Rheumatic fever: from disease targeting to child-centredness

Norman Sharpe

Rheumatic fever has featured regularly in this Journal over decades and yet has persistently defied control. It features again this month in a report from Siriett and colleagues which indicates little change during the past decade in the incidence in Tairāwhiti/Gisborne region where it occurs principally in Māori children associated with living and schooling within high deprivation areas.

Rheumatic fever also persists elsewhere in the North Island with cases often clustered in well recognised high risk settings. Most cases occur in South Auckland where the rates are highest in Pacific children.

New Zealanders would like to think we all live in a fair society which gives everyone a chance to live a healthy life. It is a shameful and intolerable paradox that rheumatic fever, a third world disease, still exists in New Zealand where we generally claim a first world standard of preventive and clinical care.

Rheumatic fever is a conspicuous marker of inequity. It is but one of a number of infectious diseases for which hospitalisations have increased in New Zealand during the past 20 years with clear ethnic and socioeconomic inequalities in risk. In the broadest sense, rheumatic fever is an indicator of child poverty and ill-health in New Zealand and how we value our children. Comparison of the inequitable poverty rates between children and the elderly in New Zealand is also pertinent—our children do not have a universal “Super Gold Card”.

There is a notable parallel between the regional incidence of rheumatic fever in Tairāwhiti and the recent mortality rates for ischaemic heart disease (IHD) in the same community. The most recent data show that age-standardised death rates for IHD by DHB region in 2009 were highest in Tairāwhiti, where they were significantly above the national rate and almost twice the rate in Waitemata. Also significantly above the national rate for IHD were Lakes, Taranaki, Mid-Central, Whanganui and Wairarapa.

Similar wide regional variation was also demonstrated for all-cause mortality and most major causes of mortality. In addition to this regional variation, as is well recognised, IHD mortality and also that of other major causes, were significantly greater for Māori men and women than non-Māori. The national age-standardised rate for IHD was 71 per 100,000; for non-Māori 66 and Māori 128 per 100,000.

In response to these disparities there is also a parallel between the current actions being taken to control rheumatic fever on the one hand and those being taken to improve the management of ischaemic heart disease on the other. A national rheumatic fever programme is in progress with the primary emphasis and expenditure being directed towards the management of streptococcal sore throat in high risk settings.
In the Midland region (centred on Waikato Hospital in Hamilton)—integrated with the work of the National Cardiac Clinical Network across all regions\(^6\) and with excellent local leadership and teamwork—more timely and equitable access for management of patients with acute coronary syndromes is progressing well.

Rheumatic fever control has recently been targeted as part of the cross-government Better Public Services work programme\(^7\) and this year Heart Health and Diabetes Checks for eligible adults have been mandated as a new national health target\(^8\). Both targets are the encouraging result of long-run advocacy leading to increased public and political understanding of the large existent inequalities and the need for urgency and priority for effective actions.

For success, we need to ensure that these targets and programmes are closely linked with and complemented by effective and enduring “upstream” interventions directed at primordial and environmental determinants of these diseases. The causal pathway for rheumatic fever is well understood and effective primordial prevention through a “whole of government” and “whole of community” response must be linked with the present primary and secondary prevention programmes.

The development of an effective vaccine for streptococcal disease which is on a distant horizon may eventually be realised. However this should not lessen the need to work “upstream” where the relevant determinants are child and family poverty, poor quality housing and overcrowding, as for the whole group of close-contact infectious diseases. For “non-communicable” ischaemic heart disease prevention and truly heart healthy children and adults throughout the lifecourse, these determinants remain highly relevant.

A recent collection of reports and recommendations related to child and family poverty in New Zealand is now engendering wide public support. The Advisory Group convened by the Child Health Commissioner\(^9\) has recommended several key interventions for immediate and longer term improvement. It is important that these do receive public and political support and are translated into action. They must also be viewed in the broad context of the “upstream” determinants of health and the need for evidence-based comprehensive policies and programmes which place the child at the centre within their family/whānau and communities. Only in this way will effective prevention and greater health equity be achieved and sustained. Programmes targeted selectively on downstream sequelae only will be insufficient.

The recent public discussion which has built around the issues of child and family poverty and inequity suggests that as a society we think it is unfair that some families cannot afford the basics in life.

We occupy a very lowly position amongst the OECD group of nations in terms of child health and safety\(^10\) and are now acknowledging an urgent need for transformation to a broad and comprehensive child-centred approach to policy making.

The OECD experience tells us that the greatest success in reducing poverty and inequity is achieved where there is greater commitment to progressive or proportionate universalism\(^11\). This simply means that there should be adequate support for all but more intensive provision for those with the greatest need. In New Zealand in recent decades we have actually seen the opposite, “disproportionate
universalism” with increasing relative inequalities. We have been going in the wrong direction despite good intentions.

These principles are not contentious amongst public health professionals but are not yet widely understood or agreed across our communities or by political representatives. The necessary transformation will require greater societal understanding and public support for enduring non-partisan policies which place the highest possible value on investment in our children.

Narrow targeting, a politically pragmatic response, may inadvertently reinforce the stigma of poverty. We need to find the right mix of broadly based universal and targeted approaches to support poor families, particularly those with young children.

Rheumatic fever is a visible and significant marker of child poverty. For success, targeting for control needs to be placed in the context of broadly based and balanced child and family/whānau-centred policies to guarantee a brighter future for all our children in all respects.

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Author information: Norman Sharpe, Medical Director, Heart Foundation, Auckland

Correspondence: Norman Sharpe, Medical Director, Heart Foundation, Auckland, PO Box 17-160, Greenlane, Auckland, New Zealand. Fax: +64 (0)9 5719190; email: NormanS@heartfoundation.org.nz

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