Māori Health Review

Making Education Easy

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In this issue:

Tēnā koutou, tēnā koutou, tēnā tātou katoa

Nau mai ki tenei Tirohanga hou Hauora Māori. He rangahau tuhi hou e paa ana ki nga hau ora a ki te oratanga o te Māori.

No reira noho ora mai raa i o koutou waahi noho a waahi mahi hoki. Noho ora mai.

Matire

Greetings

Kia ora koutou katoa. Welcome to this issue of Māori Health Research Review, our third for 2010. This review includes a couple of papers that address the smoking issue; one examines the impact of cost, and the other looks at advertising and teen smoking. The review opens with an interesting paper that investigated whether unhealthy behaviours play a stress-buffering role in observed racial disparities in physical and mental health. The analysis found that the relationship between stressful life events and depression varies by the level of unhealthy behaviours; such behaviours seem to protect against depression in African Americans but lead to higher levels of depression in Whites.

Please continue to send through papers/studies that inspire you in your mahi also!

Noho ora mai, na

Matire

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Race and unhealthy behaviors: chronic stress, the HPA axis, and physical and mental health disparities over the life course

Authors: Jackson JS et al

Summary: This analysis of survey data from the first two waves of the Americans' Changing Lives Survey (obtained from the same people at two points in time) investigated whether unhealthy behaviours play a stress-buffering role in observed racial disparities in physical and mental health. The analysis found that the relationship between stressful life events and depression varies by the level of unhealthy behaviours; such behaviours seem to protect against depression in African Americans but lead to higher levels of depression in Whites.

Comment: The issue here is 'chronically stressful environments'. Such studies add to the building evidence that ethnic disparities in health are a consequence of inequalities in the distribution of health determinants; those in more disadvantaged positions (social, economic, education, housing, etc) are more at risk for 'chronic stress' and have worse health and higher mortality. However, we must address those underlying causes of the differential distribution in 'disadvantage', one of them being, according to the authors and others, racism.

Reference: Am J Public Health. 2010;100(5):933-9.

http://ajph.aphapublications.org/cgi/content/abstract/100/5/933

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

Financial strain and smoking cessation among racially/ethnically diverse smokers

Authors: Kendzor DE et al

Summary: These researchers evaluated the influence of financial strain on smoking cessation among 424 Latino, African American, and Caucasian smokers of predominantly low socioeconomic status, who were enrolled in a smoking cessation study. They were followed from 1 week prequit through 26 weeks postquit. Greater financial strain at baseline predicted lower cessation rates at 26 weeks postquit among those who completed the study (OR 0.77; p=0.01).

Comment: With the recent focus on smoking cessation in Aotearoa, I thought it important to showcase recent evidence on 'what works'. Because although increasing the price of tobacco through taxes is effective for some populations (such as teenagers and people who have access to quality cessation treatment), it's not the case for others (those well down the addiction road). As this study shows, people are less likely to stop smoking when already under financial strain. Smoking cessation strategies must also reduce inequalities in smoking rates between Māori and non-Māori; given the results from this study, ways to address financial strain in smoking cessation interventions are required in order to achieve this.

Reference: Am J Public Health. 2010;100(4):702-6.

http://ajph.aphapublications.org/cgi/content/abstract/100/4/702

Cigarette advertising and adolescent smoking

Authors: Hanewinkel R et al

Summary: This study examined the specificity of the association between cigarette advertising and teen smoking in a cross-sectional survey conducted in 2008 with 3415 German schoolchildren aged 10–17 years. The survey used masked images of six cigarette brands and eight other commercial products. The prevalence of ever smoking was 31.1% and that of current smoking was 7.4%; 35.3% of never smokers were susceptible to smoking. Ad recognition rates ranged from 15% for a regionally advertised cigarette brand to 99% for a sweet. Lucky Strike and Marlboro were the most highly recognised cigarette brands (with ad recognition rates of 55% and 34%, respectively). After controlling for a range of established influences on smoking behaviours, the adjusted ORs for having tried smoking were 1.97 for the highest amount of exposure to cigarette ads compared with adolescents with the least exposure to cigarette ads, 2.90 for current smoking, and 1.79 for susceptibility to smoking among never smokers. Exposure to ads for commercial products other than cigarettes was significantly associated with smoking in crude but not multivariate models.

Comment: Another smoking cessation study, highlighting the strong relationship between marketing and youth smoking; and confirming the need for a stance to remove smoking-related marketing activities.

Reference: Am J Prev Med. 2010;38(4):359-66.

http://tinyurl.com/25rhs6j

Improving survival disparities in cervical cancer between Māori and non-Māori women in New Zealand: a national retrospective cohort study

Authors: McLeod M et al

Summary: These researchers sought to determine if ethnic disparities in treatment and survival exist among a cohort of Māori (n=344) and non-Māori women (n=1567) with cervical cancer (adenocarcinoma, adenosquamous or squamous cell carcinoma) who were retrospectively identified from the New Zealand Cancer Register between 1 January 1996 and 31 December 2006. Inequalities in incidence and mortality decreased over time. Over the cohort period, Māori women were more likely to have poorer cancer-specific survival than non-Māori women (mortality hazard ratio 2.07). However, from 1996 to 2005, the survival for Māori improved significantly relative to non-Māori. Māori women with cervical cancer had a higher receipt of total hysterectomies, and similar receipt of radical hysterectomies and brachytherapy as primary treatment, compared to non-Māori women (age and stage adjusted).

Comment: We have reported this study in a previous issue of the Review but I thought it useful to provide the published reference. Disparities between Māori and non-Māori for cervical cancer, although improving with time in most areas (incidence, survival and treatment), do persist. Prevention (through HPV vaccination) and early detection (through regular smears) of cervical cancer in Māori and Pacific women are priorities at the PHO I work at; I expect this will benefit all women and whānau.

Reference: Aust N Z J Public Health. 2010;34(2):193-9.

http://tinyurl.com/2cor9n7

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

A population-based approach to the estimation of diabetes prevalence and health resource utilisation

Authors: Smith J et al

Summary: Routinely collected administrative data were used to estimate diabetes prevalence and utilisation of healthcare services in Counties Manukau, which were then compared with findings for three neighbouring district health boards (DHBs): Northland, Waitemata and Auckland. Reconstructed populations were only 6% lower than census population counts, indicating that the vast majority of the population used health services over the two-year study period (January 2006 to December 2007). The age- and sex-standardised prevalence of diabetes was 7.1% in Counties Manukau and 5.2% in the other three DHBs combined. Prevalence of diabetes was highest amongst Māori (10.6% in women and 12.2% in men) and Pacific peoples (15.0% for women and 13.5% for men). Māori diabetes cases had the highest hospital discharge rate of any ethnic group. Community pharmaceutical prescribing patterns and laboratory test frequency were similar between diabetes cases by ethnicity and deprivation.

Comment: The collection of good quality diabetes data continues to be an issue in NZ. Inaccurate data has significant consequences and impacts on funding and planning for appropriate care and services; this study has tested and partially validated another means to gather data. Alarmingly, the results have shown that Māori had highest hospitalisation rates despite similar numbers in measures of community care (lab tests and prescriptions). This should raise major concerns about the *quality* of community care for Māori living in these DHBs.

Reference: N Z Med J. 2010;123(1310):62-73.

http://tinyurl.com/2aqbxwn

Treatment-related symptoms among underserved women with breast cancer: the impact of physician–patient communication

Authors: Maly RC et al

Summary: The impact of patient–physician communication on symptom resolution was assessed among 921 low-income, minority women with breast cancer (BC) treatment-related symptoms. All women were residents of California, USA. Patients most often reported depression (66%), yet physicians were the least aware of it (26.3%), especially among less-acculturated Latinas (18.9%) and Asian/Pacific Islanders (14%). Pain resolution was positively predicted by patients perceiving themselves to be able to communicate more effectively with physicians and when physicians were more aware of the symptom. Physician awareness was a significant determinant of depression resolution. Patient-perceived self-efficacy played a much more important role than physicians' awareness in nausea resolution. Less-acculturated Latinas tended to achieve less symptom resolution than whites, but this negative impact disappeared or was moderated after targeting patient–physician communication.

Comment: I found this paper slightly confusing, but my take on the results are that; effective communication between the physician and their patient plays a bigger part in the management of symptom resolution for Latina women than White women who have been treated for breast cancer; that interventions to improve communications should include strategies to improve clinical recognition and management of complications when working with other ethnicities.

Reference: Breast Cancer Res Treat. 2010;119(3):707-16.

http://www.springerlink.com/content/f26383546v387333/?p=48ea5f27255d456f8630c76293d13eec&pi=18

Psychiatrists' attitudes toward and awareness about racial disparities in mental health care

Authors: Mallinger JB, Lamberti JS

Summary: This US-based assessment of psychiatrists' awareness of racial disparities in mental health care evaluated the extent to which psychiatrists believe they contribute to disparities, and sought to determine psychiatrists' interest in participating in disparities-reduction programmes. Of the 374 psychiatrists who completed the study survey, most said they were not familiar or only a little familiar with the literature on racial disparities. Respondents tended to believe that race has a moderate influence on quality of psychiatric care but that race is more influential in others' practices than in their own practices. One-fourth had participated in any type of disparities-reduction programme within the past year, and approximately one-half were interested in participating in such a programme.

Comment: Having undertaken similar research with clinicians working in cardiology, it is interesting to see the comparable results. Clinicians may not be aware of ethnic disparities and reasons for them. And when asked about discrimination during the clinical encounter, it is often said to be 'unconscious'. Unfortunately, cultural competency training addresses those biases that are 'conscious' to the clinician; further work is required to expose and tackle the unconscious ones!

Reference: Psychiatr Serv. 2010;61(2):173-9.

http://psychservices.psychiatryonline.org/cgi/content/abstract/61/2/173

Performance of Framingham cardiovascular risk scores by ethnic groups in New Zealand: PREDICT CVD-10

Authors: Riddell T et al

Summary: These researchers compared the calibration performance of the original Framingham Heart Study risk prediction score for cardiovascular disease and an adjusted version of the Framingham score used in current New Zealand cardiovascular risk management guidelines for high and low risk ethnic groups; PREDICT, a web-based decision support programme for assessing and managing cardiovascular risk. Individual risk profiles from PREDICT were electronically and anonymously linked to national hospital admissions and death registrations in January 2008. The observed 5-year cardiovascular event rates (deaths and hospitalisations) were compared with predicted rates from the Framingham and New Zealand adjusted Framingham scores. Calibration was examined in a combined 'high risk' ethnic group (Māori, Pacific and Indian) and a European 'low risk' ethnic group. The analyses were restricted to 59,344 PREDICT participants aged 30–74 years with no history of previous cardiovascular disease. For Europeans, the original Framingham score overestimated 5-year risk by 0.7–3.2% at risk levels below 15% and by about 5% at higher risk levels, whereas for Māori, Pacific, and Indian patients combined, the Framingham score underestimated 5-year cardiovascular risk by 1.1–2.2% in participants who scored below 15% 5-year predicted risk (the recommended threshold for drug treatment in New Zealand), and overestimated by 2.4–4.1% the risk in those who scored above the 15% threshold. For both high risk and low risk ethnic groups, the New Zealand adjusted score systematically overestimated the observed 5-year event rate ranging from 0.6–5.3% at predicted risk levels below 15% to 5.4–9.3% at higher risk levels.

Comment: When the NZ guidelines for managing CVD risk factors introduced the concept of increased risk scores for Māori and Pacific people, some felt that the 5% adjustment was an arbitrary number that should be justified. This study has gone some way to address this; an adjustment is required but perhaps not as much as 5%.

Reference: N Z Med J. 2010;123(1309):50-61.

http://www.nzma.org.nz/journal/abstract.php?id=3980

Nasopharyngeal carcinoma: differences in presentation between different ethnicities in the New Zealand setting

Authors: Ianovski I et al

Summary: Radiological and biopsy records were retrospectively reviewed for all patients presenting to the Auckland City Hospital ENT department with a newly diagnosed nasopharyngeal carcinoma (NPC) between 1995 and 2007 inclusive. According to TNM stage at clinical presentation, Māori and Pacific Islanders were statistically significantly more likely than Asians to present with greater T stage ($p<0.0001$) and, for stages T2 and T4, nodal disease was significantly more advanced in Māori and Pacific Islanders than in Asians.

Comment: Nasopharyngeal cancer is a rare form of cancer, although it is known to be more common in certain regions of East Asia and Africa. Risk factors include previous infection with Epstein-Barr virus, smoking and diet. The results show that despite similarly high rates in incidence for NPC in Māori, Pacific and Asian peoples, Māori and Pacific people with NPC have delayed diagnosis. As a result, progression of the disease is more advanced and treatment options are limited. Clinicians and the public may require education that supports a 'high degree of suspicion for NPC in Māori and Pacific people' presenting with symptoms.

Reference: ANZ J Surg. 2010;80(4):254-7.

http://tinyurl.com/27cknua

Access and society as determinants of ischaemic heart disease in Indigenous populations

Authors: Curtis E et al

Summary: Ischaemic heart disease (IHD) is a leading cause of death in New Zealand and imposes a disproportionate burden on Māori, the indigenous population of Aotearoa New Zealand. Analyses of data for Māori:non-Māori disparities in risk factors, hospitalisations, the receipt of related procedures and mortality for IHD (over the years 2000–2005) revealed significant inequalities. IHD hospitalisation rates for Māori are 1.4 times that of non-Māori, however, mortality rates are more than twice that of non-Māori. In recent years, Māori revascularisation rates have increased (as have non-Māori rates) but are still considerably less than might be expected given the much higher mortality rates.

Comment: Probably a bit cheeky of me, highlighting an article in which my name appears as co-author! But I have to say, I think the paper provides a great framework for (1) describing health inequalities and (2) presenting the 'sites' for interventions – society, policy and clinical decision making.

Reference: Heart Lung Circ. 2010 May 3. [Epub ahead of print]

http://tinyurl.com/2f5enxd

Independent commentary by Dr Matire Harwood, Medical Research Institute of New Zealand and Tamaki Healthcare.

Research Review publications are intended for New Zealand health professionals.