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Making Education Easy

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In this issue:

Tēnā koutou katoa

Nau mai ki tenei Tirohanga hou Hauora Māori. He rangahau tuhi hou e paa ana ki nga hau ora a ki te oratanga o te Māori. No reira noho ora mai raa i o koutou waahi noho a waahi mahi hoki. Ngā mihi o te wā me te Tau Hou ki a koutou katoa. Noho ora mai.

Greetings

Welcome to this issue of the Māori Health Review. Each issue attempts to bring you research relevant to the health and wellbeing of Māori. I welcome feedback and suggestions for papers/research to include in future issues and I'm pleased to hear and read about the excellent work being undertaken in Hauora Māori.

Nga mihi
Matire

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Self-rated health, health-related behaviours and medical conditions of Māori and non-Māori in advanced age: LiLACS NZ

Authors: Teh R et al.

Summary: *Te Puāwaitanga O Ngā Tapuwae Kia Ora Tonu*: Life and Living in Advanced Age, a cohort study in New Zealand (LiLACS NZ) began in 2010 and is following Māori (aged between 80 and 90 years in 2010) and non-Māori (aged 85 years in 2010) to establish predictors of successful ageing. This paper describes health-related behaviours, health conditions and self-rated health of 421 Māori and 516 non-Māori in advanced age. Self-rated health was high in both cohorts: 61% Māori and 59% non-Māori rated their health as good/very good/excellent. Eleven percent of Māori and 5% of non-Māori smoked; Māori had a higher pack-year history of smoking (9.3 vs 6.6 for non-Māori; $p<0.01$). Māori drank alcohol less frequently; 23% Māori vs 47% non-Māori had alcohol on ≥2 occasions per week ($p=0.01$). Māori were not more physically active, with median scores on the Physical Activity Scale for the Elderly of 95 for Māori vs 89 for non-Māori ($p=0.29$ in analyses adjusted for the differing proportions of each gender). Māori were not at a higher nutrition risk (49% Māori vs 38% non-Māori; $p=0.73$ after accounting for the differing proportions of each gender). More non-Māori (73%) than Māori (59%) were driving ($p<0.01$). The three most common health conditions were hypertension (83%), eye diseases (58%) and coronary artery disease (44%). Interactions between gender and ethnicity were noted for smoking and physical activity. Overall, participants had a median of 5 health conditions.

Comment: As the researchers acknowledge, in-depth studies like this are necessary in order for us to better understand the health and well-being of people of advanced age. Furthermore, the information has important implications for those of us who are perhaps 'not so advanced'!

Reference: N Z Med J 2014;127(1397):13-29

Abstract

Are hearing losses among young Māori different to those found in the young NZ European population?

Authors: Digby JE et al.

Summary: This group of researchers analysed cases from the New Zealand Deafness Notification Database (New Zealand's annual reporting system on hearing-impaired children from birth to 19 years of age, covering the periods 1982–2005 and 2009–2013) and children implanted by the Northern Cochlear Implant Programme (the public provider for cochlear implants for all children and young people living in areas north of Taupo), to determine whether young Māori have more permanent bilateral hearing loss, or less severe and profound hearing loss than NZ Europeans. In Chi-squared analyses, Māori are less likely to be severely or profoundly hearing impaired and are more likely to have mild-moderate hearing loss and significantly more bilateral losses as compared with their NZ European peers. Young Māori are more likely to be diagnosed with permanent hearing loss greater than 26 dB HL, averaged across speech frequencies, with 39–43% of hearing loss notifications listed as Māori. Cochlear implant data show that Māori are less likely to receive a cochlear implant.

Comment: Similar to previous papers describing the cause and extent of sight-loss, this research provides important evidence to inform and improve the ways we prevent, treat and manage hearing loss for Māori whānau.

Reference: N Z Med J 2014;127(1398):98-110
Abstract

Evaluation of the Canterbury under-18 seasonal influenza vaccination programme

Authors: Calder K et al.

Summary: Findings are reported from an evaluation of the performance of the 2013 Canterbury under-18 Seasonal Influenza Vaccination Programme (Christchurch, NZ). Overall uptake of influenza vaccination in 2013 was 32.9% (increased from 18.5% in 2012), close to the target of 40%. Overall uptake in primary care was higher than in the school-based programme (29.2% vs 19.7%). Māori students had higher uptake than NZ European students in the school-based programme. In primary care, uptake for both Māori and Pacific children was lower than overall uptake and there was a marked gradient in uptake by socioeconomic quintile, with 30.2% uptake in the least deprived quintile (richer areas) compared to 21.9% uptake in the most deprived quintile (poorer areas). Qualitative analysis of interviews held with participating schools identified that the health and education sectors need to improve partnership and communication, to improve vaccination uptake still further.

Comment: The stand-out point for me was that school-based programmes appear to be more successful for vaccinating under-18s than delivery of immunisation through primary care.

Reference: N Z Med J 2014;127(1398):19-27
Abstract

Pharmacy-based screening for atrial fibrillation in high-risk Māori and Pacific populations

Authors: Walker N et al.

Summary: Outcomes are reported from a study undertaken in late 2013/early 2014 to determine the feasibility of using the AliveCor® iPhone heart monitor to screen for undiagnosed atrial fibrillation (AF) in a high-risk primary care population, using a community pharmacist in Auckland as the first point of contact for screening. The study recruited 121 Māori and Pacific people aged ≥55 years who visited the All Seasons Pharmacy in Te Atatu, Auckland. Twenty participants were found to have AF upon screening (7 Māori and 13 Pacific people). Two people screened had a new diagnosis of AF and 2 known AF cases appeared not to be receiving warfarin. The heart monitor was considered easy to use by both pharmacists and participants, and participating GPs gave overwhelmingly positive feedback on the study. A larger NZ study is planned to verify these results.

Comment: Although this paper focusses more on the feasibility of implementing a screening programme (for a significant health issue for Māori), I've included it here to let readers know that it will soon be fully tested and, pending those results, perhaps made more widely available.

Reference: N Z Med J 2014;127(1398):128-31
Abstract

For more information, please go to http://www.maorihealth.govt.nz

Effects of lowering the minimum alcohol purchasing age on weekend assaults resulting in hospitalization in New Zealand

Authors: Kypri K et al.

Summary: This study sought to determine the effects on assault rates following the lowering of the minimum alcohol purchasing age in NZ from 20 to 18 years in December 1999. The study researchers examined data on weekend assaults resulting in hospitalisation throughout NZ from 1995 to 2011. Outcomes were assessed separately by gender among 3 age groups: 15–17 years, 18–19 years, and a control group consisting of 20–21-year-olds. Assault rates increased significantly among males aged 18–19 years between 1995 and 1999 (the period before the law change), as well as the postchange periods 2003–2007 (incidence rate ratio [IRR] 1.21; 95% CI, 1.05 to 1.39) and 2008–2011 (IRR 1.20; 95% CI, 1.05 to 1.37), when compared with young men aged 20–21 years. Among males aged 15–17 years, assaults increased during the postchange periods 1999–2003 (IRR 1.28; 95% CI, 1.10 to 1.49) and 2004–2007 (IRR 1.25; 95% CI, 1.08 to 1.45). There were no statistically significant effects among girls and young women.

Comment: Important research showing the impacts of health policy on health outcomes.

Reference: Am J Public Health 2014;104(8):1396-401
Abstract

Independent commentary by Dr Matire Harwood

Dr Matire Harwood (Ngapuhi) has worked in Hauora Māori, primary health and rehabilitation settings as clinician and researcher since graduating from Auckland Medical School in 1994. She also holds positions on a number of boards, committees and advisory groups including the Health Research Council. Matire lives in Auckland with her whānau including partner Haunui and two young children Te Rangiura and Waimarie.

Social and economic conditions in childhood and the progression of functional health problems from midlife into old age

Authors: Agahi N et al.

Summary: These researchers examined data from the Swedish Level of Living Survey (LNU) and the Swedish Panel Study of Living Conditions of the Oldest Old (SWEOLD) in this assessment of the associations between social and economic childhood conditions and the onset and progression of functional health problems from midlife into old age, and the extent to which potential associations are mediated by educational attainment and smoking. Data from the LNU and SWEOLD were merged, resulting in a cohort of 1765 individuals aged 30–50 years and free from functional health problems at first interview in 1968, providing up to 36 years of follow-up. In multilevel regression analyses, social and economic disadvantages in childhood (e.g., conflicts or economic problems in the family) were associated with an earlier onset and a faster progression of functional health problems from midlife into old age. In subsequent modeling, differences in educational attainment, but not smoking, explained much of the association between childhood disadvantages and trajectories of functional health problems.

Comment: See below.

Reference: J Epidemiol Community Health 2014;68(8):734-40
Abstract

Childhood socio-economic status and ethnic disparities in psychosocial outcomes in New Zealand

Authors: Marie D et al.

Summary: This study used data from the longitudinal Christchurch Health and Development Study to examine the extent to which childhood socioeconomic status (SES) could account for differences in adult psychosocial outcomes between Māori and non-Māori in a birth cohort of more than 1000 individuals studied to age 30. Data were gathered on three measures of childhood SES (family SES, family living standards, family income) and adult psychosocial outcomes including mental health, substance use, criminal offending, and education/welfare dependence outcomes. Māori ethnicity was associated with significantly ($p<0.0001$) poorer scores on the three measures of childhood SES, with estimates of Cohen's d indicating a moderate effect size. Māori ethnicity was also linked to significantly ($p<0.05$) greater rates of adverse psychosocial outcomes in adulthood. Controlling for childhood SES reduced the magnitude of the ethnic differences in psychosocial outcomes, but did not fully explain the differences between Māori and non-Māori. Adjustment for childhood SES had the strongest effect on education/welfare dependence, but weaker effects on mental health, substance use, and criminal offending.

Comment: Two papers here detailing the short- and long-term impacts of childhood poverty/adversity. One paper studied communities in Sweden, the other of course looking at similar indicators for Māori. As the authors suggest, interventions may have greater impact when directed at the macrosystem – political, societal and macro-environmental changes are needed.

Reference: Aust N Z J Psychiatry 2014;48(7):672-80
Abstract

The use of interpretive description within Kaupapa Māori research

Authors: Brewer KM et al.

Summary: This paper reports outcomes from research that combined Kaupapa Māori principles and practices (an Indigenous research approach that is decolonising and transformative) with interpretive description (a qualitative methodology used to generate knowledge relevant to the applied health disciplines) to investigate the experiences of Māori with aphasia and their whānau. The paper describes how these research approaches work together in theory, and the synergies that became apparent in practice.

Comment: I've included this paper as it confirms the significance of Kaupapa Māori research in clinical research. Oh, and I am an author!

Reference: Qual Health Res 2014;24(9):1287-97
Abstract

Climate change and the right to health for Māori in Aotearoa/New Zealand

Authors: Jones R et al.

Summary: These researchers describe the impacts of climate change on health and the determinants of health for Māori, as well as the health co-benefits of climate action. Issues relating to climate change and Māori health were analysed within a right-to-health analytical framework, which encompasses all aspects of the right to the highest attainable standard of health, including the determinants of health, and articulates those obligations and responsibilities that must be met by the State. The paper considers the obligations of the NZ government, within a right-to-health framework, to address a broad range of issues at many different levels. The researchers identify a number of important areas where the government is currently failing to meet these obligations, and they go on to describe future measures that are required in order to avoid further encroaching on the right to health.

Comment: A great paper. The authors provide detailed descriptions of the implications of climate change for Māori health if current policy settings do not change; and ways in which governments should prepare for the impacts of climate change and support Indigenous communities to adapt.

Reference: Health Human Rights J 2014;16(1):54-68
Abstract

Neighbourhood availability of alcohol outlets and hazardous alcohol consumption in New Zealand

Authors: Ayuka F et al.

Summary: This NZ research sought to determine whether an association exists between the availability of alcohol products and individual-level alcohol consumption. Measures capturing the availability of alcohol retailers were calculated for neighbourhoods across the country and then appended to a national health survey. While at the national level there was no evidence for an association between hazardous consumption and alcohol outlet access, there was evidence of associations with neighbourhood retailing for younger Māori and Pacific peoples males; younger European females; middle-aged European men; and older men. The paper concludes that these findings demonstrate how 'alcogenic' environments are linked to excessive drinking in this country, within certain vulnerable populations.

Comment: Further to the previous paper on 'alcohol policy and health outcomes', the impacts of policies will affect people to varying degrees.

Reference: Health Place 2014;29:186-99
Abstract

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