Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Submission from Community and Public Health Division of the Canterbury District Health Board

5 May 2006

Christchurch City Council's Draft Long Term Council Community Plan 2006 – 2016

INTRODUCTION

1. This submission has been developed by Community and Public Health, a division of the Canterbury District Health Board. Community and Public Health provides public health services to Canterbury, South Canterbury and the West Coast.

2. We welcome the opportunity to comment on your Long Term Council Community Plan (LTCCP). The LTCCP is an important heath document.

3. Health is influenced by a wide range of factors beyond the health service sector. There is now good evidence that social, environmental and behavioral factors are the most important determinants of health. It has been estimated that only about 10 to 30 percent of improvements in health can be attributed to health services.

4. Many of these health determinants can be influenced by Council activities. For example, the quality of a person's health is closely related to a range of factors such as lifestyle (for example, physical activity), social and community influences (for example, whether people belong to strong social networks, feel valued and empowered to participate in decision-making), living and working conditions (for example safe and appropriate housing, decent working conditions, urban design and transport), environmental factors (such as air and water quality) and socio-economic conditions.

5. We congratulate the Christchurch City Council for your ongoing commitment to improving the health and wellbeing of people in our community. In fact you lead the way amongst local authorities in a number of areas.

6. We welcome the opportunity to work in partnership with the Council to improve the health of the people in our community. We believe that by working together we can be more effective and gain efficiencies. Possibilities for working together are discussed in the "ongoing relationship" section at the end of this submission.

7. **We wish to present our submission at a hearing**. We will be represented by both staff and elected representatives of the CDHB.

8. Please contact Mary Richardson mary.richardson@cph.co.nz or 3799 480 ext 819 to confirm a time for our oral submission.

9. Our submission focuses on the key health issues in the LTCCP and includes a number of recommendations. We are happy to provide additional information or clarify any aspects of our submission on request.

Evon Currie
General Manager
Community and Public Health
Canterbury District Health Board

CONTENTS

COMMUNITY OUTCOMES (PAGES 42 - 47)

10. We commend you on process to identify community outcomes. We would like to work more closely with you on future processes – with the aim of identifying shared health and wellbeing outcomes for the Council and the Canterbury District Health Board.

Health Outcome – page 45

11. We support the identification of health as a key component of the well-being of Christchurch residents. Health impacts on people's ability to be involved in community activities, use of services and enjoyment of the City's environment. Poor health can restrict people's ability to work, to engage in and succeed at education, and to enjoy leisure and recreation activities.

12. We support your approach to health:

We live long and healthy lives

We all have access to affordable health services that meet our needs

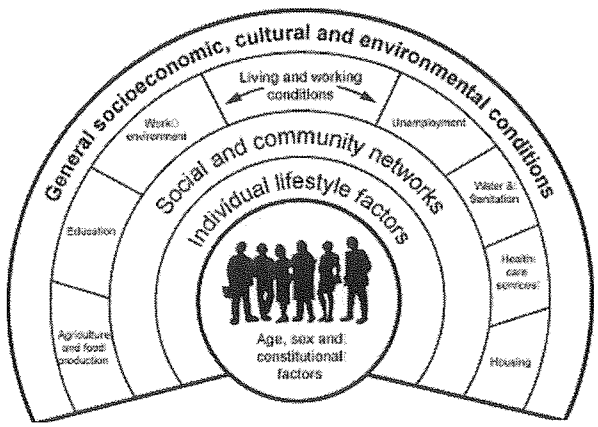
More people in Christchurch live healthy lifestyles

Out city environment supports the health of the community[1]

13. This outcome statement identifies that health is determined by factors outside the health sector: healthy lifestyles and the wider environment.

14. Health services help to restore people to good health or provide care for people when they are in need. However, various analyses of gains in life expectancy have attributed only 10 and 30 percent to health services.[2]

15. Much greater impacts are attributed to environmental, social and behavioural factors.[3] The diagram below presents some of the main factors determining the health of our local populations.



Source: Dahlgren G and Whitehead M (1991) Policies and strategies to promote social

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1 Current Community Outcomes 2003-2006 from Christchurch City Council. 2006. *Our Community Plan Volume 1 Draft Long Term Council Community Plan for the Ten Year Period Beginning 1 July 2006.* Page 42. http://www.ccc.govt.nz/LTCCP/CommunityOutcomes/

2 Ministry of Health 2005 *Advice to Incoming Minister of Health.* Wellington. Ministry of Health.

3 Public Health Advisory Committee. 2004. *The Health of People and Communities. A Way Forward: Public policy and the economic determinants of health.* Wellington: Public Health Advisory Committee.

16. Many of these health determinants can be influenced by Council activities. For example, the quality of a person's health is closely related to a range of factors such as lifestyle (for example, physical activity), social and community influences (for example, whether people belong to strong social networks, feel valued and empowered to participate in decision-making), living and working conditions (for example safe and appropriate housing, decent working conditions, urban design), environmental factors (such as air quality) and socio-economic conditions (including income, education and employment).

Health Priorities

17. We note that since the last LTCCP[4] the Community Outcomes have lost the focus on
    - Reducing health inequalities
    - Improving mental health

18. Reducing health inequalities and improving mental health were identified as key issues in the previous community outcomes (2004/14)[5] along with the factors identified in the current outcome statement (health lifestyles, environmental health and health services).

19. We believe that health inequalities and mental health are important health issues. Both identified as priorities of the NZ Health Strategy[6] and by the Minister of Health has signaled the following Strategic Priorities.[7]

20. The CHDB's *Statement of Intent* and *Strategic Plan* identify mental health and health inequalities as priorities for the region. These were confirmed through research and consultation. [8]

Health Inequalities

21. There are significant inequalities in health between groups, in particular between people with low income and low education levels in comparison to the broader population, between Maori and the broader community and between Pacific people and the broader community. These inequalities have widened over the last 20 years.

22. The Ministry of Health reported a 9 year difference in life expectancy at birth for males between the least deprived and the most deprived areas of New Zealand society. For women this difference was smaller, but still more than 6.5 years.[9] These inequalities hold for disease rates, health service use, hospital admission and self-rated health.

23. Individual behaviours, such as smoking and diet, only partly explain this relationship and such behaviours themselves are strongly related to social economic factors, e.g. housing, income, education and employment.

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4 Our Community Plan, Christchurch O-Tautahi 2004/14 http://www.ccc.govt.nz/LTCCP/CurrentPlan.asp

5 Christchurch City Council. 2004. *Current Community Outcomes 2003-2006.* http://www.ccc.govt.nz/LTCCP/CommunityOutcomes/Current/index.asp

6 Minister of Health. 20002 *New Zealand Health Strategy* . Wellington. Ministry of Health http://www.moh.govt.nz/publications/nzhs

7 The Minister of Health has signaled the following Strategic Priorities; New Zealand Disability Strategy; Reducing Inequalities; He Korowai Oranga; Health of Older People; Improving Mental Health and the Mental Health Blueprint cited in Canterbury District Health Board. 2005. *Statement of Intent 1 July 2005 – 30 June 2008* Christchurch. http://www.cdhb.govt.nz/planning/documents/SOI-finalversion-05-08.pdf

8 Canterbury District Health Board. 2005. *Statement of Intent 1 July 2005 – 30 June 2008* Christchurch. http://www.cdhb.govt.nz/planning/documents/SOI-finalversion-05-08.pdf . and Canterbury District Health Board. 2002. *Strategic Plan 'Toward a Healthier Canterbury: Directions 2006'.* http://www.cdhb.govt.nz/communications/documents/pdf/strategic-plan-for-cdhbwebsite.pdf

9 Ministry of Health 2001 *Life Expectancy and Small Area Deprivation in New Zealand*, Ministry of Health, Wellington.

24. Tackling health inequalities continues to be a major challenge for the city and county as a whole. The NZ Health Strategy identifies:

> *To improve the overall health of New Zealanders, particular attention must be paid to those with the poorest health. ..*
> *Addressing health inequalities is a major priority requiring ongoing commitment across the sector.*[10]

25. The CDHB has identified health inequalities as a key priority for the health sector. Our Strategic Plan states:

> *We aim to improve the health and wellbeing of the people of Canterbury with a particular focus on providing support to those groups where the greatest health disparities currently exist, such as Maori, Pacific peoples and those on low incomes.* [11]

26. We note that the Community Mapping Project report, sponsored by Christchurch City Council and a number of other agencies including C&PH, concluded that:

> *Tackling inequalities continues to be a major challenge for the city and country as a whole*[12]

27. That report was based on a review of trend data and literature and community consultation. Our understanding is it formed the basis for the Community Outcomes. We are therefore surprised that reducing health inequalities does not feature within the Community Outcome document.[13]

28. We note that a report to Council on consultation on the Community Outcomes and Council Strategic Direction (Council Seminar 12 July 2005) advised that the feedback has request for Council to focus on those with ***lower-economic status was one of the three key themes identified through feedback.***[14]

Mental Health

29. Mental illness accounts for 15 percent of the total burden of disease in the developed world, with depression set to become the second leading cause of disability in the world by 2020, according to the World Health Organization. In New Zealand, at any one time an estimated 20 percent of the population have a mental illness and/or addiction and 3 percent are severely affected. [15]

30. The WHO identifies lack of housing, transport, isolation, neighbourhood disorganisation and social disadvantage (among other factors) as risks for mental illness. It identifies social participation, social services and social supprt and community networks (among other factors) as being protective of mental / emotional wellbeing.[16]

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10 Minister of Health. 20002 *New Zealand Health Strategy* . Wellington. Ministry of Health. Page4

11 Canterbury District Health Board. 2005. Statement of Intent 1 July 2005 – 30 June 2008 Christchurch. http://www.cdhb.govt.nz/planning/documents/SOI-finalversion-05-08.pdf .
Canterbury District Health Board. 2002. *Strategic Plan 'Toward a Healthier Canterbury: Directions 2006'.* http://www.cdhb.govt.nz/communications/documents/pdf/strategic-plan-for-cdhbwebsite.pdf

12 Christchurch City Council et al 2004. *Christchurch Community Mapping Project Summary Report.* Christchurch. Page 34

13 Current Community Outcomes 2003-2006. http://www.ccc.govt.nz/LTCCP/CommunityOutcomes/Current/index.asp

14 Christchurch City Council. 2005. *Community Outcomes/ Strategic Directions? Activity Management Plans* Report presented Council Seminar 21 July 2005.

15 Ministry of Health. 2003. Health and Independence Report: Director-General's annual report on the state of public health. Wellington: Ministry of Health.

16 World Health Organization. 2004. Prevention of Mental Disorders: Effective Interventions and Policy Options. Geneva. WHO. Page 21

31. Mental health is a priority health area for the Government, as reflected in The New Zealand Health Strategy [17] and The New Zealand Disability Strategy [18] and as set out in Te Tahuhu -Improving Mental Health 2005– 2015: The Second New Zealand Mental Health and Addiction Plan.[19]

32. The CDHB has identified mental health as one of the top five health priorities for Canterbury.[20]

33. We note that the Community Mapping Project report, sponsored by Christchurch City Council and a number of other agencies and used as a background for the community outcomes, concluded that:

> *The consultation and data available suggested that mental illness is a major health challenge facing health services and the community as a whole*[21]

Submission

a) **We would like to work more closely with the Council on future Community Outcome processes (COPs) with the aim of identifying shared health and wellbeing outcomes for our community.**

b) **We support the identification of health as a key component of the well-being of Christchurch residents in the Community Outcomes 2006 to 21016.**

c) **We support your approach to health as including healthy lifestyles, healthy environments and health services.**

d) **We recommend that *reducing health inequalities* and *mental health* be reintroduced as a focus in the Community Outcomes.**

e) **We recommend that the Council, as a sponsor of Healthy Christchurch, works with its Healthy Christchurch partners to develop measurable health goals and strategies for action.**

Oral Health

34. Teeth and gum disease are common health problems and most are preventable.

35. While everyone is potentially susceptible to dental decay, children are particularly at risk. For children oral health has implication beyond more fillings in deciduous and permanent

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17 Minister of Health. 2000. The New Zealand Health Strategy. Wellington: Ministry of Health.

18 Minister for Disability Issues. 2001. The New Zealand Disability Strategy: Making a world of difference: Whakanui oranga. Wellington: Ministry of Health.

19 Minister of Health. 2005. Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan. Wellington: Ministry of Health.

20 Canterbury District Health Board. 2005. *Statement of Intent 1 July 2005 – 30 June 2008.* Christchurch. http://www.cdhb.govt.nz/planning/documents/SOI-finalversion-05-08.pdf Canterbury District Health Board. 2002. *Strategic Plan 'Toward a Healthier Canterbury: Directions 2006'.* http://www.cdhb.govt.nz/communications/documents/pdf/strategic-plan-for-cdhbwebsite.pdf

21 Christchurch City Council et al 2004. *Christchurch Community Mapping Project Summary Report.* Christchurch. Page 33

teeth: poor dental health causes pain and discomfort and can impact on children's dietary intake and therefore their physical and cognitive development.[22]

36. It has been shown that children in Christchurch have significantly poorer oral health than children living in fluoridated areas. For example, a recent comparison of the oral health of children from Canterbury and Wellington showed that decay levels were 30 percent lower in the fluoridated areas.[23]

37. Water fluoridation is the single most effective tool for the prevention of tooth decay within a population.[24]

38. Fluoridation is currently done in certain New Zealand cities such as four Auckland Cities, Wellington, Dunedin and Invercargill. It is not currently done in others such as Nelson, Napier, and Christchurch.[25] The natural fluoride levels in Christchurch water are only around one eighth of the level recommended for prevention of tooth decay.

39. Canterbury DHB has a position statement on fluoridation:

> *'The CDHB recognises that water fluoridation is the most cost-effective, practical and safe means for reducing and controlling the occurrence of tooth decay in communities of over 1000 people.*
>
> *The CDHB considers that, at less than one percent, the coverage of the Canterbury population by fluoridated water supplies is very low.*
>
> *As part of its efforts to improve the oral health of Canterbury people, and to reduce health inequalities, the CDHB will work collaboratively with communities, tangata whenua, and local councils to expand the level of water fluoridation in Canterbury.*
>
> *The CDHB supports research into the risks and benefits of water fluoridation, and into appropriate alternatives to water fluoridation in communities where fluoridation is not feasible.'*

40. National and international research has shown there is no persuasive evidence of harmful effects from water fluoridation.[26] Conversely, there is persuasive evidence that fluoridation benefits oral health.[27]

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22 Elderly people suffer an increased risk of dental decay if their general health worsens. Elderly people in poor health may change their diets which result in further causes complications. Certain members of society, as a result of either physical or intellectual disability, are unable to look after their teeth and require regular extensive dental treatments. Due to their disabilities these treatments quite often require the use of general anaesthesia, which is never without risk. There is a small but significant mortality (death-rate) associated with dental treatment carried out under general anaesthesia

23 Canterbury District Health Board. 2003. "Oral Health Strategy". Part B. CDBH. Christchurch.

24 Public Health Advisory Committee. 2003 *Improving Child Oral Health and Reducing Child Oral Health Inequalities.* Report to the Minister of Health from the Public Health Advisory Committee. National Health Committee. Wellington. Bates MN. 2000. *Fluoridation of water supplies – an evaluation of the recent epidemiological evidence.* .Wellington: Ministry of Health. Wright JC, Bates MN, Cutress TW, Lee JM. 2001 "The cost-effectiveness of fluoridating water supplies in New Zealand" *Australia and New Zealand Journal of Public Health* 2001; 25: 170-8. Canterbury District Health Board. 2003. "Oral Health Strategy. Part A and Part B. CDBH. Christchurch.

25 Approximately 317 million people in 39 countries benefit from artificially fluoridated water and an additional 40 million benefit from water supplies which are naturally fluoridated. The United States is now 65% fluoridated and will soon reach the low 70s when California's water fluoridation law is implemented. In Australia approximately two- thirds of the population reside in fluoridated areas, while in New Zealand 57% of the population consume fluoridated water. The Japanese Government has recently endorsed water fluoridation. Vietnam commenced water fluoridation in the last 10 years. In South Korea, 39 cities are now fluoridated and 9 others are in the process of installing fluoridation equipment. South Africa has enacted mandatory legislation requiring all water systems to fluoridate.

26 Epidemiological studies (cross-sectional, cohort and clinical trials) in different geographical areas and in different populations have shown that long-term exposure to levels of fluoride optimal for the reduction of dental decay does not have an adverse effect on bone strength, bone mineral density or fracture incidence. There is

41. Opponents of fluoridation are at times vocal, and there is a level of public concern.[28] CDHB recognises that the addition of fluoride to Canterbury water supplies is an issue for debate and decision by the relevant territorial authorities in conjunction with their communities which includes the CDHB.

42. Focusing on water fluoridation may have the effect of losing sight of the goal – improving oral health. While water fluoridation is currently the best-proved method of improving oral health, it is not the only potential option. Other options include delivery of fluoride through toothpaste or tablets; and health promotion initiatives aimed at limiting frequency of sugar intake.

Submission

f) **We recommend that improving oral health becomes a priority under the health outcome.[29]**

g) **We encourage the Council to support all efforts to improve public understanding of the link between fluoridate and oral health.**

h) **We recommend that the Council explores and supports other means to improve oral health, until such time that it fluoridates the water supply.**

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no detectable risk of cancer associated with the consumption of optimally fluoridated water (United States Public Health Service Report 2001).

27 Its safety and effectiveness have been endorsed by international bodies such as the World Health Organisation (WHO), the United States Public Health Service (USPHS), the Centre for Disease Control and Prevention (CDC) and the United States Surgeon General. Also see U.S. Department of Health and Human Services. (2002) "Recommendations for using fluoride to prevent and control dental caries in the United States and Forum on Fluoridation (2002). *The Report of Forum on Fluoridation* Stationery Office. Dublin

28 A further consideration is that water fluoridation does impinge, to some extent, on individual freedom. Whenever there is an intervention that has the potential to benefit large number of the population there is potential to impact on individual rights. Drink Driving and Smokefree Environment Legalisation are examples of such interventions - in order to protect the health and safety of the wider public the rights for individuals are curtailed. There is also legislation that allows IRD to share information between Department of Courts, ACC, and Work and Income. This infringement of individual rights is in order to protect the tax payer from benefit fraud. In that case the risks are money, in the case of oral health it is children's health and well being. The protection of Historical Buildings is another example of policy which can impinge on individual rights.

29 We note that the Local Government Act 2002 allows for additional outcomes to be identified outside the Section 91 provisions. Section 12 allows local authorities to identify additional outcomes through consultation (Section 12, Local Government Act 2002).

CITY DEVELOPMENT (PAGES 90 –95)

43. Good urban planning is a form of primary prevention and a contributor to positive health outcomes. Many of the most significant gains in health have stemmed from urban planning public health measures, notably clean water, sanitation, and improved housing.

44. The built environment impacts upon opportunities to engage in physical activity and participate in community life. For example, road traffic, footpath safety, air quality, proximity to parks and playgrounds, cycle paths, lighting and neighbourhood safety can either support or create barriers to physical activity participation.

45. The World Health Organisation recognises the importance of these links, and healthy and sustainable urban planning is a core component the WHO Healthy Cities framework.

46. Similarly, the links between urban design and health have been recognised by central government in the Urban Design Protocol launched by the Ministry for the Environment in March 2005.[30] The Ministry outlined the rationale for good urban design in terms of its economic, environmental, social and health benefits.

> *"some of the strongest emerging evidence about good urban design relates to walkability and to urban features that encourage walking. walkability is linked to the density of a neighbourhood, the mix of uses it contains (especially the retail-residential mix), the connectivity and attractiveness of the street network, the reasonable proximity of the activities that are the destination of the trips, and perceptions and conditions of safety...this report has noted strong evidence that walkable public environments can ...enhance public health for the benefit of the individuals as well as the national health budget."*[31]

47. We congratulate the Council for becoming a signatory to the Protocol in February.[32] Becoming a signatory to the protocol indicated the Council's commitment to continuous improvement of the Christchurch urban area and recognises its role in setting an example for others. We would like a greater emphasis on health and health impact reflected in Christchurch City Council Urban Design Protocol Action Plan.

48. We commend the Council for the development of the Urban Design website[33] and the development of the Crime Prevention Through Environmental Design principles.[34]

49. We commend the Council for efforts to create a healthy urban environment. We encourage you to maintain a commitment to
    - well planned networks of walking and cycling routes
    - accessible open spaces for recreation and leisure
    - conveniently located public transport stops
    - "living streets" approach
    - local neighbourhoods, and neighbourhood centres, fostering community spirit.

50. In addition to these areas, we would like the Council to take a greater lead in the following areas

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30 Ministry for the Environment. 2005. *The Value of Urban design. The economic, environmental and social benefits of urban design*. Wellington. Ministry of Environment June 2005. http://www.mfe.govt.nz/publications/urban

31 Ibid page 67

32 Report to Council 22 September 2005, Urban Design Protocol Action Plan. http://www.ccc.govt.nz/Council/proceedings/2005/September/CnclCover22nd/UrbanDesign.pdf

33 http://www.ccc.govt.nz/environment/urbandeisgn

34 The CDHB is a member of the Safer Christchurch Interagency Group, which developed the *Safer Christchurch Strategy*. This strategy include the promotion of the CPTED principles.

- ensuring that any new development includes design features that incorporate the six essential design features outlined in the Urban Design Protocol and encourage walking and cycling (e.g. access and connectivity)
- infrastructure that supports and encourages the public to walk, use public transport and cycle (see section on Streets and Transport on page 34 of our submission)

51. Community and Public Health has recently undertaken a Health Impact Assessment of the Urban Development Strategy. This was presented to the Great Christchurch Urban Development Strategy Forum (the Forum) in December 2005. We would like the Council's Action Plan to reflect a greater consideration of the impact of urban design on people's health. We assume that the Council will support the implementation of the recommendations contained in that report.

52. We believe that there are benefits to using Health Impact Assessment as a regular policy tool, particularly for more significant initiatives.

Submission

i) **We commend the Council for efforts to create a healthy urban environment.**

j) **We congratulate the Council for becoming a signatory to the Urban Design Protocol, the development of the Urban Design website and the adoption of the Crime Prevention Through Environmental Design principles.**

k) **We would like the Council to review Urban Design Protocol Action Plan to give a greater emphasis on health.**

l) **We recommend that the Council use the Living Streets Charter as a guiding policy framework for new street and asset renewal planning, design and implementation.**

m) **We recommend a greater emphasis on active forms of transport.**

n) **We recommend that the Council support the implementation of the recommendations in the Urban Development Strategy Health Impact Assessment.**

o) **We recommend the use of Health Impact Assessments as a regular policy tool across portfolio areas.**

COMMUNITY SUPPORT (PAGES 96 –101)

Community Grants

53. We support the Council's ongoing commitment to funding community initiatives and services. We endorse the Council's recent explicit commitment to maintaining its current funding level (17 February 2006).

54. Council funding plays a significant role in the Christchurch community funding picture. Its strength is the flexibility that the Council provides in response to local needs and in its ability to provide different kinds of funding to meet different needs. Council has frequently provided crucial infrastructure funding when a project doesn't quite fit the more rigid categories of other funders.

55. Grants funding to community organisations is an effective and efficient way for Council to meet some of its social, cultural, environmental and economic objectives. In addition to delivering services, community organisations provide opportunities for participation, provide avenues for communities to solve their own problems, provide re-entry to the workforce and skill enhancement, and build the networks, trust and collaboration essential for social cohesion, population health, economic growth and successful democracy.

56. While there will always be a greater level of demand on these funds than the Council is able to meet, the current level is considered to provide a significant boost to the level of community services, arts, cultural, sport, recreation and community development being provided within the city.

57. We endorse the Councils statements in its Statement of Intent Regarding the Council's Relationship with the Community and Voluntary Sectors adopted in June 2001[35]

> *The voluntary sector is fundamental to the development of a democratic, socially inclusive and prosperous society. Voluntary groups, as independent, not-for-profit organisations, bring distinctive value to Christchurch and fulfil a role that is distinct from both the state and the market. Voluntary organisations make major tangible and difficult to quantify contributions to the social, cultural, economic and political life of the city.*

and

> *The Council acknowledges that the provision of funding and other forms of support is an important means of enhancing the sector's ability to contribute to the wellbeing of the city.*

58. We congratulate the Council for its involvement in the Healthy Sports Club Christchurch initiative (ClubMark): a partnership between the Council, C&PH, ACC and Sports Canterbury. Being a ClubMark clubs signals to the wider community and funders that the club is a well organised, viable and healthy organisation. Under this initiative sports clubs are encouraged and supported to implement healthy policies and practices, including Smokefree, responsible alcohol use, injury prevention, healthy food and sunsmart policies and practices.

59. We encourage the Council to explore ways in which it can encourage other community groups to implement healthy policies and practices. It may be appropriate to link this to funding assessments.

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[35] Christchurch City Council. 2001. Minutes of Council Meeting 28 June 2001. http://www.ccc.govt.nz/Policy/StatementOfIntent.asp

Community Support

60. We acknowledge that the Council has an important role to play in supporting communities and building social capital.

61. Strong communities provide benefits in two respects:
    - Firstly they provide support, services and developmental opportunities to community members.
    - Secondly participation by people in community activities builds social capital[36]

62. There is increasing international evidence that social capital is critical to the population health as well as social cohesion, economic growth and successful democracy.[37]

63. According to the World Health Organisation:

> *A **healthy city** is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.*
>
> *(WHO, 1995)*

64. We are particularly interested in the health benefits to communities from a community development approach. We believe that community development activities undertaken by the Council have made a positive difference. We wish to see ongoing collaborative relationships with the Council, Department Internal Affairs, CDHB, Ministry of Social Development and other government agencies and the voluntary sector.

65. As discussed in paragraph 58 we commend the Council's involvement in the Healthy Sports Club Christchurch initiative (ClubMark). We encourage the Council to explore ways in which it can encourage communities and community groups to promote healthy lifestyles.

Submission

p) We endorse the Council's explicit commitment to maintaining its current funding level.

q) We support the Council's active involvement in community development and believe it has made a positive difference.

r) We endorse the Council's statements in its *Statement of Intent Regarding the Council's Relationship with the Community and Voluntary Sectors.*

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[36] Social capital refers to the creation of networks, goodwill, trust, shared values, norms, and generalised reciprocity which arise from interactions between people. Social capital acts as a resource that can be used to help realise certain interests. Forms of social capital facilitate, through multiple channels, the achievement of goals unattainable in its absence, or achieved only at a higher cost.

[37] Mounting evidence of an association between social capital and a number of desirable outcomes, for example social cohesion, public health, successful democracy, and economic growth (Putnam 1993, Fukuyama 1995, Blakeley 1997, Cox, 1995, Kawachi 1997, Walzer 1995, Richardson 1998). Research indicated how levels of social capital affected outcomes in education (Teachmann et al 1997, Knaul and Partinos 1998, Braatz and Putnam 1998, Francis et al 1998), income levels (Burt 1997, Montgomery 1991, Belliveau et al 1996, Narayan and Pritchett 1997, Grootaert 1998, Robison and Siles 1997, and Simpson et al 1992), health outcomes (Kawachi et al 1997 and Braum 1999, Berkman, L. and Syme, S. 1979, Gillies, P. 1998), the performance of firms (Barr 1998, Fountain 1997, Kantor 1995, Brautigam 1997, Fafchamps 1996, Weidenbaum and Hughes 1996, and Gulati 1995, collective action at the community level (Narayan and Nyamwaya 1996, Molinas 1998, and Grootaert 1998), opening up economic and employment opportunities within ethnic groups, gender and racial equality (Zhoou 1992, Nee, Sanders and Sernau 1994 and Waldinger 1995) and effective democratic governance, and financial performance (Coleman 1990; Putnam 1993; Fukuyama 1995; Evans 1996).

s) **We encourage the Council to explore the extension of health promotion programmes, such as the ClubMark initiative, to other community agencies.**

Housing

66. The Ottawa Charter for Health Promotion (World Health Organisation) recognised shelter as a basic prerequisite for health. New Zealand researchers and policy makers have also recognised the housing is an important determinant of health.

67. We congratulate Council for its ongoing commitment to the provision of social housing.

68. We commend the Council for its involvement with the Christchurch Housing Forum networking meetings where housing issues are discussed by the community sector groups. We also applaud the Council for commissioning research on housing issues and believe that the results have helped clarify housing issues in Christchurch.

69. For some time now, no one agency has a statutory leadership role in private housing (including rentals), and that this has led to confusion and inaction on some resistant and serious community issues related to housing.[38] We believe that the Council should take a leadership role locally.

70. A lack of adequate, affordable housing can aggravate other problems associated with low income. Individuals and families who are forced to spend a disproportionate amount of their income on housing often face food insecurity, and are unable to participate in healthy community activities such as active recreation and children's social programmes. There is little or no money left for transportation to work and for clothing and school supplies.

71. Poor quality housing is also closely linked to ill health amongst infants, the elderly and people with chronic illness and is detrimental to mental wellbeing.[39] We would value a closer communication on the extent of community needs and on possible solutions to housing issues, particularly for those most at risk. Healthy Christchurch could be used as a vehicle to form a strategic partnership for action.

72. Given that there are large numbers of older houses with inadequate levels of insulation, we suggest that Council could do more to inform and educate the more vulnerable members of the public, regarding ameliorating cold damp housing conditions. We believe that there are some strategic opportunities that could be developed, including ways of working more closely with services, such as Community Energy Action and Council initiatives like the Energy House in Papanui, to better equip the public with practical and affordable solutions.

73. Housing is important given the mental wellbeing needs of the population. The link between poor housing and depression is well recognised. Having a mental illness can result in different housing requirements, and those with mental illness are more likely to encounter housing problems and the negative impacts of poor housing.[40]

74. Increasingly, the CHDB's approach to mental illness is to focus on community based care, backed up by specialist services.[41] This magnifies the need for appropriate housing

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38 Housing Forum. 2003. *Housing Forum report 2003.* Christchurch
39 British Medical Jounal. 2004. 328:1396 (12 June).
40 Mental Health Commission. 1999. *Housing and Mental Health.* Wellington. MHC. Page 3.
41 Canterbury District health Board. 2004. *Canterbury Needs Assessment 2004.* page 86.

for those with mental illness. Housing solutions need to ensure people with mental illness:

- have access to affordable quality housing;
- are not disadvantaged by housing tenure;
- have choice of a range of housing options according to their needs and preferences within reasonable economic constraints;
- are not in serious housing need;
- are free from discrimination in relation to housing;
- are assured of accommodation which provides for privacy, personal; dignity and safety.[42]

75. We support the Council's ongoing provision of social housing for people with mental illnesses.

76. The LTCCP identifies that the city has an ageing population (page 31). The population aged 70 to 75 years is expected to increase by 67% in the next two decades. Similarly the 75 to 79 and 80 to 84 age groups will increase by around 60 per cent. The population 85 years and over is expected to double.[43]

77. We note the Council plans to build only 21 additional housing units in the next decade. We are unclear why the older persons' housing stock is not keeping pace with the population.

78. We note in a report to Council from Creating Strong Communities Portfolio Group that the Council intends to review is Social Housing Strategy.[44] We would like to express our interest in being involved in this review. We also believe that this issue could usefully be informed from input from the Healthy Christchurch network.

Submission

t) **We congratulate Council for its ongoing commitment to social housing, involvement with the Christchurch Housing Forum and its research on housing issues.**

u) **We recommend that the Council utilise wider consultation processes, including Healthy Christchurch and the Housing Forum, on the matters such as whether the older persons' housing stock should keep pace with the population.**

v) **We recommend that the same processes could be activated in regard to the Council's review of its Social Housing Strategy.**

w) **We request that the CDHB is involved in the review of its Social Housing Strategy.**

x) **We recommend that the Council clarify to all sectors the specific roles that it will take in housing issues in the city.**

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42 Mental Health Commission. 1999. *Housing and Mental Health.* Wellington. MHC. Page 3.

43 Statistics New Zealand, Census of Population and Dwellings, Sub national Population Projections (2001 Base), February 2005 Release.

44 Christchurch City Council. 2006. Creating Strong Communities Portfolio Group. Programme February – July 2006.

Early-Learning Centres

79. We note that the provision of early-childhood centres is subject to review in the next 1 to 3 years (page 98 and 99) of LTCCP. In February 2006, a report to Council identified that early childhood centres were "*not core business, other providers have expertise, [and] could be contracted/leased*"[45]

80. Quality early childhood education is a key contributor to health and wellbeing.[46]

81. There is a large body of research that clearly documents how crucial the formative years of childhood development are to overall lifelong health, learning and effective social functioning of a person [47] [48] [49] [50] (Early Childhood Development, 2003; Royal New Zealand Plunket Society, 2002; Vimpani, 2003; Brainwave Trust, 2004).

82. There is strong evidence that early childhood services, including preschools, can have a major beneficial impact on young people's lives and give real meaning to the long espoused social aim of children attaining their full potential in life. [51]

Submission

y) We support Council's ongoing support for early childhood education.

z) We support the ongoing provision of affordable quality early childhood centres at recreation facilities.

Pandemic Planning – Civil Defence

83. We note that influenza pandemic issues are absent from the LTCCP and supporting documentation (other than a few specific areas e.g. cemeteries). This omission should be addressed.

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45 Christchurch City Council Agenda Papers for Meeting 2 February 2006. http://www.ccc.govt.nz/Council/proceedings/2006/February/CnclCoverLTCCP13th/TuesPotentialSavingsCityDevt.pdf

46 McKey, R.H.; Condelli, L.; Ganson, H.; Barrett, B.J.; McConkey, C.; and Planz, M.C. 1985. The Impact of Head Start on Children, Families, and Communities. Final Report of the Head Start Evaluation, Synthesis and Utilization Project. Washington, DC: CSR, Inc.,
Lynn A. Karoly, M. Rebecca Kilburn, and Jill S. Cannon. 2006. *Early Childhood Interventions: Proven Results, Future Promise* RAND
Shonkoff J. and Phillips D. (2000). *From Neurons to Neighbourhoods. The Science of Early Childhood Development.* Washington, D.C.: National Academies Press.
Public Health Agency of Canada. 2002. Early Childhood Education and Care as a Determinant of Health. http://www.phac-aspc.gc.ca/phsp/phdd/overview_implications/07_ecec.html
Belfield, CR with PJ McEwan. 2005. An Economic Analysis of Investments in Early Childhood Education in Massachusetts. Research paper commissioned by Strategies for Children, Inc. January
Gordon Cleveland; Michael Krashinsky 1998. The benefits and costs of good child care: the economic rationale for public investment in young children. (University of Toronto: Toronto, Canada,).

47 Vimpani, G. (2003). *Promoting early childhood development. Invest now or pay later.* Oral Public Presentation. Supported by the Canterbury District Health Board: Christchurch.

48 Early Childhood Development/Ngä Kaitaunaki Köhaungahunga. (2002) *Whiria te ao Tamariki. Infants and toddlers. A professional development support resource for early childhood centres working with Early childhood development professional development co-ordinators. Issue 1. The importance of brain development.* Wellington: Early Childhood Development/ Ngä Kaitaunaki Köhaungahunga.

49 Royal New Zealand Plunket Society. (2002). College of Nurses Aoteaora (NZ) inc. *Te Puawai – The Blossoming. Plunket Nurses in 2002: Who are we and what do we do?* Refer http://www.nurse,org.nz?Te Puawai/0302/0302%sen.html.

50 Brainwave Trust, New Zealand. (2005). Refer http://www.brainwave.org.nz/content/blogsection/14/68

51 Vinson, T. (3003). Inquiry into the provision of public education in NSW. Sponsored by NSW Teachers Federation and Federations of P&C Associations of NSW (First Report), 78.

84. The Council, in conjunction with the CDHB and CDEM groups will have key roles in preparing local communities for a pandemic, and in responding to it should it arrive.

> *It is a widely-held view that the battle will be won or lost in the local communities, and therefore community leadership and preparedness will be vital elements in the response to the pandemic* [52]

85. Well-managed community response and recovery efforts can reduce the impact of a pandemic.

86. A number of specific issues will arise for Councils:
    - Workforce reductions will put at risk the delivery of essential Council services, such as water and waste services. Interruption of critical public services will make matters worse within a community already struggling with influenza.
    - Council expenses are likely to increase while the community struggles with response and recovery activities. At the same time, local revenues may drop substantially due to a failure to pay rates and reduced income from fees and charges. Managing these financial losses will be a necessity.
    - As identified in the LTCCP, the Council may have to deal with high death rates during a pandemic and this could place a strain on burial and cremation services.
    - Council will have a key role in promoting neighbourhood support in advance of a pandemic and supporting welfare groups during and after a civil defence emergency.

87. We believe that your long term intention regarding these issues should be stated in your LTCCP.

Submission

aa) We recommend that the Council's long term intention regarding pandemic planning be stated in the LTCCP.

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[52] Local Authority Pandemic Planning Working Party 2006 New Zealand Local Authority and CDEM Group Pandemic Planning Guide March 2006 Wellington Ministry of Civil Defence & Emergency Management and Local Government New Zealand. Page 5.

CULTURE AND LEARNING SERVICES (PAGES 102 –107)

Libraries

88. We endorse the Council's commitment to providing library services and maintaining free access to library facilities.

89. Health status improves with level of education.[53] Literacy and education contribute to health by equipping people with knowledge and skills for problem solving, and helps foster a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy.

90. People with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than people with high levels of literacy. People with higher levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier foods.

91. Libraries are a key contributor to community education and literacy. They are the repositories of recorded knowledge in local communities and play a major role in the development of socially cohesive and inclusive communities. As the CEO of the CDHB identified "access to books is especially important to those who are ill, aged or otherwise restricted".

92. We endorse the Council's CEO's statement in *Public Libraries Of New Zealand A Strategic Framework 2005 to 2015*[54]

> *In Christchurch city we believe libraries are about more than books and buildings. Libraries are at the hub of our communities. No longer places where everyone has to be quiet, today's libraries are busy information centres focusing on customers and offering a place to meet friends for coffee, surf the net and, of course, and the latest thriller.* ***The benefits to our communities are well worth the ongoing significant investment.****. In the future we anticipate even more innovation in the way libraries help create inclusive communities, and are centres for lifelong learning, fun and creativity.*
>
> *Dr Lesley McTurk, Chief Executive, Christchurch City Council*

93. We note that the Council has proposed closing some suburban libraries plus the Mobile Library Service, as cost cutting measures to keep rates down. Given the economic, social and cultural benefits of libraries, it would appear false economy to propose cuts to libraries. We are also unclear whether other savings will be achieved.

94. We note that advice to the Council on 2 February 2006 stated that for some of the proposals the *"Market may not deliver savings and market hasn't been tested"* [55] We note the library building on the Spreydon reserve can not be used for commercial purposes. The costs therefore of owning the building could well end up being transferred to a different Unit budget (i.e. still incurred by the Council Group). We also note that

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53. Nutbeam D. Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. Health Promot Intl 2000;15:259-67Baker DW, Parker RM, Williams MV, et al. The relationship of patient reading ability to self-reported health and use of health services. Am J Pub Health 1997;87(6):1027-30.

54 http://www.lianza.org.nz/community/pub-sig/framework/

55 Christchurch City Council Agenda Papers for Meeting 2 February 2006. http://www.ccc.govt.nz/Council/proceedings/2006/February/CnclCoverLTCCP13th/TuesPotentialSavingsCityDevt.pdf

libraries have remained within their ten year forward projections and that the cities investment in libraries has been well planned and executed.

95. We support the ongoing assessment of location and style of libraries and a planned approach to development, which was outlined in a presentation to libraries called Libraries 2025. Such a planned review should take account of citizens need about the library and information services needed, the ability to co-locate with other community facilities, the changes taking place in library service delivery and design.

96. We support the strategic framework for public libraries: *Public Libraries of New Zealand: A Strategic Framework 2006 to 2016*. We believe that the Council should work to align its strategies for libraries with that document.

Submission

bb) We endorse the Council's ongoing commitment to providing quality library services

cc) We do not support the proposed closures of libraries.

dd) We believe that the Council should work to align its strategies for libraries with the *Public Libraries of New Zealand: A Strategic Framework 2006 to 2016.*

DEMOCRACY AND GOVERNANCE (PAGES 108 – 113)

Maori Capacity to Contribute to Decision-making (page 289)

97. The Local Government Act 2002, the Local Government (Rating) Act 2002 and the Local Electoral Act 2001 introduced new provisions affecting local government in terms of their relationship with Maori. [56]

98. The cumulative intention of the provisions is that strong relationships should develop between local government and Maori. Maori should have, or be assisted to develop, the ability to contribute to those decision-making processes that relate to matters identified as important to them.

99. We note that the Council must state in its LTCCP any steps that it intends to take, having considered ways in which it might foster the development of Maori capacity to contribute to the decision-making process of the local authority, over the period covered by the plan. (Schedule 10 (5) Local Government Act 2002) We also note that each annual report what they have done to involve Maori in council processes (Schedule 10 (21) Local Government Act 2002).

100. We are concerned about the Councils lack of progress regarding consultation with Maori, Maori participation in decision making and building internal organisational capacity.[57]

101. We have reviewed the policies and LTCCPs of other Councils, particularly other metropolitan councils and we note that other councils have initiatives such as
    - Maori Standing Committees;
    - Maori membership of Council committees, sub committees and working groups;
    - Co management of sites and activities;
    - Relationship agreements;
    - Iwi/Maori liaison units;
    - Kaumatua advisors;
    - Maori policy positions and/or units;
    - Maori and/or Treaty policies or tool kits;
    - Strategies to implement the Treaty in to core business.

102. We note that the Council appears to be have made little progress since the 2004/14 LTCCP.

103. We also note that a report to Council on consultation on the Community Outcomes and Council Strategic Direction (Council Seminar 12 July 2005) advised that

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56 We note that the Local Government Act local authorities have an obligation to encourage contributions to decision-making by Maori (Section 14 and 81, Local Government Act 2002). Local authorities must:
- Establish and maintain processes that provide opportunities for Maori to contribute to decision-making processes;
- Consider the ways in which the local authority may foster the capacity among Maori to participate in decision-making; and
- Provide relevant information to Maori for the above two purposes (section81, Local Government Act 2002).

If any of the options involve a significant decision in relation to land or a body of water, the relationship of Maori, their culture and traditions with their ancestral land, water, sites, waahi tapu, valued flora and fauna and other taonga must be given particular consideration. (Section 77 of Local Government Act 2002). This is similar to te requirements on councils when taking decisions under the Resource Management Act 1991.
Under Section 82 of the Local Government Act 2002 the council re required to ensure that processes are in place for consultation with Maori and these must comply with the general consultation provisions.

57 The Local Government Act 2002 also indicates that participation can be enhanced at the organisational level through "good employer" provision (schedule 7, Part 1 (36)), and through the arrangements at the governance and management levels.

there was a strong signal from the Maori consultation that the Council needs to develop much improved relationships with Maori to enable Maori input into Council decision-making processes....

Maori desire greater focus and commitment from the Coucnil on developing durable and more effective means of engaging with Maori.

104. We note that the 7 July 2005, the Council asked for a further report regarding policies for liaising with Maori to be presented to Council in 2005.[58] It appears that report has not gone forward to Council.

Reference to Treaty of Waitangi

105. We note that the draft LTCCP has no reference to the Treaty of Waitangi.

106. The 2004/14 LTCCP identified that the need to strengthen the Council's Treaty relationship. That plan identified some general ways in which the Council would go about strengthening that relationship, including
   - Identify alternative ways to increase Maori participation in decision making processes at government and management levels
   - Develop mutually acceptable consultation procedures with Maori
   - Consider aspirations of Maori in all planning and delivery of all Council activities

107. We also note that the current Strategic Goals and Objectives (adopted by Council in 2003 and listed in the Policy registrar) identify the Treaty:

Treaty of Waitangi and Cultural Diversity - respect the unique position of tangata whenua and value the contribution of all peoples in Christchurch.

The Council will recognise the Treaty of Waitangi and value cultural diversity through

G1 Protecting the rights of tangata whenua under the Treaty of Waitangi.

G2 Maintaining mutually acceptable consultation procedures with Maori in Christchurch.

G3 Considering and protecting the aspirations of all people in all the planning and delivery of all Council activity. .

108. There is no similar commitment in the proposed Strategic Direction (page 49-57 of the LTCCP.

109. We note that a number of other Councils have made explicit statements about the Treaty of Waitangi. The CDHB makes explicit statements about the Treaty:

The Canterbury DHB recognises and respects the principles of the Treaty of Waitangi partnership, participation and protection. We are committed to reducing disparities and improving heath outcomes for Maori and to ensuring Maori involvement in planning for these.[59]

and

In making funding decisions, the Canterbury DHB acknowledges the Treaty of Waitangi, and encourages Maori participation in providing and using services. We want to ensure that services are appropriate and accessible to Maori. [60]

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58 Minutes of Council Meeting 7 July 2005.

59 Canterbury District Health Board 2005 *Statement of Intent 2004*- 2007 page 4
Canterbury District Health Board 2004 Towards a Healthier Canterbury: Directions 2006. page 2

60 Canterbury District Health Board 2004 Towards a Healthier Canterbury: Directions 2006. page 38

110. Maori comprise 7% of the city's population (25% of these are affiliated to Ngai Tahu). Maori in Christchurch are more likely than average to be living in socially disadvantaged areas, to be unemployed and to have lower levels of educational attainment and lower income levels. Maori have significantly worse health, greater disability and lower life expectancy than other New Zealanders across all socioeconomic groups. High-income Maori of either gender can expect to die younger than low-income non-Maori[61] The difference in Maori and non-Maori life expectancy at birth is 8.2 years for males and 8.7 years for females.[62]

111. Much of the relatively poor health status of Maori can be attributed to socio-economic status. However, there are other factors that lead to inequalities between Maori and non-Maori that go beyond socio-economic status.

112. These disparities must be addressed if Christchurch is to prosper socially, economically and democratically. Recent research suggests that reducing inequality offers the best hope for creating social cohesion and improving health. It is argued that the rise of an "underclass" of citizens means that society will ultimately pay the price through low production, slow economic growth and threats to cohesion.[63]

Submission

ee) **We recommend that the Council include clear statements in the LTCCP indicating its intention to improve consultation with Maori, Maori participation in decision making, and internal organisational capacity to work effectively with and for the Maori community.**

Public involvement in decision-making

113. We congratulate the Council on its aim to increase resident satisfaction in *public involvement in decision making* and *public satisfaction with decision* to 75%. This is very ambitious given the current rating of 47% and 57% respectively.

114. As democratically another elected body, the CDHB also faces challenges associated with public participation and confidence. A key objective of CDHB is to facilitate increased community participation in the assessment, planning and funding of health and disability services in its district. Efforts to increase participation include ongoing, proactive formal and informal initiatives to facilitate the participation of stakeholders in planning processes and in informing decisions about health and disability services, funding, etc. They also involve which is the formal consultation process on key proposals such as the draft Strategic Plan. [64]

115. We note that although the LTCCP has identified the desire to increase participation and confidence there appear to be no new initiatives or strategies identified in the Plan or in Portfolio strategy development/review framework [65] to promote this.

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61 Ministry of Health 2005 *Advice to Incoming Minister of Health.* Wellington. Ministry of Health.
62 Statistics' New Zealand: Life Tables
63 Sandel 1997, Cox 1998, Raphael 1999, Sampsoon 1990, Crawford 1995, Wilkinson 1999, Cox 1995, Kawachi 1997
64 Canterbury District Health Board 2004 Towards a Healthier Canterbury: Directions 2006. page 38
65 http://www.ccc.govt.nz/Council/proceedings/2006/February/CnclCover23rd/Clause7Attachment.pdf

116. We would be interested in working with Council on strategies to enhance citizen and community participation and confidence in demographic processes.

Submission

ff) **We congratulate the Council on its aim to increase citizen participation and confidence**

gg) **We would like to work with Council on strategies to improve participation in the city's democratic processes.**

PARKS, OPEN SPACES AND WATERWAYS (PAGES 120 – 127)

117. Parks, open spaces and waterways play an important role in delivering both physical and mental health benefits for people of Christchurch.

118. We support the Council's ongoing commitment to provide a network of parks, open spaces, waterways and wetland. These facilities meet a different range of interests - it is not just about sport but wider leisure and activity. They can provide the venue in which to walk and cycle around and through, space for physical activities and play and for activities for older people and others tackling isolation.

Submission

hh) We commend the Council on the provision and maintenance of parks, open spaces, waterways and wetlands.

RECREATION AND LEISURE (PAGE 128 – 136)

119. We commend the Council's ongoing commitment to physical activity, including the provision of facilities, walkways and recreation programmes.

120. Increasing peoples' physical activity is important to improving and protecting health. People who are active are healthier. Lack of regular physical activity is a modifiable risk factor for cardiovascular disease, type II diabetes, stroke, osteoporosis, some cancers including cancer of the colon and breast, feeling of anxiety and depression and falls in the elderly. Active lifestyles reduce the risk of high blood pressure, obesity and osteoporosis. The Ministry of Health has determined that the health burden created by physical inactivity is second only to that created by smoking.[66]

121. Physical activity includes active leisure (e.g. informal physical recreation like walking, swimming and cycling, dance, sport as well as formal exercise), active transportation (e.g. walking to and from work or school) and activity undertaken during paid or unpaid domestic work, and for children, activity undertaken during their schooling.

122. Many Council activities touch on the area of physical activity, recreation and leisure. Transportation, urban design (including suburb layout, street, walkway, cycle way and parks), facility design, leisure and recreation provision, and environmental health, including air and water quality, all have an impact on the physical activity of community members. While there is currently some overlap between Council Unit and Group activities, there are further opportunities to integrate strategies and services.

Pools and Leisure Centres

123. We support the proposal to build three new aquatic facilities, including the facility in Papanui and additional pool at Pioneer Leisure Centre in the period covered by this plan (page 73 of LTCCP). We encourage you to review whether the additional facilities could be built earlier than proposed (especially the complex in the East of Christchurch).

124. We note that the Council intends to close five pools.

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[66] Ministry of Health (2001) *New Zealand Health Strategy DHB Toolkit: Physical Activity*, Ministry of Health, Wellington.

125. We are aware that the usage of many of the outdoor swimming is low (subsidy required $25/$30 per user) or as in the case of Edgeware the asset is old and in need of major maintenance. We note that the Aquatic Facilities Plan[67] identifies the rationale for closing the five outdoor pools from 2006 onwards. It is unclear from the LTCCP whether the current plan is for a phased closure (over the period covered by the plan 2006 to 2016) or if all five pools are to be closed from 2006.

126. We note the Aquatics Facilities Plan identified that Council aquatic facilities have experienced strong sustained growth, with a 63% increase in patronage over the last five years (page 6, Aquatic Facilities Plan). We also note that the pools which remain open are already operating a *capacity* at weekends, holidays and peak times. It appears that there is no capacity in remaining pools to absorb the uses from the closed pools and the additional users (if increased patronage continues as expected).

127. We would prefer a staged closure of pools so that closures align with the opening of new facilities. If the Council procedures with the pool closures we suggest that additional interim non-asset initiatives to encourage physical fitness are implemented e.g. community-based recreation activities.

128. We note that there has been a suggestion that one of the Council Controlled Trading Companies (CCTO) could build the new civic offices and lease it back to the Council. We suggest that building new recreation facilities would be a more effective investment for a trading company i.e. it would have a greater impact of peoples' wellbeing. We ask the Council explore this option.

Measures

129. We note that the Council is committed to providing "*accessible recreational, arts and sporting programmes for the community to participate in at all levels".* We also note that an objective of the Council's Physical Recreation and Sport Strategy is to ensure that *"Physical recreation and sports programmes and activities are accessible to people with disabilities, older people, ethnic groups, parents with small children"*

130. The recreation and leisure *measures and targets* identified in the LTCCP are "total attendances" or "total customers". Attendance numbers are useful for some aspects of service and facility planning. However, it is also important to know *who* is attending (i.e. accessing the services), and if the facilities and programmes are being used by specifc population groups (for example, those identified in your Physical Recreation and Sport Strategy).

131. We assume that the indicators identified in the outcome monitoring programme will be available at a sub-city level, for example broken down by ethnicity and age. We understand that the Active Communities Project will identify participation by particular groups within the community. We recommend that the Council review where else it can collect and report data which is broken down by user groups.

Submission

ii) **We commend the Council for its ongoing commitment to promoting healthy and active lifestyles through the provision of facilities, walkways and recreation programmes and support the ongoing provision of these**

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[67] Christchurch City Council. 2006. Aquatic *Facilities Plan – DRAFT* http://www.ccc.govt.nz/leisurecentres/pdf/aquaticstrategy.pdf

jj) **We are concerned that there is no capacity in existing pools to absorb uses from the closed pools and additional users in the trend of increased patronage continues.**

kk) **We recommend a staged closure of pools so that closures align with the opening of new facilities.**

ll) **We request that if the Council procedures with the pool closures that additional interim non-asset initiatives are implemented to encourage physical fitness.**

mm) **We support the collection and reporting of more detailed measures around physical activity.**

Fees and Charges

132. We note that the Council may set charges for goods services or amenities under the Council's general power under Section 12 of the Local Government Act 2002.[68]

133. We note that a report to Council on 30 March made recommendations regarding the 2006/07 fees and suggested that these be set by resolution.[69] We note that Council's LTCCP consultation only includes the fees and charges requiring a special consultative procedure(i.e. Section 150 Fees and Charges).

134. We congratulate the Council for its decision to defer the setting of fees and charges (under Section 12) *to "enable a further review of any equity issues to take place"*[70]

135. The barriers to physical activity participation faced by individuals and families who live on inadequate incomes have been well documented, and have persisted over time.

136. We believe that the proposed increases to fees and charges for physical activity[71], for example pools membership (especially beneficiaries), pool concessions, children casual swim, parent caregiver, family, fitness membership, etc is a threat to equity and will act as a barrier to participation.[72]

137. We note that already 10% of respondents in your annual survey identified cost as a barrier to participation in leisure activities.[73] We also note that research commissioned by the Council identified that cost was a potential barrier to participation.[74]

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68 Fees and charges payable for a certificate, authority, approval, permit or consent from or inspection by the Council in respect of a matter provided for in a bylaw or under any statute other than the Local Government Act. These must be prescribed in the bylaw or by using the special consultative procedure under Sections 150(1) and (3) of the Local Government Act. Such fees or changes include those payable under such statutes as the Building Act 2004, Resource Management Act 1991, and the Sale of Liquor Act 1999.

69 Christchurch City Council. 2006. Agenda of Council Meeting 30 March 2006. http://www.ccc.govt.nz/Council/proceedings/2006/March/CnclCover30th/ProposedAmendmentsFees.pdf http://www.ccc.govt.nz/council/proceedings/2006/april/cnclcover6th/cnclminutes30march2006.pdf

70 Christchurch City Council. 2006. Minutes of a meeting of the Christchurch City Council. Held at 9.30am on Thursday 30 March 2006. http://www.ccc.govt.nz/Council/proceedings/2006/March/CnclCover30th/ProposedAmendmentsFees.pdf http://www.ccc.govt.nz/council/proceedings/2006/april/cnclcover6th/cnclminutes30march2006.pdf

71 Christchurch City Council. 2006 *City Council Fees & Charges 2006/07 [proposed]* http://www.ccc.govt.nz/Council/proceedings/2006/March/CnclCover30th/Clause14AttachmentA.pdf

72 Saunders, C, Dalziel, P and Greer, G. 2005. *Pricing Recreation in Christchurch.* Lincoln. Lincoln UNiversity

73 National Research Bureau 2004 *Annual Survey of Residents 2004* Christchurch . Christchurch City Council.

74 Saunders, C, Dalziel, P and Greer, G. 2005. *Pricing Recreation in Christchurch.* Lincoln. Lincoln UNiversity

Submission

nn) **We commend the Council for wishing to review the equity issues associated with increased fees and charges.**

oo) **We recommend that Council does not increase fees and charges for physical activity.**

Events and Festivals

138. We would like to see the Council extend appropriate criteria from the Healthy Sports Club tool to all groups who apply for Council funding to hold an event. With this in mind we would particularly encourage the Council to promote outdoor Smokefree events. Seeing people smoking has the effect of 'normalising' smoking in the community. Young people like to role model adult behaviour, which makes smoking very alluring. Youth smoking rates are high with 1 in 5 people who have ever smoked reporting that they started before the age of 15 years. Such an initiative would greatly assist the CDHB meeting it's goal of reducing the number of people who smoke in the region to 15% in the next 5 years (refer to paragraph140).

139. We congratulate the Council on its *Policy to Reduce Alcohol-related Harm At Public Events*.[75] We note, however, the Council has not consistently adhered to the Public Event policy since its inception (see paragraph 150).

Submission

pp) **We recommend that Council extend appropriate criteria from the Health Sports Club tool to groups applying for Council funding to hold an event.**

[75] Christchurch City Council Policy Registrar http://www.ccc.govt.nz/Policy/AlcoholRelated.asp

REGULATORY SERVICES (PAGES 142 – 147)

140. Tobacco smoking, alcohol abuse, and food safety are health issues of concern in Christchurch and that have an impact on a number of outcome areas, including education, health, communities, and safety. Health regulation and promotion have vital part to play in improving health.

Smoke Free Environment

141. Tobacco smoking remains a key risk factor for illness and death, and reducing tobacco consumption is a major objective to improve health. 1 in 5 deaths can still be attributed to tobacco smoking.[76] Smokers have a 1 in 2 chance of dying from smoking related diseases.[77] Tobacco causes, or exacerbates, about 40 different medical conditions.[78] The CDHB has identified that reducing the rate of smoking would reduce health costs in the short and long term.[79]

142. The CDHB will have a goal for reducing the number of people smoking in the region to 15% or less over the next 5 years (presently 24%). The Council's contribution to this goal will be important.

143. We note that the Council introduced a very progressive Smokefree policy as early as 1990. We congratulate the Council in taking a leadership role regarding this issue.

144. We encourage the Council to explore ways to reduce smoking initiation. Promoting Smokefree spaces will go along way towards achieving this by de-normalising smoking. For example, we would like the Council to consider promoting the concept of the children's playground including the paddling pool in the botanic gardens as being Smokefree. Children exposed to smoking role models are more likely to smoke themselves. It is therefore very important for children to grow up in Smokefree environments.

145. We note that other Councils have implemented similar initiatives. For example South Taranaki have a smoke free public spaces policy which includes promoting all council-owned playgrounds and parks and swimming pools and outdoor surrounds as smoke free. It is also provides information on the legislation and related health issues.[80]

146. As noted in paragraph 58 we support the Council's involvement in the Healthy Sports Club Christchurch initiative (ClubMark) and would like Council to consider extending this or a similar initiative to all community groups.

Submission

qq) We congratulate the Council in taking a leadership role in tobacco control and smokefree promotion

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76 Statistics New Zealand (2001b) Smoking and Alcohol, http://www.stats.govt.nz/domino/external/web/ProfileNZ.nsf/htmldosc/8.4, Statistics New Zealand, Wellington.

77 Cancer Society (1998) *Policy Statement: Tobacco*, Cancer Society, Wellington.

78 Canterbury District Health Board (October 2001) *Health Needs Assessment for Canterbury Part A*, Canterbury District Health Board, Christchurch.

79 Based on Australian data and excluding the cost of passive smoking, the most recent estimate for the total cost of smoking is $22.5 billion for the 1990 year. Cancer Society. (1998). *Tobacco Policy Statement.*

80 South Taranaki District Council. 2005. Policy position on the Smoke Free Environments (Workplace and Public Spaces

rr) **We encourage the Council to explore ways to reduce smoking initiation.**

ss) **We recommend Council to consider promoting the concept of the smokefee children's playground**

tt) **We support the Council's involvement in the Healthy Sports Club Christchurch initiative (ClubMark) and recommend this or a similar initiative is extended to all community groups.**

Alcohol Related Harm

147. In New Zealand the excessive consumption of alcohol is a major personal and public health issue. Easton (2002) estimated that the sum of social costs of alcohol harm range from $1 billion to $4 billion per year. It cost the public health sector $655 million, crime and related costs $240 million, social welfare $200 million and other alcohol-harm related government spending $330 million. Lost productivity alone cost New Zealand $1.17 billion a year.[81] Alcohol is responsible for 70% of accident and emergency hospital admissions. Heavy drinking over a long period of time has been linked to a number of health problems, particularly liver and heart damage, hypertension and some cancers.

148. In 1997, alcohol was also a contributing factor in 27.1% of fatal road traffic crashes and 17.4% of casualties involving motor vehicle-related injuries.[82] Alcohol abuse also significantly contributes to drowning, suicide, assaults and domestic violence. The New Zealand Health Survey, 1996/97 found that one-sixth of adults display drinking patterns that put them at risk of future negative physical or mental effects.[83]

149. The Council has a long-term leadership role in reducing alcohol related harm in our community.

150. We congratulate the Council on its Policy to Reduce Alcohol-related Harm At Public Events.[84] We practically support aspects of the policy such
    - Ensuring "event planning includes strategies to reduce alcohol related harm and care for any people affected by alcohol".
    - The commitment to "extensively explore other avenues before accepting alcohol sponsorship at public events".

151. We note, however, the Council has not consistently adhered to the Public Event policy since its inception. Numerous public events have been planned and approved by the Council in isolation without the input of other key stakeholders (for example the Medical Officer of Health, Canterbury Youth Workers Collective, and others). The policy acknowledges these and other stakeholders must be involved in the event planning process. Better implementation of this policy by Council staff is required.

152. We also acknowledge the Alcohol Policy adopted in 2004. For the Alcohol Policy to best achieve positive outcomes for our community it is essential that:
    - Sufficient resources are directed into the implementation of the Alcohol Policy by the Council to meet its objectives.
    - a long-term commitment is given to the Policy and it's implementation coupled with regular evaluation and review.

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81 Cited on ALAC website *Social Costs of Alcohol Abuse* http://www.alchol.org.nz/NZstatistics.aspx?POstingID=1189

82 Statistics New Zealand (2003) Smoking and Alcohol, *http://www.stats.govt.nz/domino/external/Web/nzstories.nsf/1167b2c70ca821cb4c2568080081e089/27ff39f6c46a3a46cc256b1e007deb69?OpenDocument*, Statistics New Zealand, Wellington.

83 Ibid

84 Christchurch City Council policy registrar http://www.ccc.govt.nz/Policy/AlcoholRelated.asp

- Council work in collaboration with other agencies, individuals involved in the reduction of alcohol related harm in Christchurch.

153. The recent assimilation of Banks Peninsula has increased the number of licences administered by the District Licensing Agency by approximately 60 and the number of Managers Certificates by around 400. To adequately administer these licences and certificates as well as ensuring compliance with licence condition, extra human resources are required.

154. To ensure an appropriate level of commitment between the Council, The Police and The Canterbury District Health Board, a memorandum of understanding specific to matters required by the Sale of Liquor Act 1989 is required.

Submission

uu) **We recommend the Council review staff resources allocated to Liquor Licensing. The review should be focused on determining and providing adequate FTE staff tasked with Sale of Liquor Licensing Inspections and administrative support.**

vv) **We recommend the development memorandum of understanding between Council, the Police and CDHB specific to matters required by the Sale of Liquor Act 1989**

ww) **That the Council's *Policy to Reduce Alcohol-related Harm At Public Events* is strictly adhered to.**

Safe Food

155. A prerequisite for good health is a safe food supply. Christchurch has a very high rate of enteric food borne disease, particularly Campylobacteriosis. The Council needs to make the provision of safe food for city residents and visitors a high priority. We have concerns regarding the standard of food premises and food safety in Christchurch and have formally conveyed those concerns to Council officers. We consider that the food safety section within the regulatory and Democracy Group is not adequately resourced to carry out its role effectively or efficiently.

156. The Council needs to develop long-term strategies to ensure the provision of safe food within Christchurch. These strategies need to ensure regular inspection of premises, and a high level of compliance approach to food premises and food safety practices, rather than the bottom-line approach adopted in the current plan e.g. the strategies should adopt a hazard analysis (HACCP) based approach for inspections rather than simply checking structural compliance and cleanliness of the premise.

Submission

xx) **We recommend the Council develops long-term strategies to ensure the provision of safe food within Christchurch, including regular inspection of premises.**

yy) **We recommend the Council review staff resources allocated to food safety.**

STREETS AND TRANSPORT (PAGES 148 – 147)

157. Affordable and efficient transport is vital for all sectors of society. We support Council is commitment to providing everyone with access to an efficient and affordable transport system.

158. Transport choices have major implications for the health and well-being of citizens. Transport facilitates social interaction, access to social and economic opportunities and access to health services. However, it can also have negative impacts (including road traffic injuries or the effects of air pollution).[85] High volumes of traffic can restrict people's sense of mobility and their ability to interact in public spaces which in turn can increase stress and isolation.

159. The New Zealand Health Strategy (2000) sets out a number of goals that are related to transport. Goal 4 (Healthy Physical Environments) includes improving access to public transport. Goal 6 (Healthy Lifestyles) includes increasing the level of physical activity. Active transport modes such as walking and cycling can contribute to this goal.

160. The New Zealand Transport Strategy (2002) has made the link of transport with health and identifies *protecting and promoting public health* as one of its five main objectives. The Strategy identifies that:

> *Communities where people walk and interact in streets tend to be healthier.*[86]

161. The strategy signals that health outcomes will be improved through regulation, education, encouragement and investment. Promoting health through active transport is seen as key.[87]

162. We would like to see the Council's LTCCP reflect the objectives and strategies contained it the New Zealand Land Transport Strategy and the NZ Health Strategy.

Active Transport

163. Transport configurations can either create more opportunities for physical activity or restrict opportunities by encouraging sedentary forms of transport such as cars.[88] The links between active transport (walking and cycling) and health outcomes are well documented.

164. The *New Zealand Transport Strategy*[89] and the *Getting There – on Foot, by Cycle Strategy*[90] identified that substantial health benefits would be achieved if even a small proportion of the under two kilometre trips currently made by car were made by active transport modes such as walking or cycling. These benefits would come from increased physical activity, reduced emissions, less noise and less water pollution.

165. We support your lift of the temporary freeze on cycleway capital projects.[91] We support the Christchurch Cycling Strategy (2004) and urge the Council to act on that strategy. We

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85 Ministry of Transports. 2002. *New Zealand Transport Strategy.* Wellington. Ministry of Transport.
86 Ministry of Transports. 2002. *New Zealand Transport Strategy.* Wellington. Ministry of Transport. Page 32
87 Ministry of Transport, 203 *New Zealand Transport Strategy.* Wellington. Ministry of Transport
88 Public Health Advisory Committee. 2003. *National Health Committee, Intersections Between Transport And Health: The Impacts of Transport on Health. Background Paper.* Wellington. The, National Health Committee.
89 Ministry of Transports. 2002. *New Zealand Transport Strategy.* Wellington. Ministry of Transport. Page 41
90 Minister of Transport. 2005. Getting There – on Foot, by Cycle: A strategy to advance walking and cycling in New Zealand transport. Wellington: Ministry of Transport.
91 Christchurch City Council. 2005. Minutes of Council Meeting. 24 November 2006.

also endorse the increased spending on cycling contained in the Metropolitan Christchurch Transport Strategy (2003).[92]

166. Your Cycle Strategy indicates that increasing the amount of cycling is partially dependent upon the extension of cycle routes throughout the city.

167. We would like priority to be given to the extension of both recreation cycle routes and the cycle network throughout the city. We would also like a commitment to the development and resourcing of a travel behaviour change programme that promotes active and sustainable transport (walking, cycling, public transport and car pooling) within the LTCCP.

168. The TravelSmart Programme in Perth, Western Australia is a world leader in the field of travel behaviour change. There was a 2 million hours per annum increase in physical activity across the 143,000 residents engaged in TravelSmart was since year 2000.[93] We would like Council to investigate implementing a programme similar to TravelSmart to compliment infrastructure and urban design work.

Submission

zz) We support your lift of the temporary freeze on cycleway capital projects.

aaa) We support the Christchurch Cycling Strategy (2004) and urge the Council to act on that strategy.

bbb) We would like priority to be given to the extension of both recreation cycle routes and the cycle network throughout the city.

ccc) We recommend that Council investigate the development of a travel behaviour change programme that promotes active and sustainable transport.

Public Transport

169. We commend the Council for the work it is doing in the area of public transport and support the Council continued investment in this area.

170. We support the objectives in the Christchurch City Council Public Transport Policy: increasing patronage, increasing public transport share of trips and improving image of public transport. We also support the Christchurch Public Passenger Transport developed in partnership with ECan.

171. We are unclear about the proposal to spend $59.5 million on a New Bus Exchange (page 71). There appears to be no information available about this project in the LTCCP or supporting documentation. There is not a report on this project on the Council website or available in Council Agenda Papers. We are unclear whether an appropriate cost benefit analysis as been undertaken on this project (as required by Section 77 of the Local Government Act 2002). We would like a Health Impact Assessment of this

Submission

ddd) We commend the Council for its work in promoting and enhancing public transport

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92 Christchurch City Coucnil. 2003. Metropolitan Christchurch Transport Statement. Christchurch. Christchurch City Coucnil..

93 Ashton-Graham, A. 2005. Department for Planning and Infrastructure – Government of Western Australia. Paper Presented to 5th Annual Physical activity Conference 2005.

eee) **We seek clarification on the Bus Exchange Project**

fff) **We recommend that Council undertake a Health Impact Assessment of the proposed Bus Exchange project prior to undertaking this project.**

Streets Design

172. We commend the Council on the work it has done in this area to date and the links between streets/transport and community outcomes that are within the plan.

173. Street design can promote physical activity by supporting active transport (walking and cycling) and active recreation, but can also inhibit physical activity with hostile roads that favour private vehicles as the main form of transport. [94]

174. We support the Living Streets Charter adopted in 2001. We would like to see a greater commitment to this charter reflected in the LTCCP.

Submission

ggg) **We support the Living Streets Charter and would like to see a greater commitment to this charter in the LTCCP**

Road Safety

175. Road traffic injuries are responsible for a considerable proportion of morbidity, disability and mortality.[95] The number of road crashes and injuries and cycle and pedestrian injuries in Christchurch is decreasing.[96]

176. The impact of injury on individuals, families and communities is substantial. The economic costs is considerable: around $200 million for the year 2002 in Christchurch. [97] A significant proportion of the cost of road casualties is borne by acute and rehabilitatory health services, meaning less resource for other aspects of health care and promotion.

177. We support the Christchurch Road Safety Strategy and encourage the Council to work with other agencies to implement that strategy. We note that there is no specific mention of the strategy in the LTCCP and no indication of any funding allocated to its implementation. We would like to see some explicit commitment to supporting and funding the implementation of the strategy.

178. We support the implementation of 40 k zones outside schools.

Submission

hhh) **We support the Christchurch Road Safety Strategy and encourage the Council to work with other agencies to implement that strategy**

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94 Public Health Advisory Committee. 2003. *National Health Committee, Intersections Between Transport And Health: The Impacts of Transport on Health. Background Paper.* Wellington. The, National Health Committee.

95 Christchurch City council 2004. Social Trends report. Christchurch. Christchurch City Council

96 Land Transport New Zealand: Crashes and Casualty Data.

97 Christchurch City Coucnil. 2004. *Christchurch Road Safety*

WATER SUPPLY (PAGES 162 – 167)

179. A secure and safe supply of drinking water is fundamental to public health. Water quality has been described as the single greatest factor affecting life expectancy in the 19th century.

180. We note that the long-term supply of clean water drinking water has been rated as the most important issue for Christchurch in Annual Survey of Residents.[98] We also note that 96% of respondents in the UDS consultation considered protecting water quality as *very important.*

181. Christchurch is fortunate in having access to high quality groundwater. The source of this supply is a series of aquifers situated below the City. The aquifers are recharged by seepage from the Waimakariri River and precipitation onto land to the west of the City. The water supply is not treated and there are no natural barriers in place to prevent groundwater from becoming polluted as a result of land use activities in the recharge zone.[99]

182. The security status of the city's water sources is currently being reviewed. The city's water is vulnerable to contamination from land use and discharges upstream of the water supply. Intensifying land use over the aquifer presents a considerable risk. Over abstraction could lead to contamination of the aquifer.

183. As discussed with the Council, Community and Public Health is currently developing a Policy on Christchurch Groundwater Recharge Zone. The Council will need to meet the standards included in that policy to have its Public Health Risk Management Plan (for DWSNZ) accepted. The policy will include planning controls in the Recharge Zone to reduce the risk of ground water contamination. We will continue to liaise with the Council regarding this development.

184. We congratulate Council for its work on investigating the security status of the Christchurch water supply.

185. We endorse the Council's commitment to achieving "the highest Ministry of Health drinking supply water grading" (identified on page 165 of the LTCCP).

Submission

iii) We recommend that the Council ensure that the city's aquifer catchments zones are protected.

jjj) We recommend that the Council adhere to sustainable development models for water management.

kkk) We support the Council's commitment to achieving "the highest Ministry of health drinking supply water grading.

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98 National Research Bureau 2004 *Annual Survey of Residents 2004* Christchurch . Christchurch City Council.

99 Community and Public Health. 2006. Draft Policy Christchurch Groundwater Recharge Zone.

POLICIES

Rates Remission Policy

186. We support the remission of all rates on land occupied and used by the Council for community benefit.

187. We support remission of rates where land is used by not for profit clubs, associations and churches for sport or for community benefit

188. We support rates postponement for ratepayers (usually over 65 years) experiencing financial hardship

Submission

III) We support the rates remission and postponement policies outlined in the LTCCP.

Gambling Policy

189. We congratulate the Council for its policy on Gaming Venue Policy adopted 15 March 2004.[100]

190. Over the past 10 years, New Zealand's gambling sector (including race and sports betting) has experienced rapid growth. A wide range of gambling is now available. Comparisons with overseas suggest demand will continue to grow.

191. In 2004/05 turnover (the gross amount bet) exceeded $14 billion and expenditure (i.e. player losses, or the gross amount bet minus the amount paid out as prizes) was just over $2.0 billion. Each day $38 million is gambled in New Zealand.

192. The Associate Minister of Health identified:

> *The harmful effects of gambling on individuals, families and communities can be devastating, and the social and economic costs can be huge.* [101]

193. Problem gambling is a health issue of increasing importance for Christchurch. Christchurch has one of the largest groups of problem gamblers.[102] Approximately 90% of problem gambling is attributed to gaming machines. Christchurch has 2099 gaming machines – the highest number of machines of any territorial district - the next highest is Auckland at 1749. [103]

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100 Christchurch City Council Gambling Venue And Totalisator Agency Board (Tab) Venue Policy http://www.ccc.govt.nz/Policy/GamblingVenueAndTotalisatorAgencyBoardVenuePolicy.asp

101 Ministry of Health. 2005. Preventing and Minimising Gambling Harm: Strategic plan 2004–2010.Wellington: Ministry of Health. http://www.moh.govt.nz/moh.nsf/0/0320D2273BDBF732CC256FB80009EF74/$File/problemgambling-strategicplan-2004-2010.pdf

102 Ministry of Health. 2005. Problem Gambling Intervention Services in New Zealand: 2004 National Statistics. Wellington: Ministry of Health. http://www.moh.govt.nz/moh.nsf/0/EC70456666A4CDDCCC256E36000AD159/$File/problemgambling-nationalstatistics2004.pdf

103 Gaming machine venues and numbers by region at 31 March 2006 http://www.dia.govt.nz/pubforms.nsf/URL/TAMarch2006.pdf/$file/TAMarch2006.pdf

194. National surveys of gambling, conducted in 1985, 1990, 1995 and 2000, indicate that New Zealanders have become increasingly concerned about the negative social impacts of gambling. Increasing proportions of people saw non-casino gaming as undesirable. We also note that during your consultation on the Gambling Venue Policy the majority of respondents wanted controls placed on gaming.[104]

195. By placing a moratorium on gaming machines, the Council has potentially limited some of the harm caused by gambling, and in doing so help protect the health of some of its most vulnerable citizens.

196. We note that on 21 July 2005 the Council agreed to review its Gambling Policy[105] despite officer advice that the policy should remain in place.

197. We note that on 21 April 2006 a Council seminar considered the options associated with a review of the policy. We note that the assessment of the options (included in the report to the seminar) indicated that the retention of the existing policy had greater gains in terms of social, environmental and economic benefits and was more consistent with public views that the other options.[106]

198. We do not want to see a growth in gaming machines, and would prefer to see a decrease in these numbers.

199. We belief that Christchurch has sufficient machines (as noted in paragraph 193 – the highest of any territorial authority).

200. We also note that the drop in numbers of operators (only a slight drop in Christchurch) has not appeared to impact on the money available for community purposes. As Department of Internal Affairs Department Deputy Secretary, Andrew Secker stated 1 February 2006:

> *"Despite this significant decline, information they have provided to the Department indicates that they gave out record amounts of money to community purposes in both 2003-04 and 2004-05, around $300 million in each year.*
>
> *"We think there is room for more consolidation in the pub-based sector. Fewer operators should mean that overall costs go down, because there are fewer fees and salaries to pay, fewer offices, cars, computers, phones and faxes to pay for, and so on. When the number of operators drops, the remaining operators benefit from economies of scale. The average number of venues for each pub-based operator grew from under 13 to more than 16 between June 2003 and December 2005. Reducing costs in this way could maintain a good return to the community even if the amount players spend on the machines is reduced."*[107]

Submission

mmm) We endorse the Council's Gaming Venue Policy adopted 15 March 2004.

nnn) We recommend retention of the moratorium on gaming machines.

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104 Report of regulatory and Consents Committee to the Council 15 March 2204. Christchurch City Council Gambling Venue And Totalisator Agency Board (Tab) Venue Policy.

105 Christchurch City Council Minutes of Council Meeting 21 July 2005

106 Christchurch City Council. Report to Council Seminar 21 April 2006

107 Seeker, Andrew Deputy Secretary, Department of Internal Affairs. *Further reduction in gambling facilities. Department of Internal Affairs* http://www.dia.govt.nz/web/press.nsf/d77da9b523f12931cc256ac5000d19b6/db3d35913d2adc2acc25710900726d8a!OpenDocument

Policy on Significance (Pages 292)

201. The LCCP proposes the removal of City Care Limited and Red Bus Limited as Strategic Assets.

202. We note in a report of Council 2 February 2006, the Director of Strategic Investments stated "Christchurch City Holdings Limited does not consider that they need to be listed as strategic assets. Whether or not they are owned by CCHL or the Council will not affect the delivery of service by the Council"[108].

203. We also note that the report stated that "this would mean the Council would not need to consult the public on the issue [disposal of these companies] over and above the consultation which will take place as part of the adoption of the new LTCCP". [109]

204. Section 97 of the Local Government Act 2002, requires that decisions to transfer the ownership or control of a strategic asset to or from the Council, or a decision to construct, replace or abandon a strategic asset can only be taken if the decision has been explicitly provided for by a Statement of Proposal in the Councils. Strategic assets are the assets in total and not the separate elements of the asset. The requirements of Section 97 on the Local Government Act 2002 are only triggered if the proposal relates to the asset as a whole or a major sub-part of the asset.

205. The Council may amend a long-term council community plan at any time (Section 93 (4) Local Government Act 2002). The Council must use the special consultative procedure in making any amendment to the long-term council community plan.

206. We do not believe that a requirement to consult the public using the special consultative procedure is too onerous, given the weight of this issue. We believe that the public should be involved in such decisions.

207. We have an interest in increasing the use of active transport and public transport. We therefore would wish to be consulted before any changes were made to the Red Bus company.

Submission

ooo) **We recommend that the Red Bus Company and City Care remain as strategic assets; requiring that the community is consulted before any decisions to transfer the ownership or control.**

[108] http://www.ccc.govt.nz/Council/proceedings/2006/February/CnclCover2nd/PolicyonSignificance.pdf
[109] http://www.ccc.govt.nz/Council/proceedings/2006/February/CnclCover2nd/PolicyonSignificance.pdf

OUR CITY TODAY

Older People

208. In the profile of the City Today in the LTCCP, it is reported that the city has an ageing population and that by 2026 people aged over 65 years is estimated to make up 21 per cent of the city's population.[110]

209. The Council has developed Strategic Direction statements are meant to help "ensure that everything it does – all its activities – contribute towards achieving the Community outcomes".[111] The Strong Communities Strategic Direction identified that "an aging population" was a "key challenge":

> ***Key Challenges***
>
> *Aging Population - Like the rest of New Zealand, Christchurch's population is ageing. Demand for housing, health, and other services for older people will increase. Council needs to make sure not only that these services are available but also that older people participate in and contribute to society*[112]

210. We endorse these statements. Older person's health is a priority for the CDHB.

211. Older people consume considerably more health care resources than those in younger age groups and this is particularly marked for those aged 75 years and over, which may in future mean a large increase in government health expenditure.[113] The future experience of illness and disability will depend on trends in a number of chronic disease that become more common with increasing age; these include coronary heart disease, stroke, cancers, arthritis, dementia and visual and hearing impairments. Some international research suggests that levels of disability will decline in the future in the 65-84 age group and will become increasingly compressed into the 85+ age group.[114]

212. Support for older people in the community can impact on the community in terms of their own and their caregiver morbidity.[115]

213. We note that despite these statements there appears to be no obvious planning and or additional services to cope with the aging population. The plan contains no explicit strategies in the areas of urban planning and design, recreation and leisure or community support.

214. We are aware of the existing services in the areas of housing, library services, parks (Access Policy 2002) and leisure facilities. However, it appears that these are not expanding to meet increasing needs of the ageing population. In some case it si proposed that these services will be reduced.

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110 Page 31-32 of Our Plan 2006.

111 Page 49 of Our Plan 2006.

112 Page 49 of Our Plan 2006.

113 Older people are high users of primary and secondary health and disability support services. Per capita public health expenditure for people aged 65-74 years is estimated to be $3,261, and $6,144 for people aged 75-84 years. This compares with $849 for people aged 15 years and under and $1,190 for people aged 15-64 years. In New Zealand, two thirds of people aged 75 and over, and almost half of those aged 65-74 years, live with some degree of disability, compared with a quarter of people aged 45-64 years (Ministry of Health (2001d) *The Burden of Disease and Injury in New Zealand*, Ministry of Health, Wellington).

114 Ministry of Social Development (2001b) *Statement of Government Intentions for an Improved Community: Government Relationship*, Ministry of Social Development, Wellington.

115 Ellis, P. and Collings, S. ed. (1997) Mental Health in New Zealand from a Public Health Perspective, Ministry of Health, Wellington.

ONGOING RELATIONSHIPS

215. We commend the Council on its approach to health related issues identified in the plan. We welcome the opportunity to work in partnership with you to improve the health of the people in our community.

216. Some of the largest opportunities for health gains are through aligned and combined policies and programmes across local government, the district health board, central government, and community.

217. We believe that by working together we can be more effective and gain efficiencies.

218. We would like to suggest that we explore opportunities to work together in the following area:
    - Community consultation - joint community consultation on areas of common concern or where timing and targets coincide.
    - Joint research and sharing of information
    - Joint health status reports – as part of your work on reporting on progress towards outcomes and our Heath Needs Assessments
    - Health promotion activities – physical activity and community safety initiatives
    - Environmental health
    - Joint planning and priority setting.

219. We would like to collaborate with the Council on the development of the following strategies/polices (currently under review or proposed)
    - Social Housing Strategy
    - Gambling Venue Policy
    - Community Facilities Plan
    - Open Space Strategy
    - Democracy Strategy (increasing citizen participation and confidence)
    - Strategies to build Maori capacity to contribute to decision-making

220. We currently have an excellent relationship with officials and elected representatives of Christchurch City Council and would like to build on this relationship.