

Māori Health Review

Making Education Easy

Issue 28 – 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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Race/ethnicity, quality of care, and outcomes in ischemic stroke

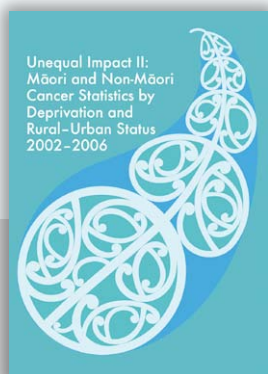
Authors: Schwamm LH et al

Summary: This study obtained data from a registry base consisting of 1181 nationwide hospitals participating in the American Heart Association/American Stroke Association's Get With The Guidelines-Stroke (GWTG) program. The researchers analysed information on 397,257 patients admitted with a principal diagnosis of stroke or transient ischemic attack (TIA). Relative to white patients, black and Hispanic patients were younger and more often had diabetes mellitus and hypertension. Patient- and hospital-level adjusted analyses revealed that blacks were less likely to receive care as measured by the GWTG program, including use of tissue plasminogen activator soon after arriving at the emergency department, deep vein thrombosis prophylaxis, smoking cessation, discharge antithrombotics, anticoagulants for atrial fibrillation, and lipid therapy. The odds of dying in-hospital were higher for black patients than for white and Hispanic patients. Whites and Hispanics received similar levels of care and had similar in-hospital mortality. However, during the course of the study, 2003 to 2008, adherence to the stroke treatment guidelines improved at similar rates for all three race/ethnicity groups.

Comment: Another study from the 'Get with the Guidelines Program' in the United States. It is important to note that unequal treatment of stroke by ethnicity may contribute to increased risk for recurrent stroke and consequently to ethnic disparities in stroke outcomes (disability, death). Quality of care improved for all ethnicities when clinicians were supported to deliver 'best practice care' through implementation of clinical guidelines. Such evidence confirms the need to continue a focus on clinical decision making in order to improve quality of care and reduce ethnic disparities.

Reference: *Circulation*. 2010;121(13):1492-501.

<http://circ.ahajournals.org/cgi/content/abstract/121/13/1492>



Unequal Impact II: Māori and Non-Māori Cancer Statistics by Deprivation and Rural-Urban Status 2002-2006

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a RESEARCH REVIEW publication

Helicobacter pylori infection and iron deficiency in teenage females in New Zealand

Authors: Fraser AS et al

Summary: In order to determine whether an association exists between *Helicobacter pylori* (*H. pylori*) infection and iron deficiency, these researchers tested a cohort of 792 female students from 7 Auckland high schools (median age 16 years) for *H. pylori* serology and iron deficiency. Significant differences were observed between different ethnic groups: the prevalence of positive *H. pylori* serology was highest for Pacific Island students (49.0%), intermediate for Māori (26.7%) and Asian (24.7%) and lowest for European (13.7%) ($p < 0.0001$). Compared to students with negative *H. pylori* serology, those with positive *H. pylori* serology had significantly lower mean levels of iron saturation ($p = 0.013$), but not of ferritin ($p = 0.068$), haemoglobin ($p = 0.08$) or mean cell volume ($p = 0.16$). In analyses adjusted for age, ethnicity and school SES decile, positive *H. pylori* serology was associated with increased risk of iron deficiency (RR 1.20), but not anaemia (RR 1.01).

Comment: Highlights the need to thoroughly investigate iron deficiency and symptoms/signs of *H. pylori* in Māori and Pacific teenagers.

Reference: *N Z Med J.* 2010;123(1313):38-45.

<http://www.nzma.org.nz/journal/abstract.php?id=4078>

Effects of a brief intervention for reducing violence and alcohol misuse among adolescents: a randomized controlled trial

Authors: Walton MA et al

Summary: This trial involved 726 American urban adolescents aged 14–18 years presenting to a level I emergency department (ED) between September 2006 and September 2009, who screened positive for both alcohol and violence and reported past-year alcohol use and aggression. Patients were randomised to a control group that received a brochure ($n = 235$) or a 35-minute brief intervention delivered by either a computer ($n = 237$) or therapist ($n = 254$) in the ED. The brief intervention combined motivational interviewing with skills training, a review of goals, tailored feedback, decisional balance exercise, role plays, and referrals. At 3 months' follow-up, compared with controls, participants in the therapist intervention showed self-reported reductions in the occurrence of peer aggression (therapist, -34.3% ; control, -16.4% ; relative risk [RR], 0.74), experience of peer violence (therapist, -10.4% ; control, $+4.7\%$; RR, 0.70), and violence consequences (therapist, -30.4% ; control, -13.0% ; RR, 0.76). At 6 months, participants in the therapist intervention showed self-reported reductions in alcohol consequences (therapist, -32.2% ; control, -17.7% ; OR, 0.56) compared with controls; participants in the computer intervention also showed self-reported reductions in alcohol consequences (computer, -29.1% ; control, -17.7% ; OR, 0.57).

Comment: Given the recent success of similar screening/interventions in women who may be experiencing domestic violence, this may be the right time to introduce a 'brief intervention' as outlined here for adolescents presenting to health/whānau ora providers.

Reference: *JAMA.* 2010;304(5):527-35.

<http://jama.ama-assn.org/cgi/content/abstract/304/5/527>

Diagnostic and therapeutic delays among a multiethnic sample of breast and cervical cancer survivors

Authors: Ashing-Giwa KT et al

Summary: This Californian study explored diagnostic and therapeutic care delays among a multiethnic sample of 1377 breast and cervical cancer survivors and examined contextual factors influencing diagnostic and therapeutic care delays. The study cohort comprised 449 European American, 185 African American, 468 Latina American, and 275 Asian American survivors. Latina Americans were significantly more likely to report diagnostic delays, whereas African Americans were significantly more likely to report therapeutic delays. In terms of cancer type, cervical cancer survivors ($n = 679$) were significantly more likely to report diagnostic and therapeutic delays compared with the 698 breast cancer survivors. "Fear of finding cancer" was the most frequently cited reason for diagnostic delays, and "medical reasons" were most frequently cited for therapeutic delays.

Comment: The study has examined where delays occur in the cancer 'pathway', disparities in waiting times by ethnicity and cancer type, and potential reasons for a delay to diagnosis and treatment. I am slightly concerned that most factors have been labelled as 'personal' (psychological, cultural, and medical factors) when, for example, 'medical' issues actually lie with the clinical decision maker. A similar study is being undertaken in NZ with lung cancer pathways – it'll be interesting to see whether the same issues occur here.

Reference: *Cancer.* 2010;116(13):3195-204.

<http://tinyurl.com/34y7pl4>

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.



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These spinning wheels are an innovative way of disseminating information contained in this publication. Selected indicators are provided in an easy-to-use and compact format. The "Overview Spinning Wheel" provides selected indicators covering Demographics, Socio-economic determinants of health, Risk and Protective Factors and Health Status indicators. The "Health Status Spinning Wheel" provides selected indicators from the Health Status chapter, covering cancer registration, hospitalisation and mortality.

Hard copies can be ordered by emailing: moh@wickliffe.co.nz or calling 04 496 2277 quoting HP5164 (Overview Wheel) and HP5165 (Health Status Wheel)

Ethnicity and management of colon cancer in New Zealand. Do indigenous patients get a worse deal?

Authors: Hill S et al

Summary: Cancer registry data were reviewed from a nationally representative cohort of 301 Maori (indigenous) patients and 329 randomly selected non-Māori patients who were diagnosed with colon cancer between 1996 and 2003. Rates of surgical resection were similar between Māori and non-Māori patients, although Māori patients were less likely to undergo extensive lymph node clearance and were more likely to die during the postoperative period. Māori patients were significantly less likely to receive chemotherapy for stage III disease (relative risk [RR], 0.69) and were more likely to experience a delay of ≥8 weeks before starting chemotherapy (RR, 1.98). Treatment disparities were not explained by differences in tumor characteristics or patient comorbidity.

Comment: There is not much more to add to this paper as it is presented here other than to reinforce that firstly it is our whānau who are affected and secondly, as health providers, we must continue to improve access to, and the quality of, cancer care.

Reference: Cancer. 2010;116(13):3205-14.

<http://tinyurl.com/32abqdx>

If nobody smoked tobacco in New Zealand from 2020 onwards, what effect would this have on ethnic inequalities in life expectancy?

Authors: Tan L et al

Summary: According to New Zealand 2006 Census data, smoking contributes to the 7- to 8-year gap between Māori and non-Māori life expectancy. The researchers specified six modelling scenarios, formed by combining two options for future per annum declines in mortality rates among never-smokers (1.5%/2.5% and 2.0%/3.5% for non-Māori/Māori; i.e. assuming a return to long-run trends of closing ethnic gaps as in pre-1980s decades), and three options for future per annum reductions in the mortality rate difference comparing current to never-smokers (0%, 1% and 2%). In 1996–1999, current smokers had an estimated 3.9 to 7.4 years less of life expectancy relative to never-smokers. This smoking difference in life expectancy was less among Māori than among non-Māori. If the 2006 census smoking prevalence remains unchanged into the future, this paper estimated that the difference in 2040 between Māori and non-Māori life expectancy will range from 1.8 to 6.1 years across the six scenarios and two sexes (average 3.8). If nobody smokes tobacco from 2020 onwards, the paper estimated additional gains in life expectancy for Māori ranging from 2.5 to 7.9 years (average 4.7) and for non-Māori ranging from 1.2 to 5.4 years (average 2.9). Going smokefree as a nation by 2020, compared to no change from the 2006 Census population smoking prevalence, is predicted to close ethnic inequalities in life expectancy by 0.3 to 4.6 years (average 1.8 years; consistently greater for females).

Comment: Many of you may have read about this study in local newspapers and I've had requests for access to the actual journal article. It provides convincing evidence that we must continue smoking cessation activities in order to improve Māori health gain.

Reference: N Z Med J. 2010;123(1320):26-36.

<http://www.nzma.org.nz/journal/abstract.php?id=4264>

Ethnic counts on mortality and census data 2001-06: New Zealand census-mortality study update

Authors: Tan L et al

Summary: This paper reports updated outcomes for the assessment of discrepancies in ethnicity counts in the 2001 census and mortality data for the 2004–2006 period. 2001 census data were anonymously and probabilistically linked to 5 years of subsequent mortality data (135,849 eligible mortality records), in order to compare ethnicity recording for the years 2001–2004 and 2004–2006. When using total ethnicity, little bias occurs in census and mortality ethnic group counts for 2004–06 and resemble comparisons in 2001–04, except at younger ages where counts for Pacific and Asian ethnicities are up to a third less for mortality data. Due to multiple ethnicities being more commonly recorded on census data, sole ethnicity counts are generally greater on mortality than census data, particularly for Māori ethnicity.

Comment: The main point to take from this paper is that the census definition for ethnicity continues to be the gold standard. This is particularly important in health care settings. We are encouraged to continue using the census question for accurate ethnicity data.

Reference: N Z Med J. 2010;123(1320):37-44.

<http://www.nzma.org.nz/journal/abstract.php?id=4269>

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Systematic care to reduce ethnic disparities in diabetes care

Authors: Kenealy TW et al

Summary: These researchers analysed outcomes of a chronic care management programme for diabetes, implemented in 2005 by a Primary Health Organisation. The cohort included 1311 people with diabetes (354 Māori, 957 non-Māori). At the start of the programme, HbA_{1c} levels were higher in Māori than non-Māori (mean 8.1% vs 7.1%) but over the approximate 2-year follow-up, HbA_{1c} for Māori improved to that of non-Māori. LDL-cholesterol and systolic blood pressure decreased during the programme in both groups. Improved glucose in Māori was not due to starting insulin or metformin, and rates of sulphonylurea prescription increased in both groups. Urinary albumin:creatinine ratio remained higher for Māori throughout the programme. Smoking rates and body mass index (both higher in Māori) did not change.

Comment: I enjoy hearing about successful programmes such as these and continue to encourage readers to consider publication/presentation of similar types of research.

Reference: *Diabetes Res Clin Pract.* 2010;89(3):256-61.

<http://tinyurl.com/3xk488m>

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Two presentations from HRC Hui Whakapiripiri

I was fortunate to facilitate a number of fantastic sessions at the HRC Hui Whakapiripiri in July. I have highlighted two here but the entire programme and most presentations can be viewed at <http://hui.hrc.govt.nz/programme/>.

The first is from Dr Lindsay. Gout is a major health issue for Māori, given the significant impact it has on quality of life, its relationship to other illness (including heart disease and renal/kidney problems) and the problems we have in managing the multiple drug interactions. As a recent immigrant to Aotearoa, Dr Lindsay was astounded to see the poor management of gout in South Auckland. Her investigation has uncovered some interesting concerns but importantly has also led to collaborative work with Arthritis NZ, primary and secondary providers, as well as communities, to tackle this issue.

Untreated gout: an unrecognised but major cause of health disparity and reduced quality of life in Pacific Islanders and Māori in South Auckland. A qualitative study

Authors: Lindsay K

Summary: This paper describes an extreme burden of untreated gout arthritis in South Auckland. Transcripts of 11 semi-structured interviews conducted with male patients with gout were subjected to grounded theory qualitative analysis. Focus groups were held with health professionals involved in the provision of healthcare to patients with gout, patient and community groups, to validate the themes arising from the transcripts and to generate realistic recommendations to improve the quality of care for Māori and Pacific island patients with gout. The majority of patients were Māori or Pacific Island. The paper demonstrates that patients who are not successfully started on uricosuric treatment in primary care experience progressive disability and deterioration in other health parameters including weight gain, hypertension, and morbidity from non-uricosuric treatments such as anti-inflammatory medication, prednisone, and colchicine. The groups with the greatest burden of disease are the least likely to be started on treatment despite regular presentations to healthcare with exacerbations of increasing severity. The paper describes a huge impact on patients in terms of pain, disability, employment, and family members. Compliance is strongly linked to the quality of the information and depth of understanding of the patient.

Reference: *Untreated gout arthritis in South Auckland. Hui Whakapiripiri, Rotorua. 8th July 2010.*

<http://hui.hrc.govt.nz/assets/NewFolder/Karen-Lindsay.pdf>

The second presentation was from a 'multi talented' team including Māori health providers, researchers, communities and clinicians. I plan to use the findings from this research in the planning of an 'oranga niho' programme at our PHO.

Oral Health Panel Discussion

Panel members: Cheryl Davies, Ruruhira Rameka, Riripeti Paine, Vilma Hape and Bridget Robson

Summary: This series of five presentations details a comprehensive investigation into issues surrounding oral health research priorities for Māori. The first presentation discusses project goals designed to improve Māori oral health and reduce disparities; the second describes an oral health research project run by Ngāti Pahauwera Hauora in 2009; the third concerns the impact of oral health problems among Māori adults with low income, elderly Māori, and Māori with special needs, disabilities or who are medically compromised; Presentation 4 discusses the involvement of Kokiri Marae in this research project; and the final presentation concludes with a vision of oral health system for all Māori for life, with appropriate models of oral health service delivery, and solutions to workforce issues.

Reference: *Oral Health Panel Discussion. Hui Whakapiripiri, Rotorua. 8th July 2010.*

Presentation 1: <http://hui.hrc.govt.nz/assets/NewFolder/Oral-Health-1-Intro-Bridget.pdf>

Presentation 2: <http://hui.hrc.govt.nz/assets/NewFolder/Oral-Health-2-Vilma-final.pdf>

Presentation 3: <http://hui.hrc.govt.nz/assets/NewFolder/Oral-Health-3-rural-provider-quantif.pdf>

Presentation 4: <http://hui.hrc.govt.nz/assets/NewFolder/Oral-Health-4-Cheryl-Davies.pdf>

Presentation 5: <http://hui.hrc.govt.nz/assets/NewFolder/Oral-Health-5-Research-Priorities-Bridget.pdf>

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