PRIMARY HEALTH CARE REPORT 2015 – 2016

Dated: 14th February 2017

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SUMMARY 2015-2016

Focus	Measure	Māori	Pacific	Asian	MELAA	Other	Total
Enrolment	Number of people enrolled with a Canterbury PHO	39,367	13,539	39,383		411,168	503,457[1]
		7.8%	2.7%	7.8%		81.7%	
Breastfeeding	% of babies exclusive/fully breastfeed at LMC discharge	68%	74%			71%	71%
Child Oral Health	% of children aged 0 to 4 enrolled in DHB funded dental services	28.9%	50.5%			69.1%	61.3%
	% of children caries-free at age 5	41.6%	37.7%			68.9%	65.1%
B4 School Checks	% of four year olds receiving B4 Schools Checks	98.3%	99.3%	100%	100%	95.1%	97.1%
Childhood Immunisation	% of eight-months olds fully immunised	94%	97%	96%		95%	95%
	% of two year olds fully immunised	92%	96%	96%		93%	95%
HPV Immunisation	% of eligible girls receiving dose 3 of the HPV vaccination programme	35%	35%	62%		43%	43%
Primary Mental Health	Share of adult referrals to primary mental health services	6.3%	0.9%	1.8%		91.0%	
	Share of youth referrals to primary mental health services	10.1%	1.5%	1.1%		87.3%	
	Share of primary mental health sessions	6.3%	0.9%	1.7%		91.1%	
	Share of clients who did not attend	10.8%	1.7%	1.3%		86.2%	
Breast Screening	% of eligible women aged 45-69 who have had a breast screen in the last two years	72.4%	62.8%			77.3%	76.9%
Cervical Screening	% of eligible women aged 25-69 who have had a cervical screen in the last three years	59.7%					74.3%
Smoking	% status ever recorded	91.6%	91.2%	91.2%		93.4%	93.1%
	% of smokers offered brief advice and cessation support	81.3%	79.6%	89.0%		89.6%	88.0%
Cardiovascular Disease	% of eligible population who have had their CVD risk assessed within the past five years	78.7%	78.1%	81.3%		86.4%	85.3%

[1] Includes Not stated/unknown ethnicity

ENROLMENT

A strong primary health care system is central to improving the health of New Zealanders and reducing health inequalities between groups. Enrolment with a general practice is voluntary, but people are strongly encouraged to enroll in order to gain the benefits associated with being an enrolled patient. These benefits include an ongoing relationship with a general practice team, subsidised doctors' visits and access to a range of services that the general practice has access to through their PHO.

Table 1: Ethnic Breakdown of Canterbury PHO Enrolled Population as at 1st July 2016

	Enrolled	%
Māori	39,367	7.8%
Pacific	13,539	2.7%
Asian	39,383	7.8%
European	402,106	79.9%
Other	6,145	1.2%
Not Stated	2,917	0.6%
Total	**503,457**	

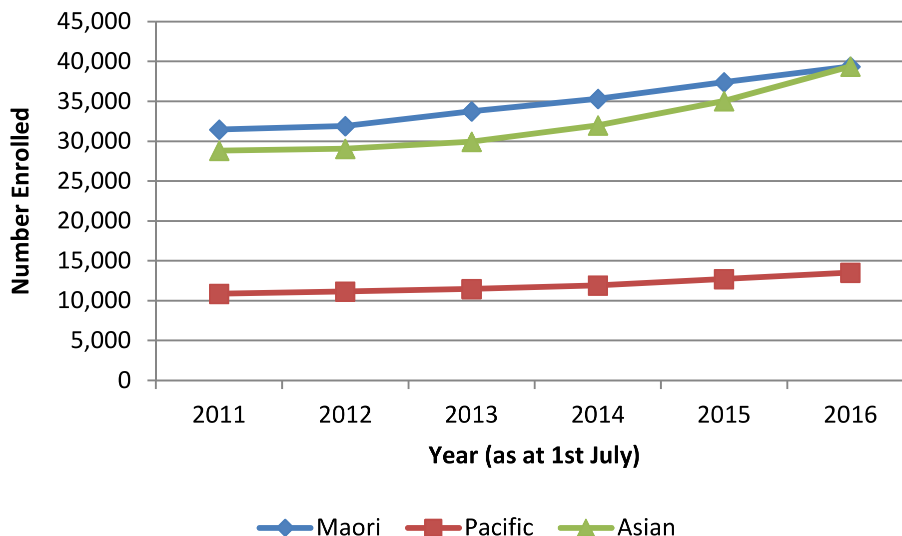
Table 1 shows the ethnic breakdown of the Canterbury PHO enrolled population. As at 1st July 2016 the combined PHO enrolled population was 503,457. After European ethnicity Māori and Asian are the joint next highest ethnic group making up 7.8% of the PHO enrolled population. Pacific peoples make up 2.7% of the population.

The Māori and Pacific populations are youthful populations. In these populations just under 11% are under 5 years old, compared to around 5% of the European/Other population. Around 50% of the Māori and Pacific populations are under 25 years, whereas only 30% of the European/Other population are under 25 and around 35% of the Asian population. Conversely Māori, Asian and Pacific peoples have a relatively smaller proportion of people who are aged 65 and over, although there has been growth in this age group for the Māori and Pacific populations.

Table 2: Ethnic Breakdown by Age Group of Canterbury PHO Enrolled Population as at 1st July 2016

	Māori		Pacific		Asian		European/Other	
0 to 4 years	4,190	10.6%	1,491	11.0%	3,911	9.9%	21,025	5.1%
5 to 14 years	8,103	20.6%	2,729	20.2%	5,444	13.8%	47,534	11.6%
15 to 24 years	7,640	19.4%	2,408	17.8%	4,394	11.2%	52,250	12.7%
25 to 44 years	10,330	26.2%	4,069	30.1%	15,168	38.5%	99,946	24.3%
45 to 64 years	7,274	18.5%	2,237	16.5%	8,170	20.7%	116,439	28.3%
65 and over	1,830	4.6%	605	4.5%	2,296	5.8%	73,974	18.0%
Total	**39,367**		**13,539**		**39,383**		**411,168**	

Figure 1: Canterbury PHO Enrolled Population 2011 to 2016



BREASTFEEDING

Exclusive breastfeeding is recommended for the first six months of life. Breastfeeding has many positive effects including optimal nutrition for infants, protection for the infant against infectious disease, reduced sudden infant death syndrome, reduced rates of diabetes, asthma, overweight and obesity and neuro-developmental benefits. Breastfeeding also has numerous benefits for the mother including improved recovery from birth, decreased risk of breast and ovarian cancer, decreased risk of osteoporosis and hip fracture later in life and other emotional and psychosocial benefits.

Improving breastfeeding rates presents a challenge as the reasons for infants not being exclusively breastfed are multi-factorial. Measures to improve breastfeeding rates need to involve families, communities and government and non-government groups and agencies. Māori and Pacific women, women from low-income families and young mothers have lower breastfeeding rates than other groups (National Breastfeeding Advisory Committee, 2009).

General practice can help increase breastfeeding rates in a number of ways, such as promoting and educating women about the benefits and techniques of breastfeeding and referring them to other providers if further assistance is needed, e.g. to a lactation consultant. Appropriately managing women with mastitis and cracked nipples can also help with continuation of breastfeeding. Both conditions commonly result in discontinuation of breastfeeding, often unnecessarily.

Target The aim is have 75% of babies exclusively/fully breastfed at time of LMC discharge

Māori breastfeeding rates are lower than for non-Māori, with 68% of infants exclusively/fully breastfed at LMC discharge compared to 71% for Other ethnicity. There has been growth in breastfeeding rates for Māori over the past three years with the rate rising from 63% and 68%. It should be noted that this data is from Well Child / Tamariki Ora providers who specifically target Māori and Pacific mothers. WCTO do not separate Asian data out.

Table 3: Canterbury Breastfeeding Rates (Exclusive or Full)[2] for dates shown:

	2012/13	2013/14	2014/15
Māori	63%	67%	68%
Pacific	66%	63%	74%
Other	70%	70%	71%
Total	**70%**	**70%**	**71%**

[2] Well Child / Tamariki Ora data

CHILD ORAL HEALTH

Caries are classified as the presence of one or more decayed, missing or filled teeth. Early childhood caries is a significant problem in New Zealand and have a harmful effect on children's oral and general health and cause a significant amount of pain and infection. Poor oral health in childhood is a predictor of poor oral health in adulthood. There is increasing evidence that poor oral health in adults is associated with poor general health, cardiovascular disease, stroke and respiratory diseases. Canterbury has multiple water supplies and all are unfluoridated. Given that, the main thrust for dental health then has to be dental hygiene and care. Improving the oral health of children and youth is a priority area for the Canterbury health sector.

Target

- 90% of pre-schoolers are enrolled in Community Dental Services
- 65% of 5 years-olds are caries-free

The total number of preschoolers enrolled with DHB Funded Oral Health Services has fallen in the last year. Consequently, the number enrolled this year of 19,596 is 10% lower than the 21,880 enrolled at the end of 2014.

Māori have the lowest rate of enrolment with the Community Dental Service, with 28.9% of the Māori under-5 population being enrolled. Pacific children under 5 also have low levels of enrolment with just over half of the under-5 population being enrolled. A contributing factor to not achieving the target for the total population is that the total population includes all children aged 0 to 4 years whereas children are only enrolled in the service from 8 months, therefore a group of children are missing. Entry to the service usually follows referral from Well Child/Tamariki Ora providers following the 9-12-month check.

Table 4: Pre-schoolers Enrolled in DHB Funded Oral Health Services 1st January 2015 – 31st December 2015[3]

	Enrolled	Population	% Enrolled
Māori	1,588	5,490	28.9%
Pacific	732	1,450	50.5%
Other	17,276	25,010	69.1%
Total	**19,596**	**31,950**	**61.3%**

The percentage of 5 year olds that attended who had no tooth decay was at 65%, which is slightly above the last 3 years with 64%, 62% and 63% being caries-free for 2012, 2013 and 2014 respectively. While the overall target of 65% of children will be caries-free at 5 years has been met, the percentage of Māori and Pacific children who are caries-free at 5 years remains low.

Table 5: Caries-free at 5 years 1st January 2015 – 31st December 2015

	Children Examined	Children Caries-free	% Caries-free
Māori	507	211	41.6%
Pacific	265	100	37.7%
Other	4,897	3,377	68.9%
Total	**5,669**	**3,688**	**65.1%**

Canterbury data is not reported to other populations groups. The New Zealand Health Survey (Ministry of Health, 2014) reports at a national level that 80% of Asian children had visited a dental health care worker in the past 12 months, with this rate increasing significantly since 2006/07 when the rate was 67%. Four percent of Asian children had to have a tooth removed due to decay, abscess, infection or gum disease in the past 12 months.

[3] As at the end of 2015

B4 SCHOOL CHECKS

The B4 School Check is a nationwide programme and is the eighth core contact of the Well Child Tamariki Ora Schedule of services. The B4 School Check includes:

- Advice and support for parents about child health and development
- A child health questionnaire
- A hearing screen
- A vision screen
- An oral health screen
- Height and weight measurement
- Questionnaires to identify developmental and behavioural problems (completed by parents and teachers in discussion with health professionals)
- Referral of the child to specialist services if the child appears to have problems that need further investigation

The B4 School Check is not solely a physical health check, but also considers the child's community and environment. The child's ability to learn and communicate, their social development and their family/whānau circumstances are also part of the check.

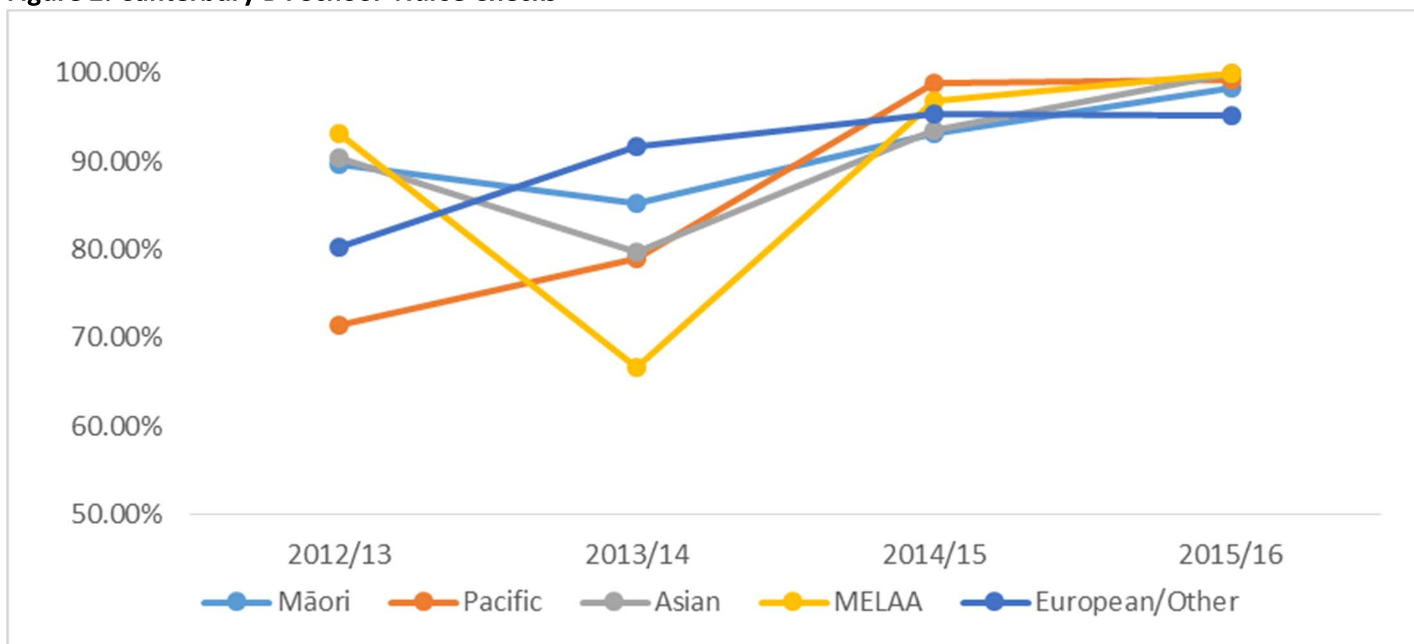
Target The target is that 90% of all 4 year olds will have had a B4 School Check

All ethnicities have shown an increase from 2014/15 coverage rates, except European which has remained stable. 833 Māori 4 year olds had their B4 School Check for a coverage rate of 98.3%, with only 14 Māori children not receiving their B4 School Check. Pacific children coverage rates rose slightly again to reach over 99%, with 2 Pacific children not receiving their check. Asian 4 year olds show a coverage rate of over 100%, as does MELAA, but this probably reflects ethnicity data collection and denominator issues.

Table 6: Canterbury B4 School Checks Coverage 1st July – 30th June

	2012/13	2013/14	2014/15	2015/16	2015/16 Checks Completed
Māori	89.6%	85.3%	93.1%	98.3%	833
Pacific	71.5%	78.9%	98.9%	99.3%	289
Asian	90.4%	79.8%	93.6%	100%	690
MELAA	93.1%	66.7%	96.9%	100%	115
European/Other	80.2%	91.7%	95.3%	95.1%	4,275
Total	**81.0%**	**89.0%**	**95.0%**	**97.1%**	**6,202**

Figure 2: Canterbury B4 School Nurse Checks



CHILDHOOD IMMUNISATION

High immunisation coverage is important to protect the health of individual children and to protect the community (herd immunity). The National Immunisation Schedule for children is timed at six weeks, three months, five months and 15 months. Vaccinations that fall within the 8-month-old group are diphtheria, tetanus, whooping cough, polio, hepatitis b, pneumococcus and haemophilus influenza. A child must receive the complete set of vaccinations to be counted by the programme. To be counted by the programme at 24 months of age children must have been vaccinated against measles, mumps, rubella, diphtheria, tetanus, whooping cough, polio, hepatitis b, pneumococcus and haemophilus influenza.

Target

- 90% of children fully vaccinated at eight months
- 95% of children fully vaccinated at 24 months

Overall in Canterbury in the year, 118 children did not receive their eight month vaccinations on time and 211 did not receive their 24 month vaccinations, when taking into account those who opted off or declined. In all, 3% of children were either opted off or declined at the 8 month immunisations and 4.9% were either opted off or declined at the 24 month immunisations.

Childhood immunisation rates remain high for Māori, with 59 Māori children not receiving their eight month vaccinations on time and 73 not having their 24 month vaccinations on time (note this does not exclude children who were opted off or declined as this is not broken down by ethnicity).

Pacific children have the highest immunisation rate across both measures, with only 12 children not receiving their eight month vaccinations on time and 13 not having their 24 month vaccinations on time (note this does not exclude children who were opted off or declined as this is not broken down by ethnicity).

Asian children continue to have high vaccination rates, with both measures showing as 96%, with 37 Asian children not receiving their eight month vaccinations on time and 33 not having their 24 month vaccinations on time (note this does not exclude children who were opted off or declined as this is not broken down by ethnicity).

Table 7: Childhood Immunisation Coverage 8 and 24 Months 1st July 2015 – 30th June 2016

	8 Month		24 Month	
	Fully Immunised	**%**	**Fully Immunised**	**%**
Māori	1,002	94%	896	92%
Pacific	336	97%	295	96%
Asian	842	96%	798	96%
European/Other	2,950	96%	2,912	93%
Total	**6,026**	**95%**	**5,759**	**93%**

HPV IMMUNISATION

The HPV vaccine (GARDASIL®) protects against HPV types 16 and 18 that cause 70% of all cervical cancers and HPV types 6 and 11 that cause around 90% of genital warts. HPV immunisation is free for females until their 20th birthday. HPV vaccinations are offered to 11-year-old girls by general practice teams. To increase coverage, the programme is also offered to Year 8 girls in school by the Public Health Nursing Service. Boys will be included in the programme from January 1 2017.

Target 60% of eligible girls receive all three doses of the HPV vaccine.

Targets are now aligned with calendar years and birth cohorts so that the 2002 birth cohort had until 31st December to have their 3 doses. Results show that overall, 43% of those eligible had all 3 doses by this time. It is encouraging to note that birth cohort 2003 who have until the end of 2016 to complete, are already tracking at similar rates, with 4 months still to go.

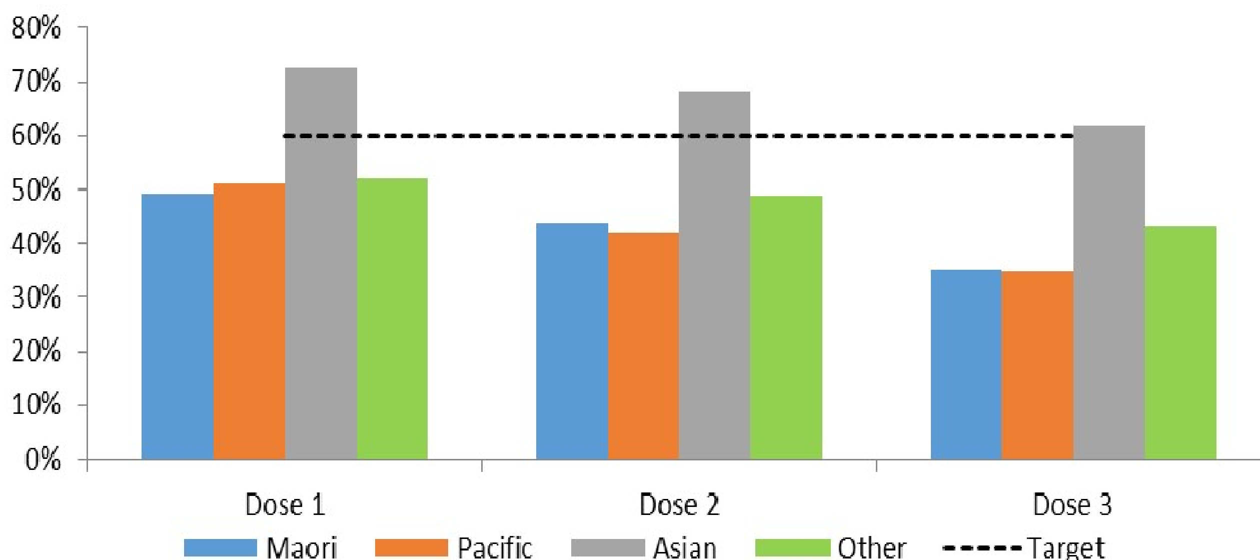
Māori and Pacific completion rates remain the lowest at 35% in 2015, but both are on track to see higher rates in 2016.

Asian girls have the highest rates at all 3 doses and have hit the 60% target rate for Dose 3 (73% dose 1; 68% dose 2 and 62% dose 3) and are also tracking higher so far in 2016.

Table 8: Canterbury HPV Immunisation Coverage by Dose and Ethnicity 1 January 2015 – 31 December 2015[4]

	Dose 1	Dose 2	Dose 3
Māori	49%	44%	35%
Pacific	51%	42%	35%
Asian	73%	68%	62%
Other	52%	49%	43%
Total	**52%**	**49%**	**43%**

Figure 3: HPV Vaccination Coverage by Dose and Ethnicity 1 January 2015 – 31 December 2015



[4] Cohort born 2002

PRIMARY MENTAL HEALTH SERVICES

Since the earthquakes Canterbury is experiencing increased demand for mental health services. PHOs have dedicated primary mental health services based in general practice and the community. The core aim of these services is to provide patient-focused, short-term interventions for people with depression, anxiety and addiction. In addition they provide an advisory function to general practice and assist in linkages between primary and secondary care services.

The New Zealand Health Survey 2013/14 (NZHS) estimates that 17.3% of Māori are diagnosed with a common mental disorder (depression, anxiety disorder or bipolar disorder). This rate is not significantly different from non-Māori, however Māori are significantly more likely to experience psychological distress[5] than non-Māori.

Similar findings are reported from the NZHS for Pacific peoples. Pacific peoples are more likely to suffer from psychological distress than non-Pacific people, although they are less likely to actually be diagnosed with a mental disorder than non-Pacific peoples, suggesting less usage of professional mental health services than non-Pacific peoples even though there is need.

The understanding, meaning and expression of mental illness varies greatly between different ethnic groups in the CALD population. Stigma around mental illness compounds the problem and can result in reluctance to seek intervention or treatment. In addition, when there is motivation to access mental health services there are often barriers to access such as lack of English proficiency, inadequate knowledge and awareness of services and cultural differences in the assessment and treatment of psychological illness. The NZHS reports that 6.9% of the Asian population is diagnosed with a common mental disorder, which is significantly less than the rate in the non-Asian population. The NZHS also reports that 4.5% of the Asian population report psychological distress, which is significantly less than the rate in the non-Asian population.

Between 1 July 2015 and 30 June 2016, 396 Māori utilised primary mental health services, making up 6.6% of users. This is an increase of 54 patients and increases Māori share of users from 5.6% in the previous year. Of the Māori primary mental health service clients, 48 clients were youth, making up 10.1% of the youth service, up from 6.7% in the previous year. DNA rates are still high for Māori and the proportion of all DNAs attributed to Māori patients has increased from 9.2% in 2014/15 to 10.8%, although this is partly explained by the increased share of overall patients.

55 Pacific peoples sought help from primary mental health services during 2015/16, of which 7 were youth. There has been no change in the proportion of Pacific primary mental health clients in the last 4 years, remaining at 0.9%.

Asian people accounted for 1.8% of primary mental health clients during 2015/16, or 106 patients. This is a decrease of 56 patients since 2013/14.

Table 9: Ethnic Breakdown of Primary Mental Health Service Clients 1 July 2015 – 30 June 2016

	Youth (12-19)		Adult (20+)		Sessions[6]		DNA[7] Number of Clients
Māori	48	10.1%	348	6.3%	1,028	6.3%	274
Pacific	7	1.5%	48	0.9%	140	0.9%	42
Asian	5	1.1%	101	1.8%	283	1.7%	34
European/Other	415	87.3%	4,996	91.0%	14,785	91.1%	2,180
Total	**475**		**5,493**		**16,236**		**2,530**

[5] Score ≥12 on Kessler Psychological Distress Scale (K10) which indicates high or very high probability of anxiety or depressive disorder.

[6] Face to face and phone sessions.

[7] Did not attend.

BREAST SCREENING

Breast cancer is the most prevalent female cancer in New Zealand and accounts for more than a quarter of all cancer diagnoses in women (Ministry of Health, 2011). The Breast Screening programme offers free mammograms to eligible women aged between 45 and 69 years. While screening mammograms cannot prevent the development of breast cancer, they do reduce the chance of dying from breast cancer by approximately one third.
The incidence of breast cancer is similar for all women. However, Māori and Pacific women are over 1.5 times more likely to die as a result of breast cancer compared to other women in New Zealand (Dachs, 2008). This is often due to Māori and Pacific women being diagnosed later than other ethnic groups, with larger higher grade tumours with more lymph nodes involved (Weston, 2008). Asian women have been found to have lower rates of participation in breast cancer screening than other New Zealanders (Zhang, 2014).

Target	The national target for breast screening is for a coverage rate of 70% of eligible women aged 50–69.

Māori coverage for breast screening has decreased 1.7% since last year but still remains above the target of 70% and above the national Māori rate of 65.2%.

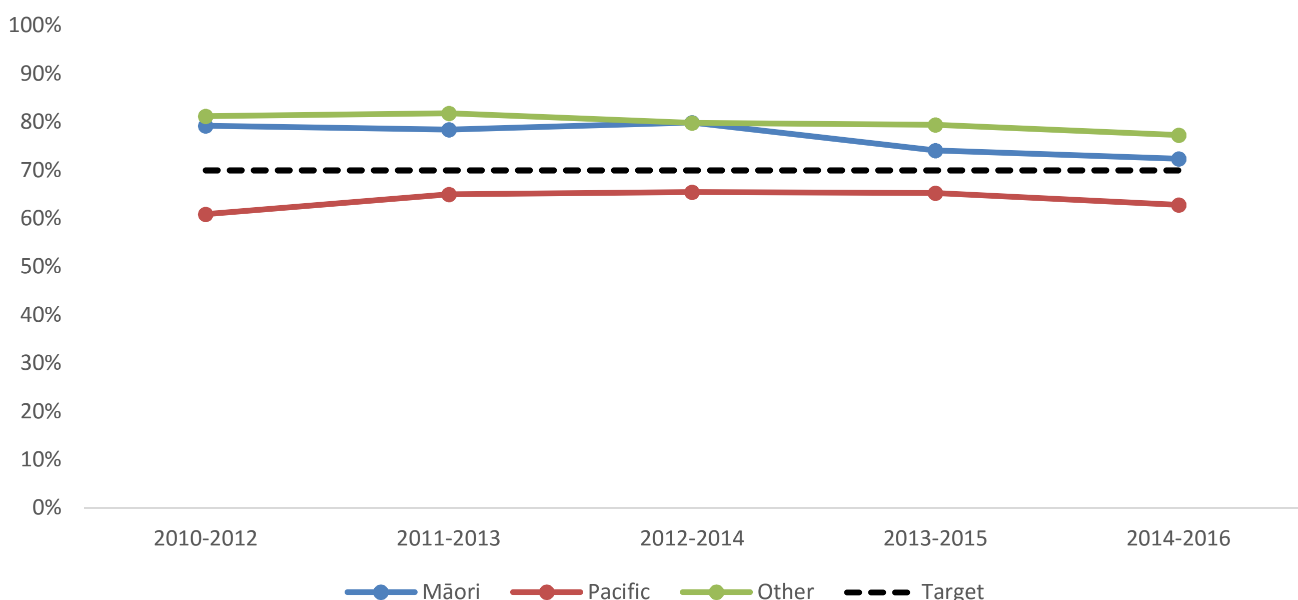
Pacific women continue to have the lowest rate of breast screening of all reported ethnic groups and remains below the national target. Breast screening rates for Pacific women have fallen by 2.5% having been stable over the last few years.

Unfortunately, separate data for CALD populations is unavailable, with these populations being included in "Other" ethnicity.

Table 10: Canterbury Breast Screening Coverage for Women Age 50 – 69 years

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2014-2016 Number Screened
Māori	79.2%	78.4%	79.9%	74.1%	72.4%	2,288
Pacific	60.9%	65.0%	65.5%	65.3%	62.8%	515
Other	81.2%	81.8%	79.8%	79.4%	77.3%	47,209
Total	**81.0%**	**81.5%**	**79.6%**	**79.1%**	**76.9%**	**50,012**

Figure 4: Canterbury Breast Screening Coverage for Women Aged 50 – 69 years 2009/11 to 2014/16



CERVICAL SCREENING

It is estimated that up to 90% of cases of the most common form of cervical cancer could be prevented if women have a smear test every three years. The National Cervical Screening Programme was set up in 1990 to reduce the number of women who develop cancer of the cervix and the numbers who die from it. The number of women who get cervical cancer and the number of women who die from it has reduced by 60% since the establishment of the programme.
The National Cervical Screening Programme is available to women in New Zealand between 20 and 70-years-old. The screening test checks for abnormal cell changes to the cervix in order to reduce the risk of women developing cervical cancer. Māori women have higher rates of cervical cancer than non-Māori women and are four times more likely to die from cervical cancer than European women (Ministry of Health, 2006). Pacific women have a higher rate of cervical cancer than the national average and are almost twice as likely to die from cervical cancer as European women (Ministry of Health and Ministry of Pacific Island Affairs, 2004).

Target The national target is that 80% of eligible women have been screened within three years.

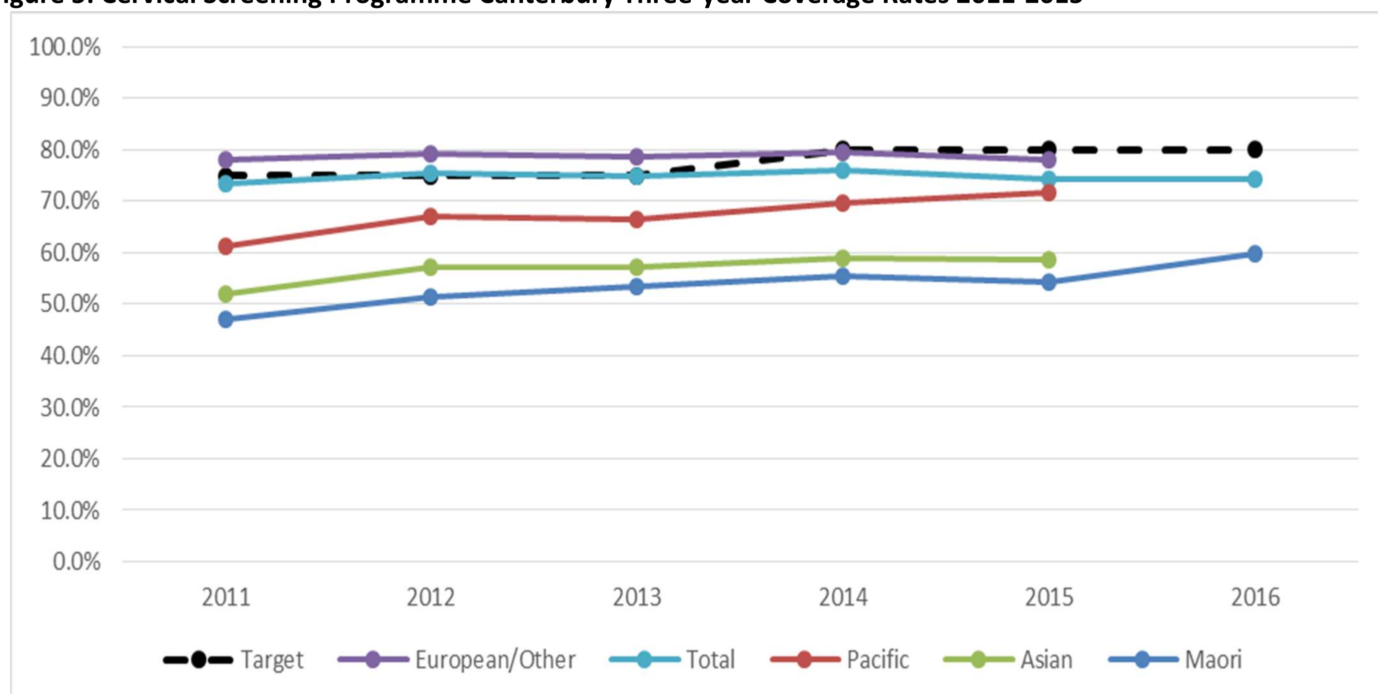
Changes have taken place around cervical screening as it has dropped off the Health Targets and the Ministry has stopped reporting to PHOs, all of which has limited what can be reported here.

Māori women have seen an increase in coverage rates but continue to have a lower than average rate for cervical screening. Approximately 3,816 eligible Māori women did not have a cervical smear in the last three years.

Table 11: National Cervical Screening Programme Three-year Coverage Rates for Women, 25-69 years 2012-2016

	2012		2013		2014		2015		2016	
	N	%	N	%	N	%	N	%	N	%
Māori	4,197	51.3%	4,477	53.4%	4,770	55.6%	5,029	54.6%	5,659	59.7%
Pacific	1,613	67.0%	1,659	66.6%	1,785	69.8%	1,891	72.6%		
Asian	6,396	57.2%	6,550	57.1%	6,993	59.0%	7,604	58.8%		
European/Other	84,359	79.3%	83,991	78.6%	85,582	79.6%	85,343	78.0%		
Total	**96,565**	**75.4%**	**96,677**	**74.8%**	**99,130**	**76.0%**	**99,997**	**74.5%**	**101,934**	**74.3%**

Figure 5: Cervical Screening Programme Canterbury Three-year Coverage Rates 2011-2015



SMOKING

Smoking is the single biggest cause of preventable morbidity and mortality in New Zealand, accounting for 9% of all illness, disability and premature mortality (Ministry of Health, 2013). It is the main cause of lung cancer and chronic obstructive pulmonary disease. Smoking is also a major cause of heart disease, stroke and other cancers. It is estimated that half of all long-term smokers die from smoking-related illness. Stopping smoking confers immediate benefits on those who already have smoking related disease and has future health benefits for all smokers.

There is a natural progression between the two smoking indicators. Accurately recording patients' smoking status is one of the first steps in helping smokers quit. Once smoking status has been recorded, where applicable a discussion should be initiated on smoking behaviour and smoking cessation. Brief advice comprises advising the patient about the benefits of stopping smoking, noting the patient's willingness to quit and if any offer of cessation support was accepted or refused. Cessation support is any referral to a smoking cessation support programme, prescribing nicotine replacement therapy and/or smoking cessation pharmacotherapy or provision of behavioural support either face to face or via telephone.

Target

- 90% or more of a PHO's target population (people aged 15-74 years) will have had their smoking status recorded.
- 90% or more of a PHO's target population who have been seen in general practice and whose most recent smoking status is recorded as a current smoker, will have been offered brief advice and/or cessation support services within the last 15 months (changed this year from 12 months).

In the quarter April to June 2016, 93.1% of people aged 15-74 years enrolled with a Canterbury PHO had their smoking status recorded. While Māori, Pacific and Asian populations reach the target of 90% their recorded smoking status is slightly lower than the rest of the population. For all ethnicities the Canterbury PHOs have reached the national target.

Table 12: Smoking Status Recorded April – June2016, ages 15 to 74

	Numerator	Denominator	%
Māori	24,228	26,450	91.6%
Pacific	8,201	8,993	91.2%
Asian	25,892	28,390	91.2%
Other	289,553	310,014	93.4%
Total	**347,874**	**373,847**	**93.1%**

Smoking advice and cessation is now reported across a 15-month period as opposed to the previous 12-month period. In the quarter April to June 2016, 88.0% of smokers attending primary care were offered advice and help to quit smoking. Canterbury PHOs are still below the national target for all ethnicities for this second smoking indicator. However, progress towards the target is being made.

Table 13: Smoking Brief Advice and Cessation Support 15 Months, April – June 2016

	Numerator	Denominator	%
Māori	7,313	8,994	81.3%
Pacific	1,545	1,940	79.6%
Asian	2,020	2,270	89.0%
Other	40,795	45,537	89.6%
Total	**51,673**	**58,741**	**88.0%**

CARDIOVASCULAR DISEASE

Many cardiovascular related deaths are premature and preventable, with Cardiovascular Disease (CVD) being strongly influenced by behavioural risk factors such as poor nutrition, lack of physical activity and smoking. Assessing and recording the CVD risk for patients enables lifestyle choices and treatment options to be established early. Additionally, it is a key opportunity to reduce inequalities through prevention, early intervention and condition management support.

A Cardiovascular Risk Assessment (CVRA) is a tool for identifying individuals at high risk of a cardiovascular event (e.g. stroke, heart attack or angina) and enables health professionals to provide appropriate patient management and support. Preventative treatment can increase life expectancy and quality of life for patients at risk of CVD.

Target

Target populations for a CVRA are Māori, Pacific and Indian subcontinent men aged 35-74 years and women aged 45-74 years and all other ethnicities men aged 45-74 and women aged 55-74 years.
The national target is for PHOs to have assessed 90% or more of the target population.

CVRA coverage continues to increase, although is still below the target of 90%. CVRAs for Māori continue to be lower than the overall average, with 78.7% of the eligible Māori population having had a CVRA in the last five years compared to 85.3% for Other ethnicity.

CVRA coverage for Pacific people is lower than for all other ethnicity, with 78.1% of the eligible Pacific population having had a CVRA in the last five years compared to 85.3% for Other ethnicity. The Asian population CVRA coverage was 81.3% as at June 30th 2016.

This year's data reported below include the "discussed" code that is in use in Canterbury, which is not eligible for PHO payments, but is eligible to be included in reported target achievement. Although not previously reported, the overall CVD result as at June 2015, including the discussed codes, was approximately 83%.

Table 14: CVD Risk Assessments April – June 2016

	Numerator	Denominator	%
Māori	8,472	10,759	78.7%
Pacific	2,743	3,513	78.1%
Asian	7,502	9,225	81.3%
Other	109,072	126,301	86.4%
Total	**127,789**	**149,798**	**85.3%**

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APPENDIX 1: DATA SOURCES

Data Source	Data
Christchurch Primary Health Organisation	Smoking status recorded Smoking brief advice and cessation support CVD Risk Assessments
Rural Canterbury Primary Health Organisation	Smoking status recorded Smoking brief advice and cessation support CVD Risk Assessments
Pegasus Health	Smoking status recorded Smoking brief advice and cessation support CVD Risk Assessments B4 School Checks
Planning and Funding, Canterbury District Health Board	HPV immunisation (NIR) Child oral health Breastfeeding (WCTO data) Primary Mental Health (from data reported from the 3 PHOs) Cervical screening coverage Breast screening coverage
Ministry of Health	PHO enrolled population Immunisation at 8 months and 24 months (NIR)