Māori Health Review

Making Education Easy

Issue 4 – 2007

In this issue:

Kia ora mo o koutou whakautu a urupare mai i tenei take.

Naaku i uru atu etahi take mo nga Māori whai COPD, ko ia te inoi i tonoa mai i nga kaipaanui o enei pukapuka.

Te taumaha ki te kite pepa whakaputa mo enei kaupapa , no reira maaku e aki atu ki a koutou ki a tonoa mai rangahau a otitatanga hoki mo nga Hauora Māori, tena pea ki a whakauruhia ki roto i nga take mo a mua.

Ki a maatou tetahi tuhi paanui mai i te Manatu Hauora mo te taha kii hou a tikanga – PHI Website.

Kaore ano au ki titiro ki nga aronga katoa o te paenga, engari ko te tino paatata taku titiro ki nga mate huka mo te waahi Whiwhia ki a Whakaritea – Get Checked sections.

Noho ora mai

Matire

Dr Matire Harwood
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Once again thank you for the feedback. In this issue I have included studies about Māori and alcohol and Māori with COPD, as requested by readers. It was difficult to find published papers on these topics and so I encourage people to send through research/audits about Maori health that we could possibly include in future issues.

We also have an article from the Ministry of Health regarding the new PHI website. I will definitely be taking a closer look at the Diabetes and Get Checked sections.

Noho ora mai

Matire

Panui – upcoming events of interest

PHA Conference 2007: Te Torino – Re imagining Health, Auckland July 2007

The only conference held in Aotearoa with a focus on public health. Themes for this year are urban design, food matters and voices. Topics will include Kaupapa Māori, systems and structures, workforce, inequalities, determinants of health and globalisation.

For more information check the website: www.pha.org.nz/phaconf2007.html

International Network of Indigenous Health Knowledge and Development Gathering, Rotorua 2007

This is a bi annual gathering of an assembly of indigenous health workers, researchers and policy makers from Aotearoa, Australia, Canada and the United States of America. The first gathering was held in Queensland 2003, Canada hosted the second meeting in 2005 and now it will be held here at the end of 2007. Knowledge is promoted at the conference through activities designed to build capacity, stimulate research and strengthen national and international networks.

You can register your interest on the website: www.inihkd.org.nz

Racial discrimination and breast cancer incidence

Authors: Taylor T et al

Summary: This paper considered whether perceived discrimination was related to breast cancer incidence in African American women in the US. Weak positive associations were found between breast cancer and both major (job, housing, and police) and everyday (e.g. being treated as dishonest) discrimination. Young African American women showed stronger associations between discrimination and breast cancer. Women under the age of 50 years who reported frequent everyday discrimination were at higher risk than were those with infrequent experiences. Those women who reported discrimination with respect to housing, job, and police, had a breast cancer incidence rate ratio of 1.48 (95% CI, 1.01-2.16) whilst the ratio for those who cited discrimination only at their job was 1.32 (95% CI, 1.03-1.70) as compared to those who reported no discrimination. The authors conclude that perceived experiences of racism are associated with increased incidence of breast cancer among African American women, particularly those of young age.

Comment: The 'Black Women's Health Study' commenced in 1995. It aims to understand more about and improve some of the health issues faced by African American women. 59,000 women enrolled at the start and over the past 12 years the researchers (most of whom are African American women) have looked at a diverse range of topics including breast and other types of cancer, lupus, hypertension, menopause, deprivation, perceived racism and physical activity. The finding reported in this paper (that perceived racism appeared to increase the risk for breast cancer in the younger population) is disturbing and raises questions about the 'severity' of perceived racism for younger women. As Dr Camara Jones says, we must acknowledge the present day existence and impacts of racism.

Reference: Am J Epidemiol. 2007. [Epub ahead of print]

http://aje.oxfordjournals.org/cgi/content/abstract/kwm056v1

Hyperglycaemia and ethnicity in patients with acute coronary syndromes

Authors: Scott A et al

Summary: This New Zealand based, retrospective analysis (n = 4,408) assessed the predictive value of admission blood glucose (ABG) and ethnicity with respect to the mortality of patients with acute coronary syndromes (ACS). Those patients presenting with acute ST elevation myocardial infarction (STEMI) were more likely to suffer early mortality. Poor patient outcome was also associated with a diagnosis of diabetes mellitus (DM) or elevated ABG (in the absence of DM). Māori were more likely than European to have diabetes (33% vs 17.5%, $p < 0.001$). Those patients who made up the highest glucose category were older, more likely to be Māori, had a higher prevalence of diabetes and longer hospital stays than those patients with lower blood glucose. Mortality risk factors included gender, age, ethnicity, diabetes, glucose and STEMI. The risk of mortality increased by 4.3% with each mmol/l increase in glucose. Following adjustments for age and gender, Māori ACS patients had a much higher mortality than Europeans (RR 2.12; $p < 0.00001$), regardless of ACS type, with raised ABG being an indicator of this increased risk.

Comment: The authors also found that the people admitted to hospital with ACS during the time period did not receive evidence based interventions. Angiography and revascularization procedures were performed less frequently in patients with DM than patients without DM. Intensive glycaemic management of ACS in people with raised blood glucose (shown to be effective in the DIGAMI study 1994) was attempted in only 10% of the sample. After adjusting for other covariates (age, gender, diabetes, diagnosis) Māori had higher mortality from ACS than NZ Europeans. As the authors state, "High risk patient groups should be targeted aggressively with evidence-based care to reduce cardiovascular morbidity and mortality".

Reference: Diabetes, Obesity and Metabolism. 2007; 9(1):121-126

http://www.blackwell-synergy.com/doi/abs/10.1111/j.1463-1326.2006.00597.x

A call to action on Māori cardiovascular health

Authors: Bramley D et al

Summary: This paper provides an overview of cardiovascular health in Māori and summarises the key themes of the Māori cardiovascular plan. The authors ultimately aim to rouse the health sector to respond to this demonstrable need and reduce disparities in cardiovascular health for Māori.

Comment: A comprehensive paper that not only describes the context for services providing cardiovascular care in Aotearoa but also outlines the steps required to reduce ethnic disparities in cardiovascular outcomes. The Action Plan was developed by the Māori Advisory committee that brought expertise in clinical cardiovascular health, public health, Kaupapa Māori research methodologies and patient advocacy. The plan itself is based on an explicit recognition of the rights of Māori as Tangata Whenua. I encourage readers to view the entire paper.

Reference: J NZMA. 2004; 117(1197)

http://www.nzma.org.nz/journal/117-1197/957/

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

Communicating mammogram screening results to African American and white women

Authors: Jones B et al

Summary: This study (n =1,145) examined whether African American women were as likely to receive mammogram results as their white counterparts and compared self-report of recent results with those in radiology records. The investigators found that inadequate communication of mammogram screening results was more likely for African American women, even when results were adjusted for sociodemographic, access-to-care, biomedical, and psychosocial factors. There was a significant inadequacy of communication of abnormal results for African American women but not white women ($p < 0.001$). The authors conclude that “African women may not be receiving the full benefit of screening mammograms because of inadequate communication of results”.

Comment: Breast cancer is diagnosed later and has poorer outcomes in African American women than white women. Mammography, as part of the screening process, is an important step for diagnosis and starting treatment for breast cancer. The researchers for this study found ethnic differences in communication of abnormal mammography results. As a result, African American women may be missing out on follow up of abnormal mammograms. The focus on ‘system’ factors and the way in which results are communicated allows us to think about ways in which the quality of breast screening programmes may be improved. Some examples: when communicating results, ask patients to repeat what they comprehended; initiate follow up at the time of communicating results; designate a staff member to case manage women with abnormal results. Finally, a similar review of screening programmes in Aotearoa should be considered.

Reference: Am J Public Health. 2007; 97(3):531-538

http://www.ajph.org/cgi/content/abstract/97/3/531

Preventive health examination in cancer screening

Authors: Fenton J et al

Summary: This retrospective cohort study (n =64,288) examined the association between receiving periodic health examinations (PHEs) and cancer testing; including colorectal cancer testing (fecal occult blood testing, sigmoidoscopy, colonoscopy, or barium enema), screening mammography, and prostate-specific antigen testing. PHEs were received by approximately half (52.4%) of the subjects and were significantly associated with cancer testing (following adjustment for confounders including demographics, comorbidity, number of outpatient visits, and historical preventive service use). Receipt of a PHE was significantly associated with completion of colorectal cancer testing (incidence difference, 40.4% [95% CI, 39.4-41.3%]; relative incidence, 3.47 [95% CI, 3.34-3.59]), screening mammography [incidence difference, 14.2% [95% CI 12.7-15.7%]; relative incidence, 1.23 [95% CI 1.20-1.25]), and prostate-specific antigen testing (incidence difference, 39.4% [95% CI 38.3-40.5%]; relative incidence, 3.06 [95% CI 2.95-3.18]). In conclusion receiving a PHE was associated with completion of colorectal, breast, and prostate cancer testing.

Comment: There are a number of important messages from this study:

1. Periodic physical health examinations or ‘well health checks’ are associated with better rates of cancer screening
2. The checks must be undertaken regularly and not just at enrolment
3. Although this study only looked at cancer screening, there is evidence that similar checks as part of the annual diabetic review or secondary prevention for CVD benefit Māori
4. Services that provide periodic health examinations must monitor for ethnic differences to ensure that Māori are receiving checks at similar rates and that outcomes are equitable.

Reference: Arch Intern Med. 2007; 167:580-585

http://archinte.ama-assn.org/cgi/content/short/167/6/580

Self-reported racism and health

Authors: Paradies Y

Summary: This systematic review considers 138 empirical, quantitative, population-based studies of self-reported racism and health. Following adjustment for confounding factors, an association between ill health and self-reported racism was found for oppressed racial groups. Negative mental health outcomes and health-related behaviours demonstrated the strongest and most consistent results. Weaker relationships were also found for self-assessed health status, positive mental health and physical health outcomes. The authors recommend that further research is required, including objective measurement of health outcomes, psychometric validation of racism tools, longitudinal studies and research in children.

Comment: Dr Yin Paradies describes himself as an Aboriginal-Anglo-Asian Australian. A principal research interest of his is the study of health effects of racism for Indigenous Australians. In this paper he collates the findings from quantitative studies investigating the impact of self reported racism on health. As he says, this is an emerging field in health research and therefore some of the definitions, tools, measures and outcomes used by researchers are not consistent. Such research is vital however as we tackle the root causes or determinants for health. Yin has developed and validated a tool to measure indigenous racism experiences, a major step in understanding more about this complex issue.

Reference: Int J Epidemiol. 2006; 35(4):888-901

http://ije.oxfordjournals.org/cgi/content/abstract/35/4/888

Audit of acute admissions of COPD

Authors: Chang C et al

Summary: This study reviewed chronic obstructive pulmonary disease (COPD) related admissions to Waikato Hospital (94 cases; 84 patients). Of those admissions, 23% were Māori and 13% received assisted ventilation. Mortality over the following 12 months was 31%, whilst 30-day mortality was 8%. Risk factors for death included decreased body mass index and an increased CURB-65 (confusion, urea, respiratory rate, blood pressure age) score. The mean length of stay for these patients (3.4 days) was significantly less than other reported COPD-related hospital stays. In the 12 months before the index admission, 55% of patients were admitted more than once for COPD. The mean age of Māori admissions, 52 years, was significantly lower than non-Māori admissions, 72 years (p =0.0001). The authors suggest that additional research regarding the COPD-related length of hospital stay and predictors of mortality is required.

Comment: As a topic for research, 'COPD and Māori' seems to receive little attention. Despite this many providers recognise that COPD is a significant issue for Māori and have developed services specific to people, Māori and non Māori, living in the community with COPD. COPD support groups are an excellent way for people to learn more about living with COPD and many groups welcome whanau. As reported in this paper, Māori are younger when admitted to hospital for treatment of COPD than non Māori. Often the burden of caring for someone with COPD falls on whanau and we must recognise and include this in a management/care plan.

Reference: Diabetes, Obesity and Metabolism. 2007; 9 (1):121–126

http://www.blackwell-synergy.com/doi/abs/10.1111/j.1445-5994.2006.01283.x

Differences in patterns of alcohol consumption between Māori and non-Māori

Authors: Harris R et al

Summary: This paper examined five large-scale surveys (n = 44,830) of alcohol consumption in order to compare differences in alcohol consumption between Māori and non-Māori in New Zealand. Whilst the research varied in sample populations and measurement tools, the differences in alcohol consumption between Māori and non-Māori were similar across the studies. Non-Māori were more frequent drinkers across all age groups, with alcohol consumption increasing with age. Whilst the average daily alcohol volume consumed was similar between Māori and non-Māori, non-Māori consistently drank 40% the volume of alcohol of Māori on any drinking occasion. The authors recommend that the frequency of drinking and the amount consumed on a typical occasion should be considered when examining the relationship between health-related problems and alcohol in Māori.

Comment: An important study because of the significant number of people included in the combined study population. Bramley (Ngapuhi) and others have shown differences in the patterns of alcohol consumption between Māori and non Māori. As the authors state, discussion of alcohol consumption by ethnicity is a sensitive topic, partly due to the way in which results have been presented in the past - 'victim blaming'. However, the researchers used kaupapa Māori methodologies and in doing so have made an excellent start in describing differences. The next step would be to conduct policy relevant research to identify policies and interventions that benefit Māori.

Reference: New Zealand Medical Journal. 2003; 116(1184):645

The New PHIOnline Interface - MOH Announcement

PHIOnline is being re-launched following the success of the pilot version, with improved functionality and more health information available. Information will now be provided at the Territorial Local Authority level (where available) as well as DHB level. This will allow for visualisation of variability within each DHB. This additional capacity is aimed at the information requirements of the health sector and will:

- Aid local agencies to achieve their desired health outcomes
- Aid Local Authorities and health providers to fullfil their responsibilities under the Local Government Act 2001
- Reduce cost of information dissemination and make government information more easily available, with a greater reach to a wider audience

www.phionline.moh.govt.nz

The web interface provides a multidimensional view of data through linked maps, charts, graphs and tables. Data is presented by total population, Māori, Non-Māori, Pacific (where possible). Datasets included on the site are:

- Routine Hospitalisation, Mortality and Incidence collections
- NZ Health Survey data
- Oral Health
- Get Checked Diabetes
- Problem Gambling
- Suicide and Self-harm