

Māori Health Review

Making Education Easy

Issue 27 - 2010

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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

Welcome to this issue of the Māori Health Review. Each issue attempts to bring you research relevant to the health and wellbeing of Māori.

I welcome feedback and suggestions for papers/research to include in future issues and I'm pleased to hear and read about the excellent work being undertaken in Hauora Māori.

Stay well, regards

Matire

Dr Matire Harwood

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The health of children in sole-parent families in New Zealand: results of a population-based cross-sectional survey

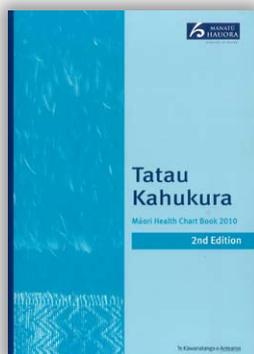
Authors: Tobias M et al

Summary: This study analysed data from the 2006/07 New Zealand Health Survey to investigate the relationship between family structure and child health. This nationally representative household survey sampled 502 children (5–14 years) of sole mothers and 1,281 children of partnered mothers. Children of sole mothers were 1.26 times as likely as children of partnered mothers to return a low physical health summary score. Adjusting for maternal health and family socio-economic disadvantage eliminated this weak association (which in any case was of borderline statistical significance). Children of sole mothers were more than twice as likely as children of partnered mothers to return a low psychosocial health summary score, adjusting for demographic variables only.

Comment: Unfortunately, some consider this issue to lie with mum (not coping) or dad (for leaving/not providing). Instead, as the authors point out, a focus on external factors is required to implement interventions that are both clinical (access to community services) and political.

Reference: *Aust N Z J Public Health*. 2010;34(3):274-80.

<http://www3.interscience.wiley.com/journal/123489779/abstract>



Tatau Kahukura:

Māori Health Chart Book 2010, 2nd Edition

Available online at: www.maorihealth.govt.nz

This publication provides a snapshot of Māori health in the mid to late 2000's and presents key indicators relating to the socioeconomic determinants of health, risk and protective factors for health, health status, health service utilisation and the health system.

Hard copies can be ordered by emailing: moh@wickliffe.co.nz or calling **04 496 2277**, quoting HP number 5097

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

Mothers' spanking of 3-year-old children and subsequent risk of children's aggressive behavior

Authors: Taylor CA et al

Summary: These researchers examined the association between the use of corporal punishment against 3-year-old children and subsequent aggressive behaviour among those children. A total of 2461 mothers were questioned how often they had spanked their 3-year-old child in the past month, as well as asked about their child's level of aggression, demographic features and eight identified maternal parenting risk factors. Nearly half (45.6%) of the mothers reported no spanking in the previous month, while 27.9% reported spanking one or two times, and 26.5% reported spanking more than twice. Mothers with more parenting risk factors were more likely to spank frequently. Even after controlling for these potential confounding factors, frequent spanking at age 3 (i.e. more than twice in the previous month) increased the odds of higher levels of aggression at age 5 (adjusted OR 1.49; $p < 0.0001$). Signs of aggression included behaviours such as arguing or screaming; cruelty, bullying or meanness to others; destroys things; fighting and frequently threatening others.

Comment: Also reported in local media, this paper adds to the building evidence about spanking and its impact on the wellbeing of tamariki. Anti-smacking, as I see it, is a health promotion activity that benefits us all.

Reference: *Pediatrics*. 2010;125(5):e1057-65.

<http://pediatrics.aappublications.org/cgi/content/abstract/125/5/e1057>

Towards a reliable and accurate ethnicity database at district and national levels: progress in Canterbury

Authors: Malcolm L

Summary: Data for July 2009 from the five Canterbury primary health organisations (PHOs) were examined to determine the extent of ethnicity and related recording in the district, any variation between general practices and PHOs in ethnicity recording, and to compare the findings with census figures with particular reference to Māori. Among a total population of 476,042, 6.2% were recorded as Māori and 2.1% Pacific people. 'No ethnicity' was recorded for 3.4% of the population. This figure varied from 0.4 to 4.5% between PHOs but was much wider between practices. Comparison with census figures showed that 95.4% of the Canterbury district population were enrolled. A total of 76.4% of Māori were classified as enrolled as compared with the census estimates.

Comment: I have to disagree with the authors. Auckland DHB has similar results – only 70% of Māori on the census are enrolled with PHOs; 120% of Pacifica people on the census are enrolled with PHOs. This suggests to me that PHOs are not collecting accurate ethnicity data and perhaps enrolling Maori patients with Pacifica ethnicity; and not as the authors suggest that PHOs have accurate ethnicity data! I understand that the Ministry of Health is looking into this and results should clear this issue up once and for all.

Reference: *N Z Med J*. 2010;123(1314):36-41.

<http://www.nzma.org.nz/journal/abstract.php?id=4108>

Rheumatic heart disease in indigenous populations – New Zealand experience

Authors: Wilson N

Summary: This paper documents the ongoing high prevalence of rheumatic fever among the indigenous Māori and Pacific Island New Zealanders and the rise in ethnic disparities in the past decade. The introduction of secondary penicillin prophylaxis with 28-day intramuscular benzathine penicillin has had great success in disease control, with high penicillin delivery rates and low recurrence rates. A landmark study for primary prevention of acute rheumatic fever for group A streptococcal pharyngitis was published in 2009. New Zealand has helped establish the role of echocardiography in acute rheumatic fever, with subclinical carditis incorporated into guidelines as a major criterion of rheumatic fever in high prevalence regions. The rates of mitral valve repair for rheumatic heart disease (RHD) currently exceed 90% in the children's cardiac unit but remain low in adult cardiac units in New Zealand. This is particularly relevant to women of childbearing age; New Zealand data reveal poor pregnancy outcomes for mothers with prosthetic valves on warfarin. New initiatives to prevent severe RHD include screening of school-aged children with portable echocardiography. The prevalence of definite RHD was 2.4% in a large cohort of socially disadvantaged children in South Auckland during 2007–2008. Cost-benefit models of screening are needed. Ongoing research involves international consensus standardisation of RHD patterns, and the need to define the natural history of subclinical RHD.

Comment: An excellent overview of recent developments in the area of rheumatic fever, many of them driven by the urgent need to address the significant inequalities in rates and outcomes between Māori, Pacifica and NZ Europeans.

Reference: *Heart Lung Circ*. 2010;19(5-6):282-8.

<http://tinyurl.com/286hXu3>

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

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Close-contact infectious diseases in New Zealand:
Trends and ethnic inequalities in hospitalisations,
1989 to 2008

Michael Baker
Lucy Teffar Barnard
Joni Zhang
Ayesha Verrall
Phillippa Howden-Chapman

He Kaitiaki Take Kōwhiri and Health Research Programme
University of Otago, Wellington
June 2010

HE KAITIAKI TAKE KŌWHIRI

This research was funded by the Ministry of Health. This report describes the epidemiology of infectious diseases and close-contact infectious diseases (CCIDs) for the 20-year period from 1989 to 2008, with a specific focus on ethnic inequalities, with a focus on Māori.

Infectious diseases, and particularly CCIDs, are making a large and increasing contribution to acute overnight hospitalisations in New Zealand. Their incidence is known to have increased during the 1990s. They continue to be an important cause of health inequalities with markedly higher rates of hospitalisation for Māori and Pacific people, compared with Europeans and others.

An electronic link to this report can be found on the Māori Health website

www.maorihealth.govt.nz

A New Zealand perspective on palliative care for Māori

Authors: Muircroft WM et al

Summary: This paper discusses approaches taken to address Māori health issues and the implications for palliative care provision in New Zealand. In 2001, the New Zealand Palliative Care Strategy was introduced, with the stated objective of providing a “systematic and informed approach to the provision and funding of palliative care services”. Its implementation was supported by structural and systemic changes to community, hospice, hospital, and specialty services. Nevertheless, Māori continue to experience both a higher cancer incidence and a higher mortality rate than non-Māori. A number of obstacles remain that prevent the provision of targeted and tailored palliative care for Māori. Active consultation and involvement of Māori people and health providers is required to identify needs and plan appropriate services. The paper suggests ways in which palliative care may most appropriately meet the needs of Māori patients, their families, and communities.

Comment: There is minimal literature available about palliative care and the Māori experience, yet cancer statistics and anecdotal stories indicate that it is a major issue. The whole journal is dedicated to the indigenous perspective in palliative care and those of you working in this area may find the other articles useful.

Reference: *J Palliat Care*. 2010;26(1):54-8.

<http://www.criugm.qc.ca/journalofpalliativecare/>

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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.

Impact of an informed choice invitation on uptake of screening for diabetes in primary care (DICISION): randomised trial

Authors: Marteau TM et al

Summary: This UK-based study compared the effect of a previously validated invitation promoting informed choice for diabetes screening with a brief, standard invitation on attendance and motivation to engage in preventive action. The study cohort comprised 1272 people aged 40–69 years, at risk for diabetes, identified from practice registers using a validated risk score and invited to attend for screening. The primary end point (attendance for screening) was analysed for all 1272 participants. A total of 55.8% (353/633) of those in the informed choice group attended for screening, compared with 57.6% (368/639) in the standard invitation group (mean difference –1.8%; $p=0.51$). Those from more socially deprived groups were less likely to attend (most deprived third 47.5% vs least deprived third 64.3%; $p<0.001$), regardless of the type of invitation received. Among attenders, intention to change behaviour was strong and unaffected by invitation type.

Comment: These results are immensely useful to those of us sending recall letters or invitations to health promotion activities. It would be great to hear from readers on the innovative ways that have improved attendance for screening programmes.

Reference: *BMJ*. 2010;340:c2138.

http://www.bmj.com/cgi/content/abstract/340/may13_2/c2138

Ethnicity of severe trauma patients: results of a population-based study, Auckland, New Zealand 2004

Authors: Creamer G et al

Summary: This population-based study combined data from coronial autopsy and four hospital trauma databases to provide age, gender, ethnicity, mechanism, mortality and hospitalisation information for the severely injured in Auckland, New Zealand, for the year 2004. Severe injury was defined as death or injury severity score >15 . Māori and Pacific people had increased risk of severe injury and injury-related mortality. A major gender difference was identified: Māori females were at increased risk and Pacific females at decreased risk compared to the remaining female population; both Māori and Pacific males had higher severe injury rates than the remaining population. The relative risk for severe injury (and mortality) for Māori RR 2.38 (RR 2.80) and Pacific RR 1.49 (RR 1.59) was higher than the remaining population, the highest risk (and more statistically significant) was seen in the 15–29-year age group (Māori RR 2.87, Pacific RR 2.57). Road traffic crashes accounted for the greatest proportion of injuries in all groups. Māori had relatively higher rates of hanging and assault-related injury and death; Pacific people had relatively higher rates of falls and assault.

Comment: Many think of ‘accidents’ or ‘violence’ when considering ‘trauma’. As these results show, in young Māori men living in Auckland, suicide is perhaps the most common cause of severe trauma. I say this because, although the paper states hanging and road traffic crashes, evidence suggests the latter is increasingly considered by young men with suicidal intent. This issue needs urgent attention.

Reference: *N Z Med J*. 2010;123(1316):1-7.

<http://www.nzma.org.nz/journal/abstract.php?id=4156>

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Mortality and Demographic Data 2007

Annual statistical publication that collates and analyses information on the underlying causes of all deaths registered in New Zealand for the calendar year of 2007.

The commentary summarises key facts, mortality rates, trends and major causes of death with data presented for Māori compared to non-Māori. Cancer, ischaemic heart disease, cardiovascular disease, diabetes mellitus and motor vehicle accidents are analysed and reviewed in more detail.

<http://www.moh.govt.nz/moh.nsf/indexmh/mortality-demographic-data-2007?Open>

Race versus place of service in mortality among Medicare beneficiaries with cancer

Authors: Onega T et al

Summary: Records were examined from over 200,000 Medicare beneficiaries treated for cancer between 1998 and 2002, in this comparison of mortality among African-American and Caucasian cancer patients and evaluation of the influence of attendance at a National Cancer Institute (NCI)-designated comprehensive or clinical cancer centre. Across all cancer care settings within the study population, the likelihood of 1-year all-cause and cancer-specific mortality was 13% higher for African Americans than for Caucasians; at 3 years, the risk had increased to 23%. By cancer site, cancer-specific mortality was higher among African Americans at 1 year for breast and colorectal cancers and for all cancers at 3 years. However, NCI cancer centre attendance was associated with significantly lower odds of mortality for African Americans (1-year OR 0.63; 3-year OR 0.71). Notably, there were no significant differences in mortality by race among those who attended NCI cancer centres.

Comment: A quick review of the website for NCI cancer centres found that the organisation is committed to reducing and eliminating disparities. Its *Center to Reduce Cancer Health Disparities* has its own Plan and research programme. I'd suggest a similar commitment from local cancer services would result in improved outcomes and reduced inequalities.

Reference: *Cancer*. 2010;116(11):2698-706.

<http://www3.interscience.wiley.com/journal/123325183/abstract>

Racial and ethnic differences in the treatment of acute myocardial infarction: findings from the Get With the Guidelines—Coronary Artery Disease program

Authors: Cohen MG et al

Summary: These researchers sought to determine whether racial/ethnic differences in evidence-based care for myocardial infarction (MI) existed among 443 hospitals participating in the national Get With the Guidelines—Coronary Artery Disease (GWTW-CAD) campaign between 2002 and 2007 and to assess whether such programmes are associated with decreasing health disparities over time. Data were analysed from 142,593 acute MI patients (121,528 whites, 10,882 African Americans, and 10,183 Hispanics). Over the 5 years of study, use of each performance measure for MI care improved significantly, regardless of race/ethnic groups. At the start of the study, there was a gap in care quality by race/ethnicity, with 70% of whites and Hispanics receiving defect-free care (defined as patients receiving all eligible performance measures), versus 60% of African Americans. Notably, by the end of the study, while small gaps remained in the care received by African Americans, which included less use of aspirin at discharge and smoking-cessation advice, the care received by Hispanic patients was almost identical to that of white patients in terms of adherence to core performance measures. Overall, progressive improvements in defect-free care were observed regardless of race/ethnic groups.

Comment: As the study suggests, any commitment to quality also requires a focus on reducing inequalities. And alternatively, a focus on reducing inequalities will improve the quality of care, and ultimately outcomes, for all.

Reference: *Circulation*. 2010;121(21):2294-301.

<http://circ.ahajournals.org/cgi/content/abstract/121/21/2294>

Narratives of deprivation: Women's life stories around Māori sudden infant death syndrome

Authors: McManus V et al

Summary: This paper contains life story interviews conducted between 2002 and 2004 with 19 mothers of Māori infants who have died of Sudden Infant Death Syndrome (SIDS). Participants were from both urban and rural locations throughout New Zealand. Experiences of alienation, marginalisation and exclusion, as narrated by the bereaved mothers, attest to lives lived under conditions of serious deprivation in an affluent society. Constructing these experiences as non-modifiable risk factors hinders the development of policy and health promotion interventions that could improve the conditions in which Māori mothers live and raise their babies.

Comment: A moving paper; the stories presented here underpin the need to take a wide approach, in order to stop the 'needless and devastating loss of Māori babies'.

Reference: *Soc Sci Med*. 2010;71(3):643-9.

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