

Māori Health Review

Making Education Easy

Issue 1 - 2007

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Tena koutou, tena koutou, tena taatou 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.

He tirohanga wehe poto o etahi o nga rangahau o te waa kainga me te take o te tino hirahira o nga tuhituhi.

E hari koa ana maatou mo te tautoko o te Tari Hauora mo to raatou whakaari putanga ia marama.

He mihi ki ia takuta e mahi ana i waenganui i te Māori ki te tono mai etahi whakatakotoranga a ma maatou o koutou rangahau e tirohia.

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

Matire

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Welcome to Māori Health Review, a new research based publication focused on major health issues affecting Māori. The Review is an independent summary of some of the most significant recently published research with a local commentary on why it is important. We are delighted to have support from the Ministry of Health to produce a monthly edition and welcome submissions from practitioners working with Māori who would like us to review their research.

This month Matire has reviewed some interesting research from some of the most prestigious journals in the world and some high quality work presented at the recent PRIDoC conference. We are delighted to be able to share the benefit of Matire's knowledge.

We look forward to hearing from you and hope you enjoy this issue.

Shaun

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Do all ethnic groups in New Zealand exhibit socio-economic mortality gradients?

Authors: Tobias M and Yeh LC

Summary: This study looked at deprivation gradients in relation to all-cause mortality (life-expectancy) for ethnic Asian, Pacific, and European New Zealanders. Deprivation gradients were evident in all four ethnic groups. In comparison to Europeans, Māori had a 25% steeper gradient, whereas Asian and Pacific peoples had shallower gradients than Europeans. In conclusion the authors found that socio-economic health gradients are evident in all major New Zealand ethnic groups. However, since these are relatively shallow for Asian and Pacific peoples "caution should be exercised in applying deprivation or other socio-economic measures as proxy indicators of need for health services".

Comment: Further evidence that deprivation does not fully explain ethnic disparities in life expectancy in New Zealand. Hopefully the investigators will look to investigate possible root causes contributing to differences in health, to differences in deprivation and other socio-economic markers between NZ European, Māori, Pacific and Asian people.

Reference: *Aust N Z J Public Health* 2006; 30: 343-9

Cost effectiveness analysis of smoking cessation interventions

Authors: Shearer J and Shanahan M

Summary: This Australian study assessed the cost-effectiveness of different smoking cessation interventions at a population level. A literature review was used to provide effectiveness data for the various interventions. Costs were assessed from the perspective of the Australian Government. The most cost-effective intervention was telephone counselling. The effectiveness of pharmacotherapies was increased with the addition of proactive telephone counselling. Combination pharmacotherapy with Bupropion plus nicotine replacement therapy (NRT) was not cost-effective, however Bupropion monotherapy was more cost-effective than NRT. These results underline the benefits of telephone counselling lines both with and without pharmacotherapy, and suggest further avenues for reducing smoking rates.

Comment: Although an Australian study, the findings are applicable to NZ and support the need for doctors (not just GP's) and other health providers to refer people who want to quit smoking for active telephone counselling. A recent RCT with a large Māori sample showed that Bupropion significantly improved quit rates when compared with NRT or counselling alone. Shearer and Shanahan found that Bupropion was also more cost effective. Bupropion should be considered for funding as first line pharmacotherapy.

Reference: *Aust N Z J Public Health* 2006; 30: 428-34

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

The views expressed in this Publication are personal to the authors, and do not necessarily represent the views or policy of the Ministry of Health on the issues dealt with in the publication

Self-reported racial discrimination and deprivation: effects on Māori health and inequalities

Authors: Harris R et al

Summary: Prevalence of self-reported racial discrimination in New Zealanders of Māori (n = 4,101) and European (n = 6,269) descent was assessed in this major study. The data analysed were from five questions relating to treatment by health professionals and collected from the 2002/03 New Zealand Health Survey. Experience of self-reported racial discrimination was more commonly reported by Māori. Discrimination occurring in three or more settings was almost 10-fold greater for Māori (4.5%) versus Europeans (0.5%). Odds ratios comparing Māori and European New Zealanders and relating to various health outcomes were reduced following adjustment for discrimination and deprivation. These included; poor or fair self-rated health OR 1.67 reduced to 1.18, low physical functioning OR 1.70 reduced to 1.21, low mental health OR 1.30 reduced to 1.02, and cardiovascular disease OR 1.46 reduced to 1.11. The authors concluded that interpersonal and institutional racism contributes to health inequalities between Māori and European New Zealanders, and that future interventions and policies should address the health effects of racism.

Comment: Dr Ricci Harris (Ngati Kahungunu, Raukawa, Kai Tahu) was nominated for the Lilly Medal for health research after this groundbreaking paper was published in *The Lancet* last year. As the authors state, racial discrimination is an unacceptable breach of human rights and here we have evidence of its effects on Māori health status. Theories to explain how racial discrimination affects health include differential access to and quality of health care services, and the direct effects such as trauma and stress. Importantly, interventions and policies that aim to improve Māori health must include ways to address discriminatory practice and attitudes in New Zealand.

Reference: *The Lancet*. 2006; 367:2005-2009

<http://www.thelancet.com/journals/lancet/article/PIIS0140673606688909/abstract>

Predictors of dental pain and general anaesthetic receipt for hospital dental procedures among New Zealand children

Authors: Jamieson LM and Koopu PI

Summary: Data from the National Child Nutrition Survey (2002) were used to predict dental pain and receipt of hospital dental general anaesthetic amongst 3,275 New Zealand children. The ethnicity of those surveyed was 37.4% Māori, 32.3% Pacific and 30.3% New Zealand European or Other (NZEO). Following adjustment for age, sex, length of time lived in New Zealand, household socio-economic status and physical factors, rates of dental pain were similar amongst Pacific and NZEO children. However Māori children were more likely to experience dental pain than NZEO children. Similar rates of receipt of a dental general anaesthetic were found amongst all three ethnic groups after adjustment for demographic, lifestyle, dietary, food security and dental factors. However overall, Pacific children were less likely to have received a dental general anaesthetic than NZEO children. These results may reflect the consequences of issues such as access to services and cultural sensitivity of services, as apposed to demand for care.

Comment: Evidence from a number of national and international studies suggests that ethnic disparities exist when it comes to pain and its management. Dental pain has wide reaching consequences for children including malnutrition (not being able to chew hard food such as fruit or vegetables, preferring soft food), reduced concentration at school and chronic inflammation. Well child/Tamariki ora checks must include screening for dental health and appropriate management of dental problems including pain.

Reference: *Journal of Public Health Dentistry*. 2006; 66(3):192-8

Ethnicity, socioeconomic deprivation and consultation rates in general practice

Authors: Health Utilisation Research Alliance (HURA)

Summary: The authors used data collected by New Zealand general practices to assess the impact of ethnicity and socioeconomic deprivation on utilisation of general practice consultations. The mean number of consultations with GPs was 3.7. Consultation rates for Māori, Pacific, Asian and other unspecified ethnicities were similar or lower than those amongst Europeans after adjustment for age, gender and socioeconomic deprivation. Rates of GP consultations increased with increasing deprivation, and were 30% greater in the most deprived groups, compared to the least deprived. In contrast, rates of consultations with nurses were 29% lower in the most deprived groups. Results for consultation rates amongst children under the age of 6 (for whom higher subsidies are available) suggested that cost may be a barrier to access for other age-groups. In summary, the correlation between increasing utilisation of GP consultations and increasing socioeconomic deprivation reflects an increase in need. However given that Māori health status is lower than that of European New Zealanders, the similar rate of service utilisation in the two groups should be a cause for concern

Comment: Two clear messages from this paper. First; that cost continues to be a barrier for people wanting to see a GP. Second; that Māori are less likely to see a GP compared with NZ Europeans, despite their high need and even after adjusting for deprivation. As the authors suggest, further investigation of barriers to general practice and primary care is required.

Reference: *Journal of Health Services & Research Policy*. 2006; 11(3):141-9

Ethnic disparities in breast cancer survival: How much is explained by screening, tumour severity, biology, treatment, co-morbidities and demographics?

Authors: Curtis E et al

Summary: 41,020 women aged 68 years or older and with a first time incident breast cancer diagnosed between 1994 and 1999 were identified from the Surveillance, Epidemiology, and End Results (SEER) database. The authors calculated racial and ethnic differences in breast cancer survival, adjusting for factors including demographic variables, mammographic screening interval prior to diagnosis, breast cancer characteristics at diagnosis, markers of biology, treatment and co-morbidity. Breast cancer specific mortality amongst women diagnosed with stage II or III breast cancer was significantly higher for African American women (HR 1.3) and significantly lower for Asian women (HR 0.63) in comparison to Caucasian women, whereas Hispanic women had non-significantly lower rates (HR 0.90) compared to Caucasian women. The author notes that that "although screening, biology and treatment do play a role, race/ethnicity appears to have an independent effect, particularly for African American women."

Comment: Dr Curtis (Te Arawa) worked on this project as part of her Harkness fellowship in 2004-5. Once again she has tried to untangle the reasons for ethnic disparities in health outcomes, this time for women living in the US with breast cancer. Dr Curtis has provided evidence here that the reasons often accepted by many health professionals and providers to explain ethnic disparities (such as interval to screening, tumour characteristics, treatment and co morbidity) are not adequate and further research into this complex issue is necessary.

<http://www.conference.co.nz/index.cfm/pridoc2006/Programme>

The accuracy of ethnicity data in New Zealand hospital records

Authors: Swan J et al

Summary: Accurate monitoring of ethnic health disparities is dependent on accurate recording of patient ethnicity in settings such as hospitals. This study used self-reported ethnicity data from the Barriers to Diabetes Care in the Waikato study, and where patient consent was granted, compared it to the data available via hospital records. Hospital records correctly identified at least one self-identified ethnicity (many were multiple) in 97.7% of subjects. Ethnicity data were correct for only 71% of Māori, compared to 99% of non-Māori. When the figures for non-Māori were broken down, the accuracy rates were 89% for Europeans, 67% for Pacific peoples, 70% for South Asians, 64% for Asians, and 41% for other ethnic groups. The authors note that; "researchers, clinicians, and policy makers must be cognisant of these continuing discrepancies when using hospital record data to describe ethnic variations in health status, service utilisation, or for policy planning activities."

Comment: Although disappointing, it is perhaps not surprising that the accuracy of ethnicity data collected at a NZ hospital, particularly Māori ethnicity, is unsatisfactory. It is understood that a number of PHO's are conducting audits of their ethnicity data collection and Research Review would be interested to hear from Māori providers as to how their data stacks up against the results from this study.

Reference: *New Zealand Medical Journal*. 2006; 119(1239):U2103

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'Race-based' or universal policies? Insights from a nationwide study exploring the health of Māori men

Authors: Jones R et al

Summary: The burden of disease is disproportionately high for Māori men in Aotearoa. The Hauora Tane project aims to "describe the health of Māori men in Aotearoa, and examine influences on their health from their own perspective." As part of the project, in-depth interviews were conducted with 66 Māori men from throughout Aotearoa. One of the major themes for the men was "endorsement of kaupapa Māori institutions, policies and programmes, and rejection of mainstream approaches." The men described universally favourable experiences of social institutions based on Māori philosophies and values, whereas social policy based on Māori assimilation was seen as damaging to health and wellbeing. Based on this evidence, the authors suggest that a more appropriate approach to social policy would be based on indigenous rights and Māori self determination.

Comment: For the first time we have a study of robust qualitative research exploring the health of Māori men. Preliminary results from Phase 1 of the Hauora Tane project were presented at Pridoc 2006 by Dr Jones (Ngati Kahungungu). The message is clear: one size does not fit all. Māori men see Kaupapa Māori initiatives as a positive step to improving their health and wellbeing. I look forward to hearing more about this study, particularly results from Phase 2.

<http://www.conference.co.nz/index.cfm/pridoc2006/Programme>

***Disclaimer:** This publication is not intended as a replacement for regular medical education but to assist in the process. The reviews are a summarised interpretation of the published study and reflect the opinion of the writer rather than those of the research group or scientific journal. It is suggested readers review the full trial data before forming a final conclusion on its merits.*

Implication of an indigenous standard population for pacific health data in Aotearoa

Authors: Simmonds S et al

Summary: Previous research has found that using a Māori standard population to age-standardise data is a better match for Māori health priorities than Segi's or the WHO world population standards. This study evaluated the Māori age standard in comparison with Segi's and WHO world with regard to health data for the New Zealand Pacific population. In comparison to Segi's or WHO, the New Zealand Pacific population is young, and has a similar age structure to that of Māori. Using Segi's or WHO with Pacific health data had impacts on both morbidity and mortality rates. Rates of conditions associated with older age were increased, whereas those associated with younger age were decreased. Using these measures also resulted in reductions in mortality ratios and hospitalisations associated with older age groups. The use of the Māori standard was a more accurate match with regard to Pacific health priorities.

Comment: An important paper for those of us analysing or reading Māori health data, Shirley Simmonds and others at the Eru Pomare Research Centre have consistently shown that current epidemiological tools do not reflect Māori realities. Data should be age-standardised to the Māori population when comparing Māori with non-Māori. The authors note that this may be applicable to Pacifica data also.

<http://www.conference.co.nz/index.cfm/pridoc2006/Programme>

How the media and politicians represent Māori health and ethnic disparities

Authors: Cormack D

Summary: The author of this study used critical discourse analysis to examine how print media, political debate and speeches represent Māori health, and health disparities between Māori and non-Māori in New Zealand. When talking about these issues, a number of explanations including socio-economic, biological/genetic, lifestyle/behavioural, and racism may be employed, and these were examined as part of the study. The author finds that there are several recurring 'commonsense' themes which appear in print media and in political debate and speeches. These themes are important in that they may both reflect and influence public understanding of these issues, and may affect the type of interventions which are employed to address inequalities.

Comment: Donna Cormack (Waitaha, Kati Mamoe, Kai Tahu), in her examination of discourse in New Zealand media, provides an insight into how Māori health and ethnic inequalities are represented. A focus on 'surface causes' (such as lifestyle choices) will only encourage surface actions and interventions, ignoring root causes (such as racism). She encourages critical reading of discourse and asks why Māori health is represented in certain ways and who benefits from these ways of telling the story. Donna suggests that we resist damaging discourses, challenge taken-for-granted assumptions and provide alternative ways to present Māori health in the media.

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