

## EDITORIAL

### Measuring Māori health status accurately – more needs doing

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As everyone knows, there is a substantial health gap between Māori and non-Māori, with non-Māori having approximately half the death rates of Māori.<sup>1-3</sup> Why is this inequality important, and why is it important to measure it accurately? There are many interpretations of the Treaty of Waitangi, but a basic understanding revolves around a governance agreement for Pākehā settlement, and a guarantee of protection of Māori interests against any negative impacts from settlement, both immediate and ongoing. Disparities in health are evidence that Māori interests are not being protected and appropriate interventions need to be put in place. Accurate health statistics by ethnic group in New Zealand are essential for monitoring our society's progress towards (or away from) equity.

Effective monitoring of disparities requires consistent and complete ethnicity data collection both within and across data-sets. This means using a standard ethnicity question (consistent with the census), allowing for identification with more than one ethnic group, and ensuring each person is asked. Self-identification underpins ethnic classification and a person's ethnicity cannot be assumed. Currently there is a poor consistency across health data sets both because of missing data and because alternative ethnicity questions are used.<sup>4</sup> To determine whether gaps are closing (or widening) over time, continuity in ethnicity data is also necessary. Inaccurate ethnicity data in health records and changes to the census ethnicity question have made it difficult to interpret trends in Māori mortality and other health outcomes.

The paper in this issue of the Journal by Smartt et al adds to the growing evidence of the difficulties in reporting ethnic differences in health status in Aotearoa/New Zealand. The authors aimed to quantify the years of life lost (YLL) per person by ethnic group. In so doing, they used mortality data from 1986 to 1994 for the numerators, and 1986 and 1991 census data to interpolate denominators for the same years. Best practice for this time-period was to use census sole-ethnic group counts for the denominator to adjust (at least partially) for the suspected undercounting of Māori deaths on mortality data relative to census data.<sup>2</sup> The authors find that the YLL per person were similar between Māori and non-Māori when using the larger (denominator) total Māori ethnic group. Using the census sole Māori ethnic group resulted in moderately elevated YLL for Māori compared to non-Māori – but still less than the twofold difference reported elsewhere using late 1990s data (page 125, ref<sup>6</sup>). They conclude that using the total Māori ethnic group for the late 1980s and early 1990s underestimates Māori mortality and support Thomas' proposal for developing standard protocols in the collection and reporting of ethnic specific health statistics.<sup>4</sup>

However, we would go further than this and say that for the early 1990s using sole ethnic group still grossly

underestimates Māori mortality rates. The reason is that the procedure used in the 1990s to assign ethnicity on death records systematically and substantially undercounted Māori. The extent of this bias became apparent with the change to ethnicity recorded on the death registration form in September 1995 – the number of Māori deaths increased by 70% between 1994 and 1996 (90% based on Māori ethnic group).<sup>5,6</sup> In a paper recently published in this Journal we found that compared to death data, 29% more 0-74 year old Māori had identified as sole-Māori on the 1991 census (or 46% for total Māori ethnic group).<sup>7,8</sup> This percentage was greater still for younger deaths, which would lead to even further underestimation of YLL due to this measure's sensitivity to mortality at younger ages. We recommend adjusting for numerator-denominator bias for mortality data in the early 1990s, and will soon be also publishing adjustment ratios for the 1980s and late 1990s. Adjustment ratios for hospitalisation data will be available if hospitalisation data are also anonymously and probabilistically linked to census data. In the meantime, sole Māori denominators should be used for calculating hospitalisation rates based on the 1991 and 2001 census extrapolations.<sup>6,9</sup>

A commitment to eliminating ethnic health disparities requires a commitment to improving ethnicity data quality. There are a number of challenges to be met. The high proportion of Māori deaths recorded as sole Māori (91%) implies the ethnicity question is still being applied as a single option question and Māori ethnic group deaths may still be under-reported.<sup>5</sup> There is evidence that Māori are now undercounted more in hospital discharge data than in mortality data.<sup>10</sup> Population health initiatives in primary care have led to increasing collection of ethnicity data in general practice, but so far very few practices have achieved a high level of data completeness. Primary care is well-placed to collect such data if senior staff understand the value of ethnicity data and support those who collect it. Data collectors need to know what happens to the information, why it is collected and how to collect it consistently and accurately. (Pamphlets to assist staff and patients are available from Bridget Robson or at <http://www.wnmeds.ac.nz/academic/gp.research/index.html>.)

A complementary strategy in the monitoring of ethnic inequalities in health is to use health data that do not require census data for the calculation of rates by ethnicity. An example is the New Zealand Health Survey, where rates of morbidity can be calculated internal to the dataset. The challenge is to ensure such surveys are designed and implemented in a way that meets Māori health information needs (eg, sufficient sample size).

Proposed explanations for ethnic inequalities in New Zealand include demographic forces, socioeconomic conditions, cultural influences, and differential access to

and quality of health care. Discrimination is recognised as underlying these determinants, while also having a direct impact on health.<sup>6</sup> Treatments and services designed for the majority of the population may not be effective for all ethnic groups. Even at the basic level of how disease outcomes are defined, ethnicity may be an important factor.<sup>11</sup> To appreciate these important differences, and to tailor services where this is appropriate, we need reliable measures of ethnicity.

Ethnic disparities are monitored in order to intervene appropriately and to judge how well our interventions are working. A concerted, rapid and comprehensive improvement in ethnic data quality is needed so we can proceed with monitoring the effect of policy changes instead of artefactual effects of data changes. The current emphasis by government on reducing inequalities in health, the increasing recognition of the role that discrimination and racism play in determining social, economic and health outcomes for Māori and the associated implications of Treaty

risk - these are all reasons why more needs to be done to measure Māori health status more accurately.

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## Highest French court awards compensation for "being born"

French obstetricians and specialists in prenatal diagnosis last week protested about a decision by France's highest court of appeal that upheld damages to a boy for "being born."

The decision states that a child can be compensated for being born with a handicap or a malformation if a mother had not had the opportunity to ask for a therapeutic abortion because she had not been informed of the risk that could have been evaluated during prenatal diagnosis.

Compensation was awarded to two boys born with Down's syndrome. The court judged that further testing, notably amniocentesis, should have been proposed and that, informed of the risk, the mothers would have chosen therapeutic abortion.

The judgment confirmed a previous hotly disputed case, the Perruche case, in which compensation was awarded last year to Nicholas Perruche, a boy who had been born with severe malformations caused by rubella contracted by his mother during pregnancy.

Doctors deemed to be responsible have to pay compensation, normally covered by insurance. Doctors say they can now be condemned for not being able to predict a malformation with 100% certainty.

In France, where every year about 14 000 babies are born with anomalies of varying severity, the Perruche precedent could encourage hundreds of parents to lodge a complaint. Dr Roger Bessis, president of the French College of Fetal Echography, said that the practice of antenatal diagnostic techniques would be threatened by insurance costs, which would inevitably rise.

Members of the associations for handicapped people demonstrated in front of the court, protesting that the decision reflected contempt for handicapped children.

A Dorozynski. *BMJ* 2001; 323: 1384.

## Can't go to sleep? Don't count on sheep

Oxford psychologists have cut through the woolly thinking about insomnia. Don't count sheep. Think waterfalls, or languid picnics in the Pyrenees, the advise.

Doctors have sound advice for sufferers who want to avoid sleeping tablets. A light meal, light exercise, a dull book and a quiet room figure highly in the prescriptions. But even the weariest insomniacs tend to snap awake as they snuggle under the duvet.

New Scientists reported last week that Allison Harvey, a cognitive psychologist at Oxford University, tested that classic recipe for numbing thought and quelling anxiety: counting sheep. Fifty volunteer insomniacs were divided into groups, a strategy was proposed for each, and the rates at which eyelids closed and breathing became regular was then monitored.

Those who imagined torpid afternoons in the south of France, or lazy twilights in the Tyrol, went to sleep on average 20 minutes earlier than they would normally do on nights when they were not concentrating on faraway places. The sheep counters actually stayed awake for longer than their normal ration of restlessness.

"Counting sheep is just too mundane to effectively keep worries away," Dr Harvey said.

Tim Radford. *Guardian Weekly* 2002, Jan 31 - Feb 6.