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MAORI HEALTH

Key Findings

- At the 2001 census 5840 Maori were recorded as living in the Wairarapa and projections indicate that Maori as a proportion of the Wairarapa population will increase.
- Maori represent over 24% of the total population under 25.
- Wairarapa Maori are disproportionately represented in areas of greater deprivation and over 82% of Maori live in an area with a NZDep2001 score of decile 6 or higher.
- The Maori standardised avoidable hospitalisation rate is significantly higher than the Maori national rate and non-Maori Wairarapa rate.
- The Maori standardised mortality rate is decreasing and is generally lower than the national Maori mortality rate.
- The Wairarapa Maori injury hospitalisation rate is significantly higher than the national Maori rate.
- The Maori asthma hospitalisation rate is significantly higher than the NZ Maori rate and the “Other” DHB rate
- The results of the National Health Survey 2002/03 show that Maori in the Wairarapa have a higher prevalence of smoking than non-Maori and Maori females than Maori males.
- The Maori hospitalisation and mortality rate for diabetes in the Wairarapa is higher than non-Maori but not significantly different than the NZ Maori population.
- The rate of dental extractions for Wairarapa Maori children in 2003/04 was significantly higher than the non-Maori, non-PI population in both the under 5s and the 5 – 12 year olds. In both age groups it was also higher than the comparable New Zealand population.
- Maori in the Wairarapa have a markedly higher prevalence of smoking than those of non-Maori.
- Wairarapa Maori have a higher prevalence of hazardous drinking than non-Maori.

STRATEGIC CONTEXT

The New Zealand Health Strategy, Primary Care Strategy, Maori Public Health Action Plan and *He Korowai Oranga* acknowledge the importance of prioritising Maori health gain and development by identifying a need to reduce and eventually eliminate health inequalities that negatively affect Maori.

He Korowai Oranga – the National Maori Health Strategy (Nov 2002) - places ‘whanau ora’ at the centre of public health policy and outlines twelve Maori Health-priority areas that DHBs and the Ministry of Health are expected to progress.

The Maori health strategic priority areas identified within the Wairarapa DHB Strategic Plan are:

- Improving child, youth and family health
- Better mental health
- Reducing the incidence and impact of diabetes

- Reducing the incidence and impact of respiratory disease.

These priorities were based on an analysis of local, regional and national data as well as consultation with the Wairarapa community including several Hui with Wairarapa Maori.

Data issues

Over recent years there have been changes in the way that Maori (and Pacific) ethnicity has been defined resulting in changes in the numbers of people counted as Maori or Pacific. The lack of a consistent baseline causes difficulty in interpretation of statistical information and makes it difficult to know whether variations in rates and proportions both over time and between groups is been real or simply coding artefacts.

However, while there is a need to better understand the figures, inequalities in health between Maori and non-Maori are pervasive and significant

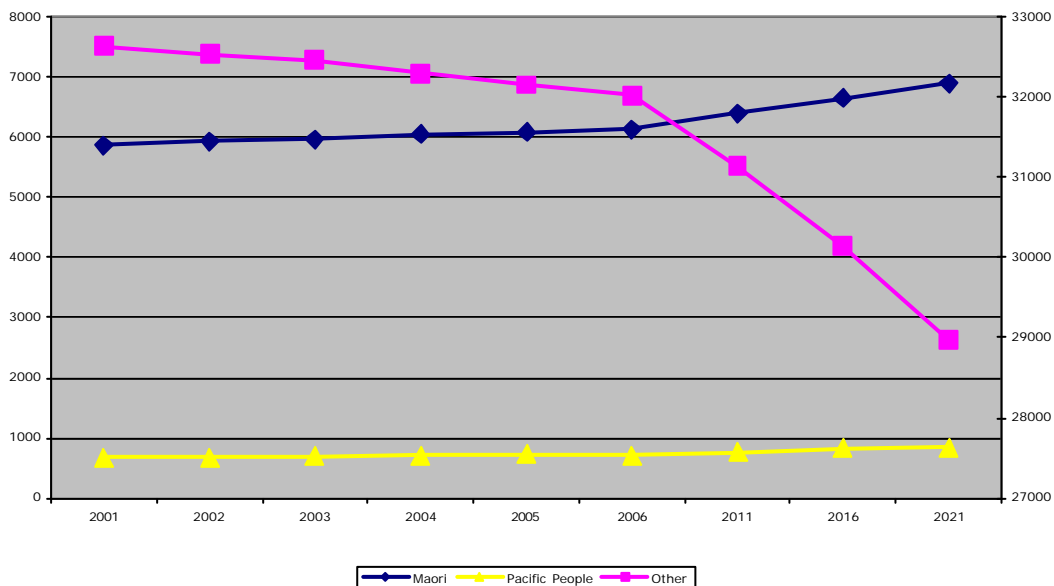
This health status report uses information provided by TAS based on population figures supplied by the Ministry of Health. The Ministry of Health and the TAS uses the Maori (or prioritised) group as the denominator. This does have the disadvantage of underestimating the extent of disparities, and this should be borne in mind.

Demographic information

Mana Whenua in Wairarapa comprise of Ngati Kahungunu ki Wairarapa and Rangitane o Wairarapa.

At the 2001 census 5840 Maori were recorded as living in the Wairarapa. This is the same proportion, 14%, as the national average. Ministry of Health projections indicate that Maori as a proportion of the Wairarapa population will increase following a national trend.

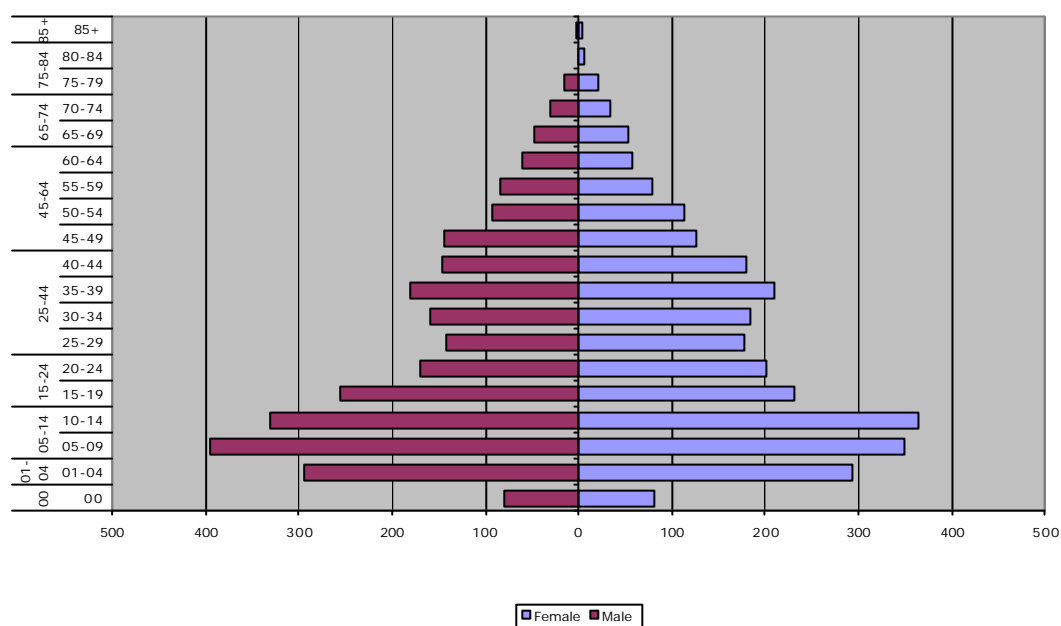
Figure 1: Wairarapa usual resident population ethnicity projections, 2001-2021



Age Structure

The Maori age profile is younger than the non-Maori profile. Maori aged under 25 years make up 56% of the Maori population in the Wairarapa and represent over 24% of the total population under 25.

Figure 2: Wairarapa Maori age sex profile, 2001

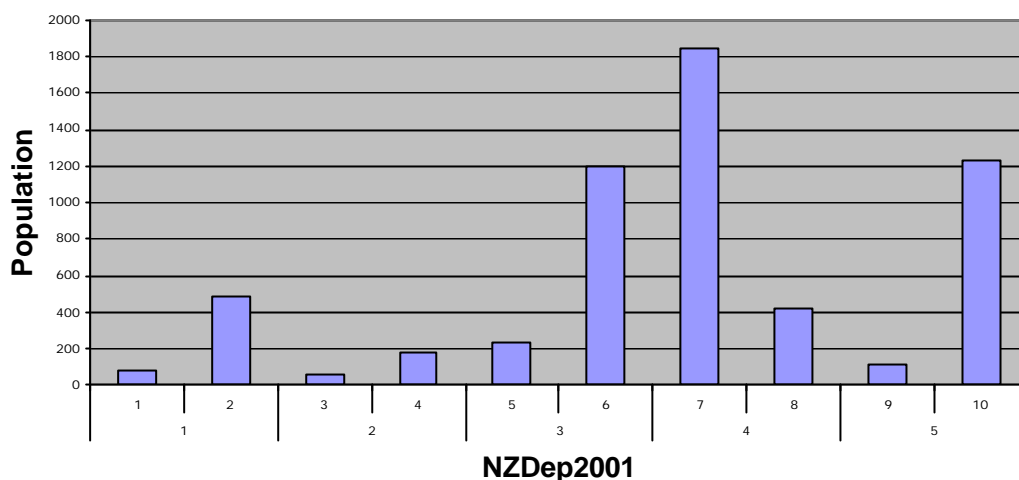


Deprivation

Wairarapa Maori live in areas of greater deprivation than the non-Maori Wairarapa Population. Over 82% of Maori live in an area with a NZDep2001 score of decile 6 or higher.

This is consistent with the national figures which show Maori are disproportionately represented in the more deprived areas of New Zealand.

Figure 3: Wairarapa Maori deprivation profile



Socioeconomic factors

Maori had a higher percentage in the labour force than both total New Zealand Maori and non-Maori in Wairarapa. In all of Wairarapa Maori had a lower unemployment rate than New Zealand Maori, however are still more than twice as likely to be unemployed than non-Maori within each of the Territorial Authorities.

Maori are more likely to earn less than \$10,000 per annum and less likely to earn more than \$50,000 per annum than non-Maori, non-Pacific people in the Wairarapa region.

Maori have an even higher proportion with no qualifications than non-Maori in the area and a significantly lower proportion with a degree than non-Maori in the area and have a lower rate than total Maori in New Zealand.

Avoidable hospitalisations

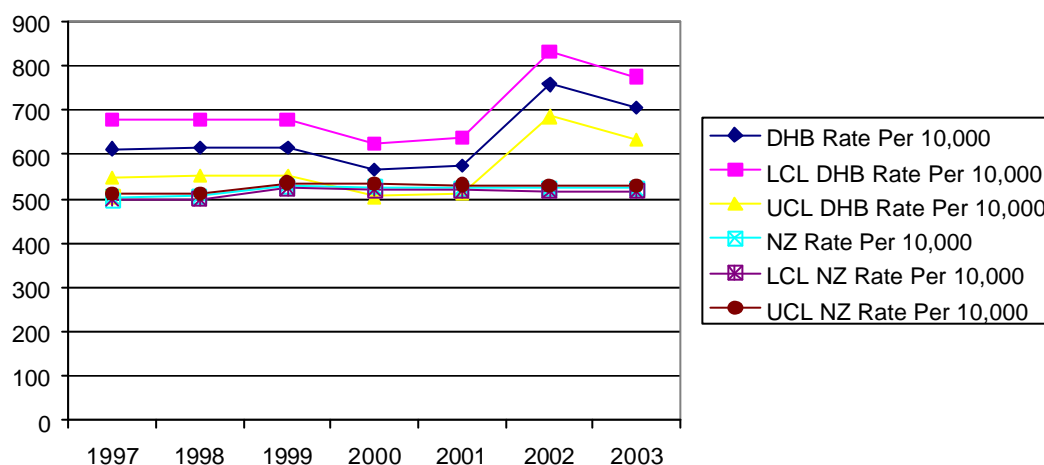
The top ten causes of avoidable hospitalisation are shown in Table 1 below and the standardised rate of avoidable hospitalisation in Figure 4. Nine of the top ten causes of mortality are the same as the national top ten. Nationally CORD features but not epilepsy.

The Maori standardised rate is increasing at a greater rate than the national rate and is significantly higher than the national rate.

Table 1: Wairarapa Maori, Top Ten causes of avoidable hospitalisation.

Condition	Number	% of DHB Total
Respiratory infections	424	5.0%
Asthma	281	3.3%
ENT infections	216	2.5%
Angina	171	2.0%
Road traffic injury	164	1.9%
Gastroenteritis	161	1.9%
Dental conditions	157	1.8%
Epilepsy	157	1.8%
Cellulitis	144	1.7%
Congestive heart failure	104	1.2%

Figure 4: Wairarapa Maori avoidable hospitalisation rate



Avoidable mortality

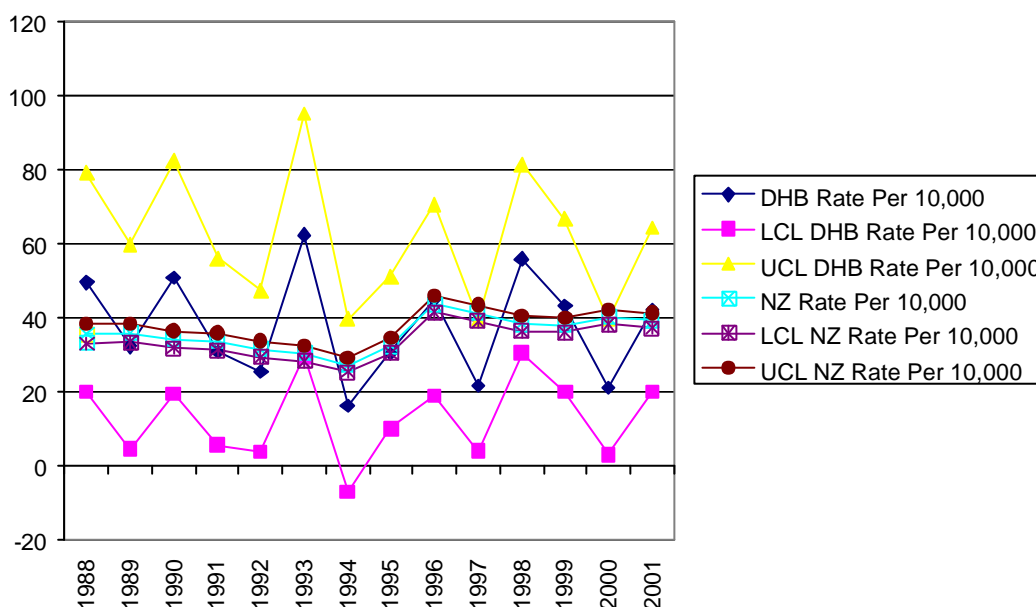
The top ten causes of avoidable hospitalisation are shown in Table 2 below and the standardised rate of avoidable hospitalisation in Figure 5. Eight of the top ten causes of mortality are the same as the national top ten. Nationally, suicide and SIDS feature but not asthma or colorectal cancer.

The Maori standardised mortality rate is decreasing and is generally lower than the national Maori mortality rate.

Table 2: Wairarapa Maori, top ten causes of avoidable death.

Condition	Number	% of DHB Total
Ischaemic heart disease	40	12.1%
Lung cancer	31	9.4%
Road traffic injury	16	4.8%
CORD	16	4.8%
Diabetes	15	4.5%
Stroke	10	3.0%
Colo-rectal cancer	8	2.4%
Breast cancer	8	2.4%
Stomach cancer	8	2.4%
Asthma	7	2.1%

Figure 5: Wairarapa Maori, Standardised Mortality rate



Maori health status priorities

This section describes the 12 Maori Health Gains Priorities identified in ‘*He Korowai Oranga*’: Immunisation, Injury Prevention, Hearing, Asthma, Smoking, Diabetes, Mental Health, Oral Health, Disability Support Services, Rangatahi Health, Sexual and Reproductive Health and, Alcohol and Drug Use.

Two additional priorities, Cardiovascular Disease and Cancer, have been further included because of their significant effects on the New Zealand and Maori health profile. Each priority is discussed in terms of its importance to Maori health nationally and from a district approach.

Immunisation

Immunisation is one of the most cost-effective and successful public health interventions however vaccine preventable diseases continue to play an important part in the health of New Zealanders. In particular measles and whooping cough have both occurred in epidemic proportions in New Zealand in recent years whilst hepatitis B contributes to morbidity and mortality in New Zealanders, particularly Maori.

New Zealand has not achieved its target of 95% of children being fully vaccinated by the age of 2 years and inequalities exist, with coverage rates being lower for Maori and Pacific people children. The Health Funding Authority 1999-2000 concluded that Maori levels of immunisation are inadequate to prevent morbidity and mortality for a range of vaccine-preventable diseases.

Injury Prevention

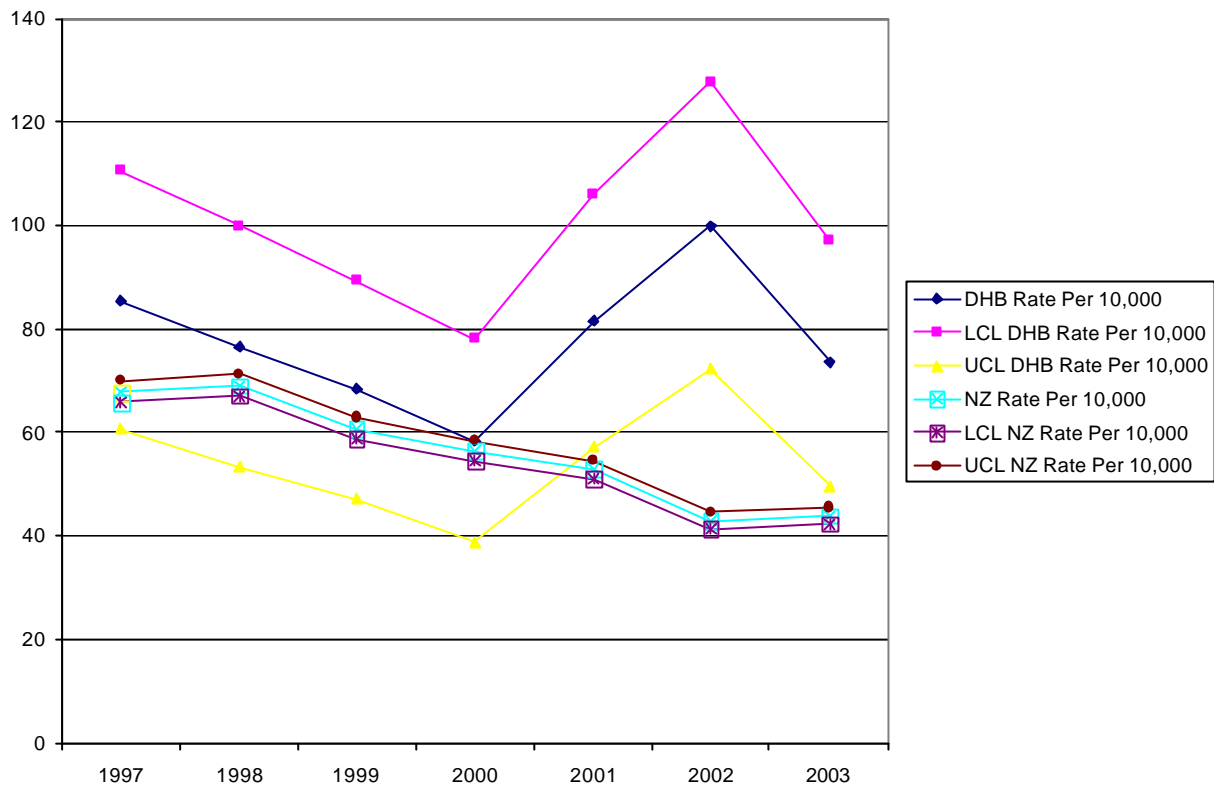
Nationally, and in the Wairarapa, injury is the leading cause of death and a significant cause of hospitalisation for Maori between 1 and 34 years of age. Maori are over-represented in motor vehicle accidents. Injury deaths are an important cause for disparity in life expectancy between Maori and non-Maori non-Pacific people ethnic groups (Ministry of Health July 2003).

The Wairarapa Maori rate is significantly higher than the NZ Maori rate.

Table 3: Wairarapa Maori age standardised injury hospitalisation rate per 10,000

Year	DHB Maori Rate Per 10,000	DHB Other rate Per 10,000	NZ Maori rate per 10,000	NZ Other Rate Per 10,000
1997	85.62	85.28	67.9	60.7
1998	76.55	80.4	69.13	61.38
1999	68.25	74.43	60.76	55.72
2000	58.34	59.43	56.48	52.9
2001	81.47	65.7	52.82	46.74
2002	100.01	70.75	42.94	41.44
2003	73.48	81.6	43.89	40.17

Figure 6: Wairarapa Maori age standardised injury hospitalisation rate per 10,000



Hearing

Hearing loss at childhood has a significant effect on speech and language development as well as emotional, social and educational development. The main cause of hearing loss in New Zealand is glue ear of which Maori children have higher rates than non-Maori.

Information on hearing screening carried out on new entrants shows that nationally Maori children show an overall new entrant failure rate of 12.6%. This is double the failure rate of the European/Pakeha children. In over 50% of DHBs the Maori failure rate exceeds 10%, however for the 2002/03 year the Wairarapa Maori failure rate was one of the lowest in the country.

The Maori failure rate for three year olds was 11.1%. As with the new entrant figures in over 45% of districts the failure rate for Maori exceeds 10%, the Wairarapa rate was 43.8%.

The large variations around the national rate may be explained by small numbers in the Wairarapa.

Table 4: Wairarapa hearing screening: failure rates by ethnicity, new entrant and three year olds

	Failure Rates (%)			
	Overall	Maori	Pacific Is	European/Pakeha
New entrant failure rates				
Wairarapa	2.5	2.5	-	-
New Zealand	8.1	12.6	16.1	5.6
Three year old failure rates				
Wairarapa	6.7	43.8	-	1.7
New Zealand	6.9	11.1	14.3	5.7

Source: NZ Hearing Screening Statistics, July 2002 – June 2003, National Audiology Centre

Asthma

The prevalence of asthma is increasing world wide and in New Zealand. Tobacco use is likely to be a key factor in higher rates of respiratory related illnesses such as asthma that is experienced by Maori. While the prevalence of asthma is similar for Maori and non-Maori, Maori child and youth experience higher levels of morbidity and hospital admission than non-Maori.

The Maori asthma hospitalisation rate is significantly higher than the NZ Maori rate and the “Other” DHB rate. The numbers of Maori deaths attributed to asthma are small and do not allow conclusions to be drawn with the NZ Maori population.

Table 5: Wairarapa Maori age standardised asthma hospitalisation rate per 10,000

Year	DHB Maori Rate Per 10,000	DHB Other Rate Per 10,000	NZ Maori Rate Per 10,000	NZ Other Rate Per 10,000
1997	70.08	28.54	48.13	24.69
1998	54.74	24.94	41.4	20.6
1999	67.79	28.17	41.16	21.52
2000	33.06	15.31	34.04	16.52
2001	42.55	15.33	32.2	16.28
2002	53.74	15.03	33.18	13.73
2003	68.77	10.33	33.51	14.37

Smoking

Smoking has a serious negative impact on Maori health. Exposure to smoke has been shown to cause adverse effects such as sudden infant death syndrome, glue ear, respiratory infections, cardiovascular disease and lung cancer. Maori have disproportionately higher numbers than non-Maori in all of these key areas.

Reducing Maori smoking prevalence is a key focus of the National Drug Policy. Maori women have a significantly higher prevalence of smoking than any other ethnic group.

The results of the National Health Survey 2002/03 show that Maori in the Wairarapa have a higher prevalence of smoking than non-Maori and Maori females than Maori males.

Diabetes

Diabetes has multiple impacts on health and the full impact on individuals and whanau is difficult to determine. Diabetes, in particular Type 2 or Non-Insulin dependent diabetes mellitus, is a growing health problem nationally and internationally. Key issues contributing to the growing incidence and prevalence are the aging population and changing diets, levels of exercise and increases in weight. There are high rates of diabetes in Maori but also in other indigenous populations.

The results of the New Zealand Health Survey 2002/03 show that the prevalence of self reported diabetes in Maori in the Wairarapa is higher than that of non-Maori.

The Maori hospitalisation and mortality rate for diabetes in the Wairarapa is higher than non-Maori but not significantly different than the NZ Maori population.

Mental Health

In New Zealand it is estimated that at any one time 20% of the population have a mental illness and 3% have a serious mental illness¹. Historical data from 1993, based on in-patient activity, suggested major differences in the way Maori used mental health services. Maori were seen as accessing services later and with greater severity at the point of entry.

In New Zealand hospital admission rates for mental health or alcohol and drug related disorders are 40% higher for Maori than for non-Maori (Ministry of Health 2001h). Maori have higher rates of presentation to crisis, acute and forensic services; and Maori are more likely than non-Maori to suffer from alcohol and drug disorders (Mental Health Commission 1998). A 2001 review of forensic services in New Zealand found that 50% of inpatients in forensic services at that time were Maori. Overall Maori represented 15% of all people receiving mental health treatment (Ministry of Health 2001).

The exact extent of access needs for Maori is unknown. However, until this need is identified, the Mental Health Commission (1998) suggests that the access target for Maori should be 6%, double that for the general population rate of 3%.

Oral Health

It is apparent that there are significant inequalities in oral health status for Maori and other low socioeconomic groups. Maori are more likely to experience poor oral health in all age groups, such as caries, tooth loss, periodontal disease, and be edentulous. Maori adults are less likely to have filled teeth than Europeans however they are more likely to have missing teeth. Maori children have worse oral health than non-Maori. Adult oral health inequalities have their origin in child inequalities, which have been linked to factors such as socioeconomic status and mothers' educational level.

Ethnic disparities are present in the oral health status of Wairarapa's children, with Maori children experiencing poorer oral health outcomes at both 5 and 12 years.

As shown in Table 6 below, the rate per thousand of dental extractions for Wairarapa Maori children in 2003/04 was significantly higher than the non-Maori, non-PI population in both the under 5s and the 5 – 12 year olds. In both ages groups it was also higher than the comparable New Zealand population.

Table 6: Dental extractions for Maori children under 12, 2003-2004, rate per 1,000

Dental extractions children under 5, 2003/04	Rate per 1,000			
	Total	Maori	Pacific peoples	Other
Wairarapa	13.0	19.7	—	9.7
New Zealand	7.8	11.3	14.0	5.5
Dental extractions children 5-12, 2003/04				
Wairarapa	6.3	8.3	—	5.5
New Zealand	4.7	5.7	6.3	4.1

Source: NMDS data, Ministry of Health

Disability Support Services

Disability is a relatively common situation for both Maori and non-Maori, with one in five New Zealanders having a disability of some type. Physical disabilities are the most common type for Maori adults and “Other” disabilities for Maori children. This “Other” category includes speech, learning and developmental disorders requiring special education. The most common cause of disability for Maori is disease or illness, followed by accidental injury.

Rangatahi Health

According to the 2001 census young Maori represent 4% of Wairarapa total youth population and 30% of the Wairarapa Maori population. Young Maori are expected to increase as a proportion of the total Wairarapa population and but decrease as a proportion of the Maori population. In 2016 the young people are projected to be 15% of the Maori population.

The health issues affecting Maori in the teenage and young population include sexual and reproductive health, suicide, injury, misuse of motor vehicles, mental health, tobacco, alcohol and drug abuse, and pregnancy and child-birth.

Mortality

The top ten conditions, in descending order, for the 15-24 age group nationally, based upon total volume are: Suicide, Unavoidable Mortality, Drowning, Asthma, Rheumatic fever-heart disease, Epilepsy, Poisoning, Alchohol-related conditions, and Fire

In the Wairarapa Injury and poisoning [92.3%] and cancer [7.7%] were the causes of mortality for young Maori, 15 – 24 years of age over the period 1998 – 2001.

Avoidable hospitalisations

The top causes of avoidable hospitalisations, for young Maori 15 – 24, in the Wairarapa are road traffic injury, kidney-urinary infection, respiratory infections, cellulitis, and suicide.

Table 7: Top causes of avoidable hospitalisation for Maori, 15-24, 1996 – 2003, Wairarapa and NZ rates per 10,000.

Year	Road traffic injury		Kidney-urinary infection		Cellulitis		Respiratory infections		Suicide	
	DHB Rate	NZ Rate	DHB Rate	NZ Rate	DHB Rate	NZ Rate	DHB Rate	NZ Rate	DHB Rate	NZ Rate
1997	89.05	45.69	44.52	17.95	17.81	23.42	26.71	15.26	53.43	18.72
1998	53.86	50.51	17.95	18.51	17.95	26.8	8.98	10.51	8.98	19.57
1999	71.88	45.51	17.97	16.44	17.97	26.16	44.92	16.14	0	17.5
2000	26.53	43.17	26.53	16.94	0	32.5	26.53	11.65	17.68	17.92
2001	71.28	40.33	40.73	18.53	20.37	34.64	0	16.69	10.18	18.33
2002	127.33	34.52	48.97	15.98	58.77	39.72	19.59	12.86	48.97	15.13
2003	48.08	40.4	67.31	16.4	48.08	36.88	48.08	14.73	19.23	17.05

Avoidable hospitalisation rates, categorised by the three subcategories of avoidable hospitalisation, rates for young Wairarapa Maori are similar to comparable New Zealand rates as shown in Table 7 below.

Table 8: Avoidable hospitalisation rate per 10,000 Wairarapa and NZ young Maori 15 – 24, 1 July 1996 – 31 Dec 2003.

Year	Ambulatory Sensitive		Injury Preventable		Population Preventable	
	DHB Rate	NZ Rate	DHB Rate	NZ Rate	DHB Rate	NZ Rate
1997	240.43	157.99	187	101.46	17.81	10.65
1998	168.76	154.89	98.74	105.17	28.73	10.54
1999	221.02	163.92	98.83	86.16	3.59	12.68
2000	157.38	163.35	53.05	75.28	37.14	12.86
2001	168.02	168.93	101.83	72.85	45.82	14.02
2002	251.71	175.58	176.3	57.88	42.12	13.58
2003	292.31	175.49	96.15	65.23	34.62	13.15

Sexual and Reproductive Health

The Ministry of Health audited the Sexual Health service in 2003 and recommended further development and planning is undertaken around guidelines in schools regarding sexual discrimination, closer links with primary care, and assistance for disabled, Maori and Pacific people populations.

Alcohol and Drug Use

Substance abuse causes significant harm to the health of New Zealanders. The most widely used drugs, alcohol and tobacco (tobacco is discussed under its own heading), account for the majority of that harm. There is evidence of disproportionate harm from alcohol and cannabis use among Maori compared to non-Maori.

Tobacco smoking

The results of the New Zealand Health Survey 2002/03 show that Maori in the Wairarapa have a markedly higher prevalence of smoking than those of non-Maori. The Maori age standardised prevalence rate was 43.4% as compared with 21.2% for non-Maori. The same study showed that, in general, Maori females had a higher prevalence of smoking than Maori males.

Alcohol consumption

The NZ Health Survey also showed that Wairarapa Maori have a higher prevalence of hazardous drinking than non-Maori.

Cardiovascular Disease

Cardiovascular disease is the leading cause of death in New Zealand, accounting for 41% of all deaths in 1999. The burden of cardiovascular disease is greatest among Maori and Pacific people. Mortality from all cardiovascular diseases is higher among Maori than the general population. Coronary heart disease is the leading single cause of death for Maori. Maori have the highest rate of hospital admissions for heart failure (nearly three times that of Europeans/Others). The chance of being dependent at 12 months post stroke is three times higher among Maori and Pacific people than among Europeans who have a stroke. Maori and Pacific people have the highest discharge rates for both rheumatic fever and rheumatic heart disease¹.

Cancer

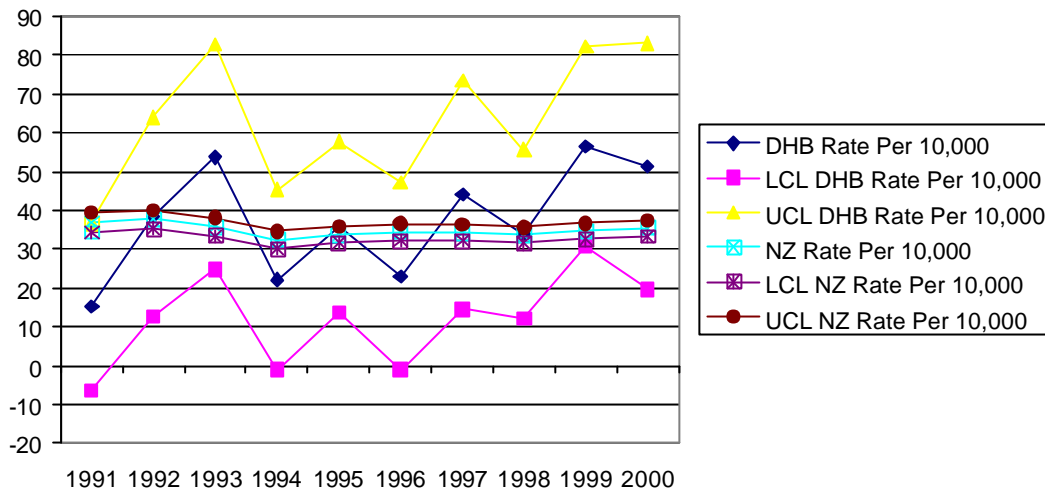
Cancer is a major cause of premature mortality and disability for New Zealanders in particular for Maori. Cancers make the second-largest contribution to health loss in the Maori population after cardiovascular disease².

The Wairarapa Maori standardised cancer registration rate is increasing greater than the national rate and is generally higher than the national rate although similar to the total Wairarapa rate.

¹ Ministry of Health (2001). *Toolkits*, <http://www.newhealth.govt.nz/toolkits/toolkits.htm> Wellington.

² Ministry of Health (2001). *Priorities for Māori and Pacific Health: Evidence from Epidemiology*. Wellington.

Figure 7: Wairarapa Maori age standardised cancer registration rate.



Summary

This health profile for the Wairarapa Maori population draws a picture of Maori health status based on the most recent data available in 2005.

It clearly demonstrates Maori health status is generally worse than that of non-Maori where information is available. It validates the need to prioritise Maori health gain and development in order to reduce and eliminate health inequalities that currently exist.

ⁱ Ministry of Health 1997