



This Issue in the Journal

Assessing Māori/non-Māori differences in cardiovascular disease risk and risk management in routine primary care practice using web-based clinical decision support: (PREDICT CVD-2)

T Riddell, R Jackson, S Wells, J Broad, L Bannink

Current New Zealand guidelines recommend cardiovascular disease (CVD) risk assessment be conducted for men over the age of 45 years, and women over the age of 55 years. CVD risk assessment for Māori is recommended a decade earlier—i.e. at ages 35 years for Māori men, and 45 years for Māori women. A computerised decision support programme, PREDICT, has been developed to assist general practitioners and practice nurses assess and manage CVD risk in these target groups. This paper describes the CVD risk factor status and risk management of Māori patients compared to non-Māori patients (European and other, Pacific, Indian, and other Asian) who were assessed using this tool in a large Auckland primary healthcare organisation. It demonstrates that PREDICT can be used to systematically generate CVD risk burden and risk management data for Māori and non-Māori populations in routine clinical practice to inform health services and improve care.

Māori and non-Māori differences in caesarean section rates: a national review

R Harris, B Robson, E Curtis, G Purdie, D Cormack, P Reid

Caesarean sections are becoming increasingly common in New Zealand, with differences noted by ethnicity and socioeconomic position. This study investigated the relationship between caesarean sections, deprivation, and ethnicity by examining differences between Māori and non-Māori women using national hospital data for the years 1997–2001. Results showed significant differences between Māori and non-Māori women for total, elective, and acute caesarean section, with non-Māori women more likely to have a caesarean section than Māori women. These differences persisted even after taking into account deprivation, age, number of previous births, and other available clinical factors, and thus raises the possibility that non-clinical factors may be operating.

Is it possible to distribute a scarce resource equitably? Access to invasive procedures for patients with acute myocardial infarction

P Insull, R Kejrewal, H Patel, J Christiansen, A Scott, H Hart, C Edwards, G Armstrong

This study compared waiting times for inpatient cardiac catheterisation between a hospital with on-site cardiac catheterisation facility (Auckland City Hospital) and one of its referring hospitals without such a facility (North Shore Hospital, NSH). Inpatients with myocardial infarction (resulting in heart attack/pain) waited longer for coronary angiography and percutaneous coronary intervention procedures at NSH.

Improving care to stroke patients: adding an acute stroke unit helps

C Hanger, V Fletcher, J Fink, A Sidwell, A Roche

Stroke units save lives, reduce dependency, and increase the chance of returning home. A 15-bed Acute Stroke Unit (ASU) was opened at Christchurch Hospital to complement an established Stroke Rehabilitation Unit (SRU) at the Princess Margaret Hospital. The aim of this study was to address whether patient care was improved with the establishment of the ASU. A before and after design was utilised to audit the processes of care (PoC) using an internationally validated stroke audit tool. 648 patients were admitted to the ASU in the first year. A subset of these patients were audited. The “after” cohort had more severe strokes (greater incontinence at 1 week and worse level of consciousness). Despite this length of stay, domicile on discharge and mortality outcomes were similar for the two cohorts. Processes of care improved in the “after” cohort in 27 of the 43 domains audited. Adding an ASU to complement an existing SRU can give major improvements in PoC across many different facets of stroke care. We believe this is one step closer to both the ideals of an overall coordinated stroke service and better overall care for patients with stroke.