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Reducing inequalities in asthma care for children

As a follow up to BPJ 13, Professor Asher continues the theme of addressing disparities in Māori health.

All New Zealand children with asthma need:

- Access to appropriate medication
- An asthma management plan
- Appropriate consultation time
- Recording of household smoking status in clinical records
- Identification of who usually supervises their asthma inhaler use

For some children, there is a lot of ground to make up, and we each have a role. Māori children may need extra care to ensure they have the best chance of a good outcome. We need to examine our own cultural attitudes. I have learnt more from reading about our history,[1] modern interpretation of the Treaty,[2] staying on marae and starting to learn Te Reo. Each of these has helped to open my eyes, and my heart, and I hope that I am becoming a better doctor because of it.

In our consultations, what can practitioners do? Firstly, be well connected with our patients and recognise that we can do things better. We must ensure that Māori are well-informed about asthma and its management, let them know what is possible, and discuss what is wanted by Māori parents and whānau. We also need to be able to identify and work with different family dynamics and parenting structures. If we find out about barriers to care faced by whānau, we can give consideration to any role we may have in overcoming these barriers. Often we may need to "go the extra mile" to ensure that children can achieve the best possible health care outcomes. Referral to Māori health services may augment our care. Clinical audits that compare the care we deliver to children in each ethnic group against guideline recommendations may be helpful.

New Zealand is a great place to be a child – but only if you don't live in severe or significant hardship, as 26% of our children do.[3] Our society has become the most unequal in the OECD, and we have very high rates of preventable diseases.[4] Admissions to hospital for preventable diseases such as bronchiolitis, pneumonia, bronchiectasis, gastroenteritis and serious skin infections are higher than they used to be.[5] State policies since 1990 that have led to a reduction in incomes of households with children contribute to this increase in inequality,[6, 7] with many families having to choose between basic necessities. The issue of low income needs to be addressed, taking into account factors such as the retrofitting of uninsulated homes which would help respiratory health.[8] It is welcome that the costs of primary health care have reduced for many children, but after-hours primary care costs remain a significant barrier and can lead to delays in treatment.

In this whole picture, where is asthma? From the 1980s to 1990s asthma became more common in New Zealand, and symptoms of asthma in New Zealand children are still among the highest of any country in the world, though the prevalence has fallen in the last decade.[9, 10] This indicates that energies are better directed towards optimising treatment. The evidence-based Paediatric Society of New Zealand Guideline,[11] based on the SIGN guidelines, defines the approach we should take. While standards of asthma care in children have improved over the last two decades, with greater use of preventers, and the availability of spacers, many of our children still receive suboptimal care.

In particular, **Māori children with asthma have more severe symptoms compared with Pacific and European New Zealanders.**[12] They are admitted to hospital almost twice as commonly as non-Māori, and have more days off school due to asthma.[13] A community-based study of asthma-related primary care for children found ethnic differences in the provision of asthma education, parental asthma knowledge and medication that suggested there were differences in the quality of care received by Māori and Pacific children compared to "Other" ethnic group children.[14] PharmHouse data ending May 2007 suggests that the greatest unmet need for inhaled corticosteroid treatment is among Pacific and Māori children, continuing earlier trends.[15] At the same time, short acting β-agonists are more commonly used in Māori and Pacific children from birth to nine years. In view of our constitutional commitment to the Treaty of Waitangi, and our legal commitment to the UN Declarations on the Rights of Children and the Rights of Indigenous Peoples, why do we have this inequality?

There are many reasons for this disparity. The experience of some Māori with the health care system discourages rather than encourages future health seeking behaviours. Māori are more likely to report having experienced discrimination in the healthcare setting.[16] Māori are over-represented among lower socioeconomic families, where the cost of accessing health care may involve choosing between other necessities such as nutritious food.[6] There may be cultural differences in communication (verbal and non-verbal) which can result in poorer care if not recognised and addressed. We also need to accept that the New Zealand health system, and those working within it, have contributed to this disparity. The important thing is that, as doctors working in this system, we can be part of the solution.

Ma tōu rourou, ma tōku rourou, Ka ora ai nga tamariki

With your small basket and my small basket we can keep the children well

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