

Māori Health Review

Making Education Easy

Issue 23 – 2009

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Tēnā koutou, tēnā koutou, tēnā tātou katoa

Ko tēnei te mihi mahana ki a koutou katoa. Nau mai ki tēnei tirohanga hou Hauora Māori. I tēnei putanga ka pāhotia ētahi kōrero whakahirahira mai i te hui o Te Ohu Rata o Aotearoa. Nō reira noho ora mai rā.

Matire

Greetings

Welcome to the final Māori Health Research Review for 2009. It has certainly been a 'busy' year for health and in particular hauora Māori. There have also been some wonderful opportunities and outcomes. I'd like to congratulate the successful Māori applicants in the EoI process for primary care; and those of you who have been invited to the next stage of the Māori Health Innovation Funding round – nga mihi nui ki a koutou katoa! It does mean more work for you leading up to, if not over, the holidays so kia kaha! Until the next issue in 2010, have a wonderful xmas and new year. Arohanui to you and your whānau.

Matire

Dr Matire Harwood

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Fruit consumption among people living in a high deprivation New Zealand neighbourhood

Authors: Jaeger SR et al

Summary: Outcomes are reported from 99 door-to-door interviews conducted in 2007 in a high deprivation neighbourhood in Auckland investigating fruit consumption. On average, participants reported eating a serving of fresh fruit five to six times per week. At the time of the interview, 38% of respondents did not have any fresh fruit in the house and 60% reported that in the past month they had thrown out fruit between one to four times per week because it was considered to be past its best in terms of eating quality. Fruit juice was consumed on average one to two times per week. Self-efficacy for fruit consumption was positively associated with consumption. Relative to participants with lower levels of self-efficacy for fruit consumption, those with higher levels of self-efficacy were more likely to achieve the target of consuming ≥ 2 daily fruit servings. The study authors suggest that "strategies that aim to increase self-efficacy beliefs for fruit consumption may contribute to improving compliance with the recommended two or more servings daily".

Comment: The results raise a number of questions – what would 'strategies that increase self-efficacy for fruit consumption' look like? And in order to increase fruit consumption, are these more effective and cheaper than say supplying low-cost/high-quality fruit? Many reported having fruit in the home, but the majority of respondents had thrown fruit out because it was rotten. This may reflect the fact that people want to buy fresh produce but can only afford the less expensive and unfortunately old fruit.

Reference: *Aust N Z J Public Health*. 2009;33(5):471-6.

<http://www3.interscience.wiley.com/journal/122620762/abstract>

He Ritenga Whakaro: Māori Experiences of Health Services



This research was funded by the Health Research Council, Accident Compensation Corporation and the Ministry of Health.

The research notes that while Māori have lower life expectancy, greater morbidity and higher rates of disability, they have less access to health and rehabilitation services than do non-Māori. The research sought to capture the perceptions of Māori consumers in order to contribute to a robust understanding of how the health system is or is not facilitating their access to health care.

An electronic link to this report can be found on the Māori Health website www.maorihealth.govt.nz



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

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The association between perceived provider discrimination, healthcare utilization and health status in racial and ethnic minorities

Authors: Lee C et al

Summary: These researchers examined the extent to which perceived provider discrimination explains racial/ethnic differences in healthcare utilisation and subsequently health status, in a sample of 5642 adults living in the USA, who participated in the 2001 Survey on Disparities in Quality of Health Care. The researchers applied structural equation modelling to evaluate the relationship between perceived provider discrimination, healthcare utilisation, and health status. Significantly higher levels of perceived provider discrimination and poorer health were reported by African Americans, Hispanics and Asians than by non-Hispanic whites. The model revealed poor health to be significantly mediated by two paths: (1) by perceived provider discrimination and (2) by perceived provider discrimination through unmet need for healthcare utilisation.

Comment: Although this confirms what many of us suspected/knew anyway, these studies are really useful in discussions with those who continue to argue that clinicians don't treat people differently. The next step is to look at ways to address provider discrimination at the system level. Possibilities include training, ongoing audit, and workforce development to increase the number of Māori clinicians.

Reference: *Ethn Dis.* 2009;19(3): 330-7.

<http://tinyurl.com/yzy3dzm>

A cost-based equity weight for use in the economic evaluation of primary health care interventions: case study of the Australian Indigenous population

Authors: Ong KS et al

Summary: This paper weighs up the efficiency-equity debate from the health economics perspective. It contends that as currently available qualitative and quantitative methods designed to incorporate equity into economic evaluation are beset by definitional uncertainties and other inherent limitations, no method has been universally adopted to date. The researchers propose a concept that may overcome some of those limitations; a cost-based equity weight for evaluating the cost side as opposed to the outcomes side of interventions delivered by primary health care programmes. As this concept focuses on achieving equity in processes rather than outcomes, it is sensitive to the context and health beliefs of target groups. The researchers evaluate primary health care delivery to the Australian Aboriginal and Torres Strait Islander (or Indigenous) population, as an illustrative case study. The 'equity of access' decision-making tool is a potentially important avenue for further health economics research, conclude the researchers.

Comment: Not being a health economist, many of the concepts discussed in this paper were new to me. However, there is increasing interest in the area of health, economy and equity. As Gareth Morgan argues in his new book 'Health Cheque', an investment in reducing health inequalities now will have long-term benefits for all New Zealanders (see his website and prescription at www.healthcheque.co.nz).

Reference: *Int J Equity Health.* 2009;8(1):34.

<http://www.equityhealthj.com/content/8/1/34>

Beliefs and barriers to follow-up after an emergency department asthma visit: a randomized trial

Authors: Zorc JJ et al

Summary: These US-based researchers evaluated the effect of an emergency department (ED)-based intervention addressing beliefs and barriers to follow-up asthma care among inner-city families. The study recruited 433 children aged 1 to 18 years who were discharged after asthma treatment in an urban paediatric ED. Controls received instructions to follow-up with a primary care provider (PCP) within 3 to 5 days. Intervention subjects additionally underwent asthma symptom screening, viewed a video addressing beliefs about asthma control and they were mailed a reminder to follow-up with a PCP. All subjects were contacted by telephone 1, 3, and 6 months after the ED visit. After the intervention and before ED discharge, intervention subjects were more likely to endorse beliefs about the benefits of follow-up than controls. However, rates of PCP follow-up during the month after the ED visit (44.5%) were similar to control subjects (43.8%) as were asthma-related quality of life, medication use, and ED visits.

Comment: One important 'confounder' may be the fact that the intervention was delivered in the ED. Community-based studies, including the Wairarapa Asthma study in which education was delivered on marae, have had very different results. And given the disparities in asthma management between Māori and non Māori, this should continue to be an area for improvement. For example, the Asthma and Respiratory Foundation of NZ is looking to develop an asthma education programme for HealthTV, to be delivered in waiting rooms

Reference: *Pediatrics.* 2009;124(4):1135-42.

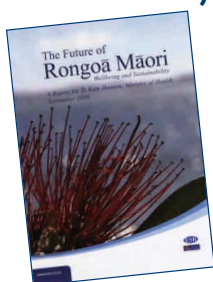
<http://pediatrics.aappublications.org/cgi/content/abstract/124/4/1135>

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The Future of Rongoa Māori: Wellbeing and Sustainability



This research was undertaken by the Institute of Environmental Science and Research Ltd and the Ministry of Health.

Through two literature reviews, this research examined healer focus groups and stakeholder workshops and how Rongoā Māori contributes to indigenous wellbeing. The research also identifies issues for the ongoing sustainability of traditional Māori healing in New Zealand. For a synopsis of the issues examined in this research a summary report is available.

An electronic link to this report can be found on the Māori Health website www.maorihealth.govt.nz



Mental health first aid for Indigenous Australians: using Delphi consensus studies to develop guidelines for culturally appropriate responses to mental health problems

Authors: Hart LM et al

Summary: This paper describes the development of culturally appropriate guidelines for providing first aid to an Australian Aboriginal or Torres Strait Islander experiencing a mental health crisis or developing a mental illness. A panel of Aboriginal mental health experts participated in six independent Delphi studies investigating depression, psychosis, suicidal thoughts and behaviours, deliberate self-injury, trauma and loss, and cultural considerations. The panellists reached consensus about culturally appropriate first aid for mental illness. A total of 536 statements about first aid actions were accepted for inclusion in a guideline (94 for depression, 151 for psychosis, 52 for suicidal thoughts and behaviours, 53 for deliberate self-injury, 155 for trauma and loss, and 31 for cultural considerations). The panellists affirmed the methodology and the guidelines themselves as useful and appropriate.

Comment: An interesting paper, particularly for those people involved in the development of guidelines. Importantly, it describes the way in which a health need was identified by the indigenous community; how they've utilised evidence that is validated by cultural expertise, and in working with indigenous experts, have also increased their knowledge about an important health issue. The methodology may be useful for similar activities in Aotearoa.

Reference: *BMC Psychiatry*. 2009;9:47.

<http://www.biomedcentral.com/1471-244X/9/47>

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

Utilisation of inpatient cardiology services including by Māori: a study of hospital discharges for patients enrolled with Partnership Health practices for the 2 years ending June 2007

Authors: Malcolm L, Barnett R

Summary: Māori and non-Māori rates of utilisation of cardiology inpatient services were analysed by linking the enrolled population of Partnership Health with hospital discharge data from the New Zealand Health Information Service. Rates of discharges for the 2 years ending June 2007 (n=127,246) were analysed in relation to age, gender, ethnicity (19,712 Māori), deprivation score and other variables. Rates of utilisation including cardiology in patient services were analysed by diagnosis-related groups (DRGs). Standardised Māori rates of utilisation for almost all major cardiology DRG categories were substantially higher than the non-Māori population. Overall rates for cardiology DRGs were 1.47 times higher for Māori. Standardised Māori rates were higher than the non-Māori population for higher deprivation scores. Māori cardiology inpatients had almost twice the level of Care Plus levels than the non-Māori population. The researchers stress that the higher rate of hospital utilisation suggests that higher quality data rather than increased access is the explanation.

Comment: As the authors have indicated, the results may in fact reflect better data quality and not actual improvements. It would be useful to also know confidence levels and statistical significance of results. Finally, the authors haven't stated if utilisation reflects health need, or is associated with equitable outcome. A follow-up study is required.

Reference: *N Z Med J*. 2009;122(1304):63-71.

<http://www.nzma.org.nz/journal/abstract.php?id=3822>

Determinants of inequalities in cervical cancer stage at diagnosis and survival in New Zealand

Authors: Priest P et al

Summary: To assess whether ethnic inequalities in cervical cancer mortality are due to differences in survival independent of stage and age at diagnosis, and to assess the contribution of screening to stage at diagnosis, this investigation examined demographic data and cervical screening history for 402 women with histologically proven primary invasive cervical cancer, diagnosed in New Zealand between 1 January 2000 and 30 September 2002. Date of death was available for women who died up to 30 September 2004. In an age-adjusted Cox proportional hazard model, the Māori mortality rate was 1.80 times that of non-Māori. This reduced to 1.25 after adjusting for stage at diagnosis. Among determinants of late stage at diagnosis, older age and being Māori significantly increased the risk, while screening was protective.

Comment: PHO Performance Programme (PPP) data for cervical screening rates in primary care, when analysed by ethnicity, show that Māori are not receiving cervical screening at the same rate as non Māori, non-Pacific women. Some PHOs (including the one I work for) have introduced specific programmes that aim to reduce inequalities in cervical screening; major improvements have resulted. I'd be interested to hear from others who have implemented successful interventions for Māori cervical screening.

Reference: *Cancer Causes Control*. 2009 Oct 22. [Epub ahead of print]

<http://tinyurl.com/yf2fvko>

Evaluation of the Māori Provider Development Scheme now available online



The Evaluation of the Māori Provider Development Scheme (MPDS) is now available on the Māori Health website. The evaluation highlights the positive impact MPDS funding has had on building the capability and capacity of Māori providers. The report also makes a number of recommendations to improve the MPDS programme.

To download a copy of the report please visit www.maorihealth.govt.nz

At a cultural crossroads: lessons on culture and policy from the New Zealand DISABILITY STRATEGY

Authors: Wiley A

Summary: Findings are reported from a year-long qualitative outcome evaluation of the implementation of Objective 11 of the New Zealand Disability Strategy (NZDS): promote the participation of disabled Māori. Semi-structured interviews conducted with ministry officials, service provider organisations, Māori consumers with disabilities and caregivers to Māori consumers, uncovered common themes that included issues surrounding the effectiveness of the NZDS and the conflict between indigenous worldviews framed within a mainstream service paradigm. Themes unique to specific interview groups covered areas such as accountability structure design, perceived levels of cultural competency, collaboration across sectors and information exchange. The paper concludes that the NZDS provides several pertinent lessons regarding the development of culturally comprehensive disability policy.

Comment: This paper presents the findings from an evaluation of a high-level strategy with input to the assessment from all stakeholders. Chapter 12 of Haurora: Māori Standards of Health IV provides a more in-depth description of Māori understandings of disability and disability support. Together, the two references provide an important focus on a critical issue – support for Māori with impairment and their whānau – and should inform the development of a Whānau Ora Framework.

Reference: *Disabil Rehabil.* 2009;31(14):1205-14.

<http://tinyurl.com/yh6pkzi>

General Practice funding to improve provision of adolescent primary sexual health care in New Zealand: results from an observational intervention

Authors: Morgan J, Haar J

Summary: This study sought to determine whether the introduction of free GP sexual health consultations for registered under-25-year-olds in rural and low socioeconomic areas of the Waikato region, New Zealand, in late 2003–2004 improved provision of primary sexual health care, using testing and detection rates of *Chlamydia trachomatis* as a measurable outcome. Chlamydia testing among under-25 year olds at the 20 intervention practices increased over time, but not among the 29 non-intervention practices; coverage of females aged 18–24 years within the intervention increased from 13.9% in 2003 to 15.5% during the roll-out phase and to 16.8% in 2005. Intervention practices had higher test positivity rates than non-intervention practices (8.7% vs 5.9%; $p < 0.01$), increasing from 7.7% in 2003 to 10% in 2005, relating mainly to increases in positive tests among females aged <25 years. In contrast, no increases occurred in testing or detection among those aged ≥25 years at intervention practices.

Comment: A great example of how easy it is to evaluate an intervention in primary care. Practice staff must be supported to 'normalise' the Chlamydia screening questions and introduce them opportunistically. Importantly, with free, targeted health care, disease detection and hopefully also management increase.

Reference: *Sexual Health.* 2009;6(3) 203-7.

<http://www.publish.csiro.au/nid/164/paper/SH09012.htm>

Indigenous health part 1: determinants and disease patterns

Authors: Gracey M, King M

Summary: This paper describes the disparities in health and disease statistics among Indigenous people worldwide. It focuses on Indigenous Australians as an example of health gaps between Indigenous and non-Indigenous peoples. Simple, affordable, and effective ways to improve Indigenous health are discussed. The authors advocate that increased awareness, political commitment, and recognition is needed to correct these inequalities and they urge that Indigenous people be encouraged, trained, and enabled to become increasingly involved in overcoming these challenges.

Comment: I've included this paper as an extremely useful reference for those needing health statistics for indigenous peoples across many nations. The fact that it, and its sequel Part 2, appear in one of the top medical journals should also speak volumes.

Reference: *Lancet.* 2009;374(9683):65-75.

<http://tinyurl.com/yImzxrj>

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