



A call to action on Maori cardiovascular health

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Introduction

Maori have the poorest cardiovascular health outcomes in Aotearoa (New Zealand).¹⁻⁵ Although disparities in these health outcomes have been documented for many years, progress toward reducing them has been alarmingly slow.¹

Disparities in health are seen as being unjust and inequitable, avoidable, and potentially detrimental to all members of society. Furthermore, efforts to reduce disparities may be cost effective.⁶

Full recognition of Maori rights as tangata whenua, as reflected in the Treaty of Waitangi, is an important driver towards the goal of Maori having at least the same standard of health as non-Maori. Disparities also reflect the fact that Maori health status has not been afforded the 'protection' the crown intends under the Treaty of Waitangi, using the government's health framework of the guiding principles of the Treaty.⁷

In 2001, the Ministry of Health in association with the New Zealand Guidelines Group convened a National Cardiovascular Advisory Committee. The aim of this group was to:

'advise on the development of an integrated managed approach to cardiovascular disease, from primary prevention through to tertiary treatment in Aotearoa, New Zealand. The work of the committee was to draw upon the best available evidence and was to be conducted in accordance with the principles of the Treaty of Waitangi'.

A key task of this group was to facilitate the production of a Maori cardiovascular action plan. To produce this plan, a separate Maori cardiovascular group was formed.

The aims of this paper are to:

- Provide a brief overview of the current status of Maori cardiovascular health,
- Outline the key themes of the Maori cardiovascular action plan, and
- Stimulate co-ordinated action by the health sector to reduce Maori cardiovascular disparities.

Although many of the determinants of health lie outside of the realm of the health sector, the sector has a key role in ensuring that access to procedures is equitable and that healthcare responsiveness is based on demonstrable need.⁸

An overview of Maori cardiovascular health status

Mortality rates for cardiovascular disease in Aotearoa have been declining. However the decline in Maori cardiovascular mortality has occurred more slowly. This has led

to an increase in disparities.¹ For the period 1996–1999 the Maori male cardiovascular mortality was 3.0 times higher than that for non-Maori, non-Pacific males—and the Maori female mortality rates was 4.2 times higher than that for non-Maori, non-Pacific females.¹

In 2002, 30-day age standardised case fatality rates following acute coronary syndrome were 158 per 1,000 patients for Maori compared to 112 per 1,000 patients for Europeans/Others.⁹

Maori also have the highest prevalence of many cardiovascular risk factors. The AC Neilsen Tobacco Survey (2002), found that 44% of Maori males (aged 15+ years) compared to 24% of European males and 51% of Maori females compared to 24% of European females were smokers.¹⁰ Smoking is the leading modifiable risk factor causing disease.¹¹

Provisional release data from the 2002/2003 New Zealand Health Survey (which included over 3,900 Maori) has provided a wealth of information regarding the prevalence of cardiovascular risk factors in Maori and non-Maori.¹² From this survey, the prevalence of self reported diabetes in adults over 45 years was 21.4% in Maori males and 13% in Maori females—compared to 8.6% in non-Maori males and 7.5% in non-Maori females.¹²

The prevalence of self-reported high blood pressure was 23.2% in Maori males and 22.1% in Maori females—compared to 17.5% and 18.7% respectively in European New Zealanders.¹² Furthermore, the prevalence of obesity (measured by the interviewer and defined as a BMI =30 kg/m² in non-Maori and =32 kg/m² in Maori) was 31.5% in Maori males compared to 16.5% in European males, and 26.7% in Maori females compared to 19.1% in European females.¹²

Given this context of high need, it would be expected that cardiovascular intervention rates would be substantially higher for Maori. However, the converse is true. Interventions for coronary artery bypass grafting (CABG) and percutaneous transluminal coronary angioplasty (PTCA) have been consistently lower for Maori over many years.

Tukuitonga and Bindman reported that over the period 1990–1999, Maori men had a mean age standardised CABG and PTCA intervention rate ratio of 0.40 and 0.29 respectively when compared to European men.¹³ Although these intervention rates have been increasing in recent years, they are still far below that which would be expected given the higher prevalence of risk factors and the higher incidence of disease in Maori.

Similarly (though data is sparse and is derived from administrative data-sets) it would appear that Maori have lower utilisation of diabetes screening. Only 35% of Maori people estimated to have diagnosed diabetes had a free check in 2002 compared to 51% of all people estimated to have diagnosed diabetes.¹⁴ Compared with Europeans, Maori diabetic patients were also less likely to be on cholesterol-lowering medications and ACE inhibitors, and were less likely to have good glycaemic control (HBA1c <8%).¹⁴

The Maori cardiovascular action plan

The overall aim of the Maori Cardiovascular Action Plan is to improve Maori cardiovascular health and to remove inequalities in cardiovascular disease outcomes between Maori and non-Maori. The action plan has six categories. These categories reflect the need for a multi-level, multi-sector approach to improving cardiovascular outcomes. The categories for action include the following areas: policy development, improved information systems, needs assessment, quality standards, Maori workforce development and a proposed research agenda.

The Treaty of Waitangi and policy development

The explicit recognition of the Treaty of Waitangi is central to the Maori Cardiovascular Action Plan. Indeed, the Treaty of Waitangi and Whakatataka (the Government's Maori health action plan 2002–2005) are to be included in all policy development. The Maori Cardiovascular Group endorses Jackson's (2001) comment that the very reason Maori have high need is because Maori rights under the Treaty of Waitangi have not been respected.¹⁵

Flowing from the recognition of the Treaty of Waitangi is the need to prioritise Maori health gain in all health policy directives. Therefore, consultation, engagement, leadership, and representation of Maori in all areas of policy development and implementation are needed.

It is worth noting here that the Waitangi Tribunal has recently confirmed that the Treaty of Waitangi assures to Maori:

- Equal standards of healthcare,
- Equality of access to healthcare, and
- A general equality of health outcomes.¹⁶

Information systems

To monitor disparities and health status, complete and consistent collection of ethnicity data resulting from health services encounters is essential. To facilitate this, there is a need to implement a standardised ethnicity question across the health sector.

Specifically, to ensure consistency between numerators and denominators within health data-sets, the 2001 census question should be used. The way in which ethnicity data is coded and stored should also be standardised. Furthermore, resources and educational material for the training of key health personnel in the area of ethnicity data collection are also needed. The Maori Cardiovascular Group endorses the use of regular audits to monitor the accuracy and completeness of the ethnicity data collected by health providers.

Regarding health provider funding, the amount and level of health expenditure on Maori cardiovascular health should be monitored. In particular, expenditure should be consistent with Maori cardiovascular need and efforts to reduce disparities. In the short term, this will require an additional investment in Maori cardiovascular health until disparities are eliminated.

Needs assessment

Cardiovascular health needs assessments for Maori are required in order to identify the level of met and unmet need in the community. Access barriers to preventive, primary, secondary, and tertiary services should be identified in partnership with Maori stakeholders. Creation and implementation of strategies to address identified barriers will then be required. Access to preventive services including the promotion of 'healthy environments' should be emphasised in order to reduce the incidence of cardiovascular disease.

A long-term goal of the Action Plan is the need for accurate Maori cardiovascular disease prevalence and incidence data. Quality indicators should be developed that measure Maori access to cardiovascular interventions, and treatments should be based on prevalence and incidence of disease, rather than calculating access to cardiovascular interventions based only on ethnicity demographics.

Quality standards

To improve Maori cardiovascular health, it is essential that Maori gain access to (and utilise) evidence-based treatments that have been shown to reduce morbidity and mortality. To achieve this, quality indicators appropriate for medical care are currently being developed by the Ministry of Health to monitor cardiovascular health in New Zealand. Such an approach is consistent with the worldwide trend of an increased emphasis on the measurement of the quality and outcomes of medical care.¹⁷ The Maori Cardiovascular Advisory Group has strongly recommended that Maori specific performance indicators in cardiovascular health be measured. The group has produced a number of indicators of particular interest for ongoing monitoring of Maori cardiovascular health gain. These include indicators for cardiovascular disease prevention and care at primary, secondary and tertiary levels.

Workforce development

There is a critical shortage of Maori involved in cardiovascular healthcare. To adequately document this shortage, a benchmark audit of the number of Maori working in the field is needed. After this has been completed, targets should be set for the ongoing recruitment and training of Maori in the field. Priority areas for Maori recruitment and training include cardiology specialists, cardiology registrars, coronary care level III and IV nurses, cardiac rehabilitation nurses, health researchers, and public health workers (including health promotion staff).

The workforce of Maori specific providers that specialise in cardiovascular care should also be expanded and their skill mix upgraded. Specific recommendations regarding Te Hotu Manawa Maori have also been included in our action plan, as this organisation is the largest Maori specific cardiovascular health provider in the country.

Regarding non-Maori workforce development, the Group advocates for health organisations to have service-wide recognition of the Treaty of Waitangi. Specifically, training courses and educational resources should be available to all staff—with staff actively encouraged to participate. For large cardiovascular health organisations, Treaty of Waitangi audits should be undertaken to measure their responsiveness to Maori.

Innovative ways of delivering care to Maori are needed in the long term. This may necessitate models of health promotion and care that are based in the community, and deliver services directly to Maori.

Research agenda

Kaupapa Maori research is needed. When research is undertaken from this perspective, Maori cardiovascular health concerns and needs become self-determined, as well as the research response needed to address them. Kaupapa Maori research also advocates for the use of Maori: non-Maori comparisons and produces results that have 'equal' meaning and relevance to Maori as non-Maori. The Maori Cardiovascular Advisory Group supports research that prioritises Maori concerns and that use a Maori defined analytical framework to address them.

Research findings are currently lacking regarding the current status of Maori cardiovascular health (including accurate prevalence and incidence data). Research should be undertaken, both qualitative and quantitative, regarding access to care (including access barriers), equity of process along pathways of care, and equity of health outcomes for Maori.

New electronic decision support tools for cardiovascular health such as PREDICT are currently being developed. They offer the promise of a better understanding of the relationship between the Maori population's cardiovascular risk factors, and mortality and morbidity (in essence a Framingham-type risk assessment specific to Maori). It is important that these new tools are used to improve Maori health, and imperative that Maori researchers are actively involved in their development and utilisation.

The group also endorses the need to investigate and evaluate alternative models of service delivery for cardiovascular prevention and care. To date, the current organisation and delivery of the health system has been ineffective in reducing disparities. New and innovative methods of delivery (for example, care delivered in community based settings relevant to Maori) should be explored and evaluated.

Any discourse on disparities would not be complete without commenting on the wider determinants of health, in particular, socioeconomic determinants. Although, discussion of these factors is beyond the scope of our Action Plan, the Group is aware that the elimination of disparities will require action on numerous 'fronts'—including (although not limited to) employment, education, housing, and welfare. Utilisation of methodological frameworks that present a broader view of wellbeing (such as Te Pae Mahutonga and the Ottawa Charter) may assist the development of policy that is more holistic and better reflects Maori realities.¹⁸

Moving forward

The next step of the Maori Cardiovascular Action Plan is the assessment of the above recommendations (including financial implications) by policy makers. If no specific action is taken to address the issues identified in this Plan, it is likely that the current disparities that exist in cardiovascular health for Maori will continue.

Conclusion

Disparities in cardiovascular health outcomes in Aotearoa continue to negatively impact upon Maori. Little progress has been made in reducing the size of these

disparities. A Maori-specific Cardiovascular Health Action Plan has been developed that we hope will improve the responsiveness of the health sector to Maori. This plan is consistent with the full recognition of Maori rights as tangata whenua—as reflected in the Treaty of Waitangi. A multi-level, multi-sector approach is needed to address these disparities. The Maori Cardiovascular Advisory Group hope that this Plan will go some way in providing the guidance that is needed to address the role that the health sector can make in reducing these disparities.

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