaping New Zealand's Drinking Culture*. Auckland: Public Policy and Research Ltd, for The Salvation Army Social Policy and Parliamentary Unit.

Mauriora-ki-te-Ao/Living Universe (2009). *TE TOI HAUORA-NUI: Achieving excellence through innovative Māori health service delivery.* Wellington: Ministry of Health.

Ministry of Education (2010). *Secondary Subject Roll by Year Level and Subject Name. Wellington:* Ministry of Education.

Ministry of Health (2007). *An Indication of New Zealanders' Health 2007*, Public Health Intelligence Monitoring Report No. 16. Wellington: Ministry of Health.

Ministry of Health (2008a). *New Zealand Suicide Prevention Action Plan 2008–2012: The Summary for Action.* Wellington: Ministry of Health.

Ministry of Health (2008b). *A Portrait of Health – Key results of the 2006/07 New Zealand Health Survey.* Wellington: Ministry of Health.

Ministry of Health (2010a). *Annual Report: Including the Director-General of Health's Annual Report on the State of Public Health for the year ended 30 June 2010*. Wellington: Ministry of Health.

Ministry of Health (2010b). *Mortality and Demographic Data 2007.* Wellington: Ministry of Health.

Ministry of Health (2010c). *Report on Indicators of DHB Performance (IDP) for Quarter Four 2009/10*, Health Report No. 20101301, DHB Performance Reports. Wellington: Ministry of Health.

Ministry of Health (2010d). *Suicide Facts 2008 – Suicide Deaths.* Wellington: Ministry of Health.

Ministry of Health (2010e). *Suicide Facts: Deaths and Intentional Self-harm Hospitalisations 2008.* Wellington: Ministry of Health.

Ministry of Health (2010f). *Tobacco Use in New Zealand: Key Findings from the 2009 NZ Tobacco Use Survey.* Wellington: Ministry of Health.Ministry of Social Development (MSD) (2008a). *Children and Young People: Indicators of Wellbeing in New Zealand 2008*. Wellington: MSD.

Ministry of Health (2008b). *Information for the Royal Commission on Auckland Governance: The Social Landscape in Auckland Region*. Wellington: MSD.

Ministry of Health (2010). *The Social Report 2010: Regional Indicators*. Wellington: MSD.

Ministry of Youth Development (2008). *Briefing to the Incoming Minister: Working with Young People for a Better Future*. Wellington: Ministry of Youth Development.

New Zealand Election Study (NZES) (2008). *New Zealand Election Study 2008*. Retrieved 5 October 2010 from http://www.nzes.org/

Oakley Browne, M. A., Wells, J. E. and Scott, K. M. (2006). *Te Rau Hinengaro: The New Zealand Mental Health Survey.* Wellington: Ministry of Health.

Paynter, J. (2010). *National Year 10 ASH Snapshot Survey, 1999-2009: Trends in Tobacco Use by Students Aged 14–15 Years.* Auckland: Health Sponsorship Council and Action on Smoking and Health, Ministry of Health.

Peterson, D., Barnes, A. and Duncan, C. (2008). *Fighting Shadows: Self-stigma and Mental Illness: Whawhai Atu te Whakamā Hihira*. Auckland: Mental Health Foundation of New Zealand.

Reid, A. (2009). *Quality of life in New Zealand's largest cities. 2008 residents survey: Results for the Auckland region*. Auckland: Social and Economic Research and Monitoring Team, ARC.

Social and Economic Research and Monitoring Team (2008). *Auckland Sustainability Framework: Headline Indicators 2008*. Auckland: Regional Sustainable Development Forum, ARC.

St John, S. and Wynd , D. (2008). *Left Behind: How Social & Income Inequalities Damage New Zealand Children.* Auckland: Child Poverty Action Group.

Wilkins, C., Sweetsur, P. and Girling, M. (2008). *Trends in Drug Use in Auckland, Wellington and Christchurch: Findings from the three site locations of the 2006 and 2007 Illicit Drug Monitoring System (IDMS)*. Auckland: Centre for Social and Health Outcomes Research and Evaluation & Te Ropu Whariki, Massey University.

Endnotes

---

[i] Decile ratings from the Deprivation Index are from 1 (lowest levels of deprivation) to 10 (highest level of deprivation). They should not be confused with school decile ratings, which are from 1 (students from low socio-economic communities, i.e. high levels of deprivation) to 10 (students from high socio-economic communities).