Māori Health Review

Making Education Easy — Issue 24 – 2010

In this issue:

Tēnā koutou, tēnā koutou, tēnā tātou katoa

Ko tēnei te mihi mahana ki a koutou katoa. Nau mai ki tēnei tirohanga hou Hauora Māori. I tēnei putanga ka pāhotia ētahi kōrero whakahirahira mai i te hui o Te Ohu Rata o Aotearoa. Nō reira noho ora mai rā.

Matire

Greetings

Welcome to the first issue of Māori Health Research Review for 2010. Firstly, I'd like to thank Te Kete Hauora and Ministry of Health for their ongoing support, nga migi nui ki a koutou katoa. And to those of you who read the reviews and provide wonderful feedback, also a big thank you. I'm looking forward to 2010 and the exciting opportunities I hope it brings. Wishing you all the best in your mahi and with your whānau also.

Noho ora mai, na

Matire
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Racial/ethnic differences in bystander CPR in Los Angeles, California

Authors: Benson PC et al

Summary: Bystander CPR rates are reported for three ethnic groups living in Los Angeles – African Americans, Latinos, and Caucasians – based on data from the Cardiac Arrest Resuscitation Evaluation in Los Angeles (CARE-LA) database as well as the California Death Statistical Master File (CDSMF). Available information included location, race/ethnicity/ethnic background, witnessed status, socio-economic status, and other variables that have previously been associated with differing rates of bystander CPR. The study group consisted of 814 individuals (53% Caucasian, 28% African American, 19% Latino). African Americans and Latinos were younger than the Caucasians, had more events in the home and had a bystander CPR rate of 13% versus 24% for the Caucasians (OR 50.47 for African Americans and OR 50.48 for the Latinos). Bystander CPR was an independent predictor of survival to hospital discharge and, after adjusting for other variables, Latinos in Los Angeles receive bystander CPR at approximately half the rate of Caucasians (OR 0.45).

Comment: Very interesting. Although some may have argued that the bystander's ethnicity and ability to perform CPR may play a role, the researchers have attempted to account for such variables. Given the fact that bystander CPR saves lives, perhaps a session on 'non-discrimination' should be incorporated into CPR training.

Reference: Ethn Dis 2009;19:401-6.

http://www.ishib.org/journal/19-4/ethn-19-04-401ab.pdf

Māori smoking and tobacco use
profile available now

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For more information, please go to http://www.maorihealth.govt.nz

Changing trends in indigenous inequalities in mortality: lessons from New Zealand

Authors: Tobias M et al

Summary: These researchers describe trends from 1951 to 2006 in inequalities in mortality between indigenous (Māori) and non-indigenous (non-Māori, mainly European-descended) New Zealanders and relate these trends to the historical context in which they occurred. The economy underwent a major structural adjustment from the mid 1980s to the mid 1990s, after which the government retreated from neoliberal social and economic policies from the late 1990s onwards. This period was accompanied by economic recovery and health reforms, with a reorientation of the health system towards primary health care. Life expectancy gaps and relative inequalities in mortality rates (aged 1–74 years) widened and then narrowed again, with only a short lag behind the trends in social inequalities. A steady decrease in the contribution of cardiovascular disease (CVD) to absolute mortality inequalities among females was partly offset by an increasing contribution from cancer. Among males, the contribution of CVD increased from the early 1980s to the 1990s, then decreased again. The extent of socio-economic mediation of the ethnic mortality inequality peaked in 1991–94, again more notably among males.

Comment: Māori researchers have led the study of unemployment and its impact on health; it is pleasing to see others tackling this issue. This paper speaks not only to the inequitable impact of the economic environment on Māori health, but also to the place of policy and service design in reducing that impact. Given the recent recession and proposed restructuring of the health system, as this paper states, it is essential that we monitor health outcomes by ethnicity/level of deprivation.

Reference: Int J Epidemiol 2009;38(6):1711-22.

http://tinyurl.com/y9anvz2

Will the financial crisis get under the skin and affect our health? Learning from the past to predict the future

Authors: Blakely T, McLeod M

Summary: These researchers contend that the current global economic crisis will have health consequences for the New Zealand population. With reference to the economic and social changes of the 1980s and 1990s in New Zealand, the article suggests that the health impacts will probably have the greatest affect upon those who are already socio-economically deprived, and in ethnic minority groups. The article contends that we should expect to see increases in suicide rates that will be amplified if primary and mental health services are weakened by parallel funding restraints. In addition, it is predicted that we shall see increased rates of short-term morbidity from mental illness, infectious diseases, and acute incidents of cardiovascular disease. The researchers list some policy recommendations that would enable the prioritisation of publicly funded services, and help to monitor and reduce the impacts of the economic recession on health.

Comment: While the Tobias et al. paper presented historical data, the authors of this paper describe the current context and attempt to predict the impact of the recession on health and health inequalities. Importantly, the authors provide recommendations that may be useful for policy makers AND service providers alike.

Reference: N Z Med J 2009;122(1307):76-83.

http://www.nzma.org.nz/journal/abstract.php?id=3915

Kaupapa Maori Action Research to improve heart disease services in Aotearoa, New Zealand

Authors: Kerr S et al

Summary: These researchers describe the Kaupapa Māori Action Research methods being used in the Māori Utilisation & Experience of Ischaemic Heart Disease Management project that intends to improve the health and well-being of Māori within the northern region of Aotearoa/New Zealand. The research processes and outcomes are informed by the application of `by Māori for Māori' approaches to understanding Māori pathways and barriers to care for ischaemic heart disease. Māori understandings of their illness and experiences of treatment, and healthcare providers' perspectives on care of Māori with ischaemic heart disease, have been combined into Māori-led actions to improve service provision. The paper examines critical factors in an action research approach to health service innovations and implications for efforts to reduce entrenched health disparities.

Comment: I often refer to this piece of research and it is wonderful to have it published. The study is robust and of high quality; but the investigators also provide very practical recommendations on how to tackle 'systems issues' that ultimately achieve improved health care and outcomes for Māori.

Reference: Ethn Health 2009:1-17.

http://tinyurl.com/y8wkh4c

Independent commentary by Dr Matire Harwood, Medical Research Institute of New Zealand

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Te Toi Hauora-Nui
Achieving excellence through innovative Māori health service delivery

Te Toi Hauora-nui provides information about innovative service approaches to improving Māori health, with particular emphasis on cardiovascular and diabetes mellitus programmes delivered in the primary care setting. The report outines key findings, critical success factors that providers use to achieve successful results and areas for improvement.

This report is available online on the Māori Health website www.maorihealth.govt.nz

Children in out-of-home care: Does routine health screening improve outcomes?

Authors: Nathanson D et al

Summary: These researchers investigated the impact of the comprehensive health screening offered to children in care by the Child Protection Unit at Sydney Children's Hospital. The clinic makes recommendations for remediation, but does not offer follow-up. The researchers sent research questionnaires to the Department of Social Services caseworkers of the first 100 children screened, to determine how many of the health recommendations made for each child had been implemented and, if possible, what the health outcome had been. Adherence to health recommendations was high; however, it was not possible to quantify the degree of health benefit to the children screened. A number of systemic problems were identified that are likely to hinder the accessibility of health care for children in care, the researchers conclude.

Comment: Provides an example of sectors trying to work together to address an extremely important issue – the wellbeing of children. Also highlights the fact that unless system-level issues are addressed, outputs (such as undertaking health assessment) will not necessarily result in better health outcomes.

Reference: J Pediatr Child Health 2009;45(11):665-9.

http://tinyurl.com/y874jl2

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Fear of racism, employment and expected organizational racism: their association with health

Authors: Bécares L et al

Summary: This UK-based study used data from the 2005 Citizenship Survey to identify self-reported experiences of racism that vary by socio-demographic characteristics; to explore the association between health and racism and its contribution to ethnic inequalities in health; and to explore how gender, age, ethnicity and socio-economic position (SEP) moderate the relationship between racism and health. Females were significantly more likely to report fear of racial and religious attacks, but reported lower odds of experiencing employment and expected organisational discrimination. A trend was observed for decreasing employment discrimination as SEP decreased. A reverse association was found for SEP and expected organisational discrimination, where people in the lowest employment categories reported lower odds of experiencing discrimination. The detrimental impact of racism on health was the same across socio-demographic groups.

Comment: As Papārangi Reid, Bridget Robson and others have always argued, social markers (such as level of deprivation or defined in this paper as socio-economic position) do not fully explain ethnic differences in health – Māori women in the least deprived decile have significantly higher mortality rates and lower life expectancy than non-Māori women living in the most deprived neighborhoods. The results here support this argument; although the type of racism may differ across SEP, the health impact remains the same. Going further, interventions to address racism may need to be tailored for different social environments.

Reference: Eur J Public Health 2009;19(5):504-10.

http://eurpub.oxfordjournals.org/cgi/content/abstract/19/5/504

Association between neighborhood-level deprivation and disability in a community sample of people with diabetes

Authors: Schmitz N et al

Summary: The association between neighbourhood deprivation and self-reported disability was assessed in a community sample of 1439 adults (18–80 years) with self-reported type 2 diabetes living in Quebec, Canada. A strong association existed between disability and material and social deprivation: individuals living in advantaged neighbourhoods had lower levels of disability than those from disadvantaged neighbourhoods. Mean disability scores for men were 7.8, 12.0, and 18.1 for low, medium, and high deprivation areas, respectively ($p<0.001$); corresponding values for women were 13.4, 14.8, and 18.9, respectively ($p<0.01$). Neighbourhood deprivation was associated with disability even after controlling for education, household income, socio-demographic characteristics, race, lifestyle-related behaviors, social support, diabetes-related variables, and health care access problems.

Comment: Personally I think that most Māori providers are already aware that neighbourhood characteristics play a significant role in quality of life, including level of disability. It's always useful though to have the 'evidence' that confirms our experience; that can be used when working with local bodies to address this health determinant; and that should be taken into account during evaluation of specific programmes.

Reference: Diabetes Care 2009;32(11):1998-2004.

http://care.diabetesjournals.org/content/32/11/1998.abstract

Workforce and Health Sciences latest statistics available

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Increasing the number of Māori health professionals is vital to providing appropriate care to Māori individuals, their whānau and all New Zealanders. Available online is the latest statistics and data on:

- Year 11 to 13 Māori candidates studying science
- Māori studying health-related subjects in tertiary institutions
- regulated Māori health workforce, by occupation.

To download a copy of the latest statistics please visit www.maorihealth.govt.nz

Are there disparities in care in people with diabetes? A review of care provided in general practice

Authors: Lawrenson R et al

Summary: This study used the computerised records from three general practices in Hamilton, New Zealand, to generate a comprehensive diabetes register including diagnostic codes and hypoglycaemic prescriptions. The overall prevalence of diabetes in patients aged ≥20 years was 1221/26,096 (4%). Eighty percent had attended for a 'Get Checked' annual review in the last 12 months. Age-adjusted analyses showed that Māori, males and those diagnosed more than 5 years ago were at increased risk of having unsatisfactory glycaemic control. Māori, Asian patients and women appeared less likely to have accessed retinal screening in the last 2 years.

Comment: Have included this paper as an example of an audit in primary care. The methods may be useful to others; the results highlight the value of auditing care and care pathways. As the authors state, the challenge now lies in addressing disparities and monitoring changes.

Reference: J Primary Health Care 2009;1(3):177-83.

http://tinyurl.com/ycspvk9

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Effect of pharmacological treatment of depression on A1C and quality of life in low-income Hispanics and African Americans with diabetes: a randomized, double-blind, placebo-controlled trial

Authors: Echeverry D et al

Summary: To determine the value of pharmacological treatment of depression in low-income minorities with diabetes, patients in a Los Angeles County diabetes clinic were screened for depression with Whooley's two-question tool. A total of 150 subjects answered positively to at least one question on the questionnaire. Eighty-nine depressed subjects with HbA1c levels ≥8.0% were randomly assigned to receive either sertraline or placebo for 6 months. Seventy-eight patients identified as Hispanic, 10 as African American, and one as `Other'. A total of 75 patients completed the study. At 6 months, an intention-to-treat analysis revealed significant differences from baseline for both groups in Hamilton Depression Scale (HAM-D) and pain scores, quality of life, and HbA1c and systolic blood pressure levels; the decreases from baseline in HbA1c and systolic blood pressure levels were significantly greater with sertraline. A significant correlation of 0.45 was observed between the changes in HAM-D scores and HbA1c levels in all subjects ($p<10^{-6}$).

Comment: Reading this made me think of my own practice and the fact that I tend to focus on trying to improve glycaemic control through diabetes-specific treatment (i.e. education, self-management, medication) and not consider the risk, let alone management of, depression. I'll certainly consider it now as a possible factor when HbA1c% remains high

Reference: Diabetes Care 2009;32(12):2156-60.

http://care.diabetesjournals.org/content/32/12/2156.abstract

Dental caries experience of children in Northland/Te Tai Tokerau

Authors: Gowda SS et al

Summary: These researchers detail the dental caries experience of children from four Northland communities; Kaitaia, Kaikohe, Kawakawa/Moerewa and Dargaville. Of 369 5–6-year-olds and 171 12–13-year-olds who underwent dental examinations, approximately two-thirds were Māori. Almost 88% of 5–6-year-olds had experienced dental caries, and this was lower among the Pakeha/Other group, those attending higher-decile schools, and those from Dargaville. Overall caries experience was higher among Māori children, those attending lower-decile schools, and those from Kaikohe, Kawakawa/ Moerewa or Kaitaia, as was the number of untreated decayed surfaces. Almost one in four children had lost at least one tooth due to caries, and this was higher among Māori children and those from schools in more deprived areas, and lower among children from Dargaville. Caries experience was greatest among the second molars in either arch, and lowest among the mandibular incisors. Among the 12–13-year-olds, 85% had experienced dental caries. The number of untreated surfaces with decay (more than 3, on average) was considerably lower among children from Dargaville. Caries experience was greatest among the first molars in either arch (followed by the second premolars), and absent among the mandibular incisors.

Comment: Oranga niho and inequalities in dental health between Māori and non-Māori is a major concern. The prevalence of dental caries is much higher in our communities; it is also a leading cause of hospitalisation. The opportunity to address oranga niho is pertinent and will be supported by the government's focus on Whānau Ora, including interdisciplinary care, and 'better, sooner, more convenient' primary health care that will reduce acute demand at hospitals.

Reference: N Z Dent J 2009;105(4):116-20.

http://tinyurl.com/ykxstxg

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