

Māori Health Review™



Making Education Easy

Issue 58 – 2015

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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 mahana 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.

This issue is dedicated to my mum's sister, Susie Hokimate Millynn, who passed away last week. She had a significant influence on me, having supported me into and through my study. Some may remember her from her role as Matron of the old Carrington hospital. Aue, ka tangi te ngākau. E te hunga mate, te hunga kua whetūrangatia moe mai rā, moe mai rā, moe mai rā.

Please have a safe and loving holiday with your whanau.

Nga mihi

Matire

Dr Matire Harwood

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The sharp end of cardiovascular disease in New Zealand: A review of acute type A aortic dissections of the Waikato

Authors: Gupta AK et al.

Summary: A search of Waikato Hospital clinical records and cardiothoracic surgery database identified 143 patients with a diagnosis of type A aortic dissections from 1990 through 2013; 54 were Māori and 89 were non-Māori patients (82 New Zealand European). While the overall 30-day mortality rate of 28% and overall 30-day survival rate of 72% is consistent with published international data, there were significant ethnic and gender disparities between Māori and non-Māori populations. The 30-day mortality rate in New Zealand European males is approximately 20% lower than that in Māori males. Māori females have the highest mortality rates with almost half succumbing within 30 days of surgery. This is more than twice that of their Māori male counterparts, more than two-and-a-half times that of their New Zealand European males and approximately 29% more than non-Māori females. Disparities identified in early survival were found to be even larger in late survival data. Moreover, Māori were found to have a significantly higher prevalence of aortic dissections (2.5 per 10,000) in the Waikato population compared to non-Māori (1.4 per 10,000) and have a 5-year earlier mean age at presentation compared to non-Māori.

Comment: I welcome the fact that the authors, although they touch on 'lifestyle factors', have focused their discussion on ways to improve health systems in order to address the inequities they have identified here.

Reference: *N Z Med J. 2015;128(1419):22-8*

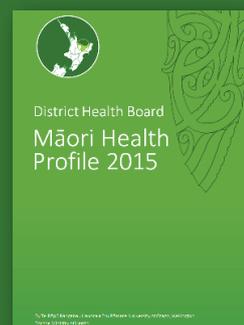
[Abstract](#)

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DHB MĀORI HEALTH PROFILES

DHB Māori Health Profiles 2015 was released on 15 October 2015. The DHB profiles present an analysis of Māori health compared with non-Māori, across a range of health related indicators and provide reliable and accessible district information that is consistent across all 20 DHBs. The reports were written by Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago, and commissioned by the Ministry of Health.



DHB Māori Health Profiles 2015 are available at www.otago.ac.nz/MHP2015



Mā mahi, ka ora: by work, we prosper – traditional healers and workforce development

Authors: Ahuriri-Driscoll A et al.

Summary: Findings are reported from a nationwide survey that was completed in 2013 by 38 rongoā Māori practitioners/rongoā clinics. Rongoā Māori is a traditional approach to health and wellbeing. This survey explored rongoā practice and service delivery. Respondents were primarily Māori (88%), female (69%), ≥50 years of age (60%), and worked as volunteers. Healers' aspirations for professional development and training emerged as a key focus; 85% of respondents stated that they would like further training. Informal, culturally-embedded training modes were the most preferred means of skill/knowledge acquisition, focusing on te reo, mātauranga and tikanga.

Comment: A fantastic summary of what's happening, and what more is needed to support the valuable mahi undertaken by our healers.

Reference: *N Z Med J.* 2015;128(1420):34-44

[Abstract](#)

Toward making inroads in reducing the disparity of lung health in Australian Indigenous and New Zealand Māori children

Authors: Chang AB et al.

Summary: This paper concerns the work being undertaken by a partnership formed in 2012 of Australian and New Zealand Indigenous leaders, paediatric and adult clinicians, laboratory scientists, and educationalists, under the umbrella of the Centre of Research Excellence (CRE) in Indigenous Children's Lung Health, funded by the National Health of Medical Research (Australia). This partnership seeks to improve the lung health of children, particularly Indigenous children, through high-quality scientific research and care. The paper describes their framework and key discussions from their second annual workshop held in 2014, which was attended by CRE partners, external experts, and higher degree research scholars involved in projects linked with the CRE. This conceptual framework shows the development of severe lung disease (chronic obstructive pulmonary disease [COPD] and/or bronchiectasis) in adulthood and the possible factors that likely influence the progression of disease. The workshop highlighted several questions concerning the airway microbiome and related host responses in children with chronic suppurative lung disease/bronchiectasis. These are discussed in the paper.

Comment: The authors' comment that "While a perception remains that Indigenous populations are "over-researched," in reality there are few RCTs relevant to ethnic disparities in clinical outcomes" is interesting. I wonder if the point is that we are 'over-researched' in research that isn't reducing inequities or contributing to our health gain. As they go on to say, some nations insist that clinical trials have equal explanatory power for Indigenous peoples. The hope is that it will build evidence-based medicine but I wonder if we still need to understand why this isn't always put into practice.

Reference: *Front Pediatr.* 2015;3:9

[Abstract](#)

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Disclaimer: This publication is not intended as a replacement for regular medical education but to assist in the process. The reviews are a summarised interpretation of the published study and reflect the opinion of the writer rather than those of the research group or scientific journal. It is suggested readers review the full trial data before forming a final conclusion on its merits.

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Health, health inequality, and cost impacts of annual increases in tobacco tax: multistate life table modeling in New Zealand

Authors: Blakely T et al.

Summary: These researchers estimated the impacts of ongoing tobacco tax increases (10% annually from 2011 to 2031) compared with no tax increases from 2011 in New Zealand, where there are large ethnic inequalities in smoking-related and noncommunicable disease burden. Sixteen tobacco-related diseases were modelled in parallel using national data by sex, age, and ethnicity, to estimate undiscounted quality-adjusted life-years (QALYs) gained and net health system costs over the remaining life of the 2011 population (n=4.4 million). Compared to the 2011 cohort exposed to no tax increases, 260,000 QALYs were gained among those exposed to annual tobacco tax increases from 2011 to 2031. Cost savings associated with this intervention amounted to US\$2,550 million over the remainder of the 2011 population's life. QALY gains and cost savings took 50 years to peak. The QALY gains per capita associated with annual tobacco tax increases were 3.7-fold higher for Māori compared with non-Māori because of higher rates of smoking and price sensitivity among Māori. Health inequalities measured by differences in mortality rates among Māori and non-Māori aged 45+ years were projected to be 2.31% lower in 2041 with ongoing tax rises, compared with no tax rises. Percentage reductions in inequalities in 2041 were maximal for 45–64-year-old women (3.01%).

Comment: The significant reduction in smoking rates over recent years may be about to plateau and the call has gone out to either develop new strategies, or to intensify what we know has worked. This research suggests that further tax increases will advance Māori health gains and reduce health inequities between Māori and non-Māori. However, the delivery of evidence-based smoking cessation must occur alongside.

Reference: *PLoS Med.* 2015;12(7):e1001856

[Abstract](#)

30-year trends in stroke rates and outcome in Auckland, New Zealand (1981-2012): a multi-ethnic population-based series of studies

Authors: Feigin VL et al.

Summary: In this study, 5400 new stroke patients aged ≥15 years were registered in four 12-month recruitment phases (1981–1982, 1991–1992, 2002–2003 and 2011–2012) in Auckland, New Zealand. Ethnicity was self-identified into 4 major groups: 79% New Zealand/European, 6% Māori, 8% Pacific people, and 7% Asian or Other origin. From 1981 to 2012, overall stroke incidence and 1-year mortality decreased by 23% and 62%, respectively. Whilst stroke incidence and mortality declined across all groups in NZ from 1991, Māori and Pacific groups had the slowest rate of decline and continue to experience stroke at a significantly younger age (mean ages 60 and 62 years, respectively) compared with New Zealand/Europeans (mean age 75 years). There was also a decline in 28-day stroke case fatality (overall by 14%) across all ethnic groups from 1981 to 2012. However, there were significant increases in the frequencies of pre-morbid hypertension, myocardial infarction, and diabetes mellitus, but a reduction in frequency of current smoking among stroke patients.

Comment: I am aware that a lot of work has been undertaken in secondary care to address the previously reported differences in care and outcomes between Māori and non-Māori presenting with stroke. Therefore it is encouraging to see the positive impacts on stroke equity from the efforts of stroke units and physicians. A similar commitment to ensuring prompt and effective management of modifiable stroke risk factors for Māori is now required.

Reference: *PLoS One.* 2015;10(8):e0134609

[Abstract](#)

The distribution and frequency of blood lipid testing by sociodemographic status among adults in Auckland, New Zealand

Authors: Exeter DJ et al.

Summary: This study examined population-based patterns of blood lipid testing by sociodemographic status among adults residing in the Auckland Region of New Zealand. Nationally held datasets (primary care enrolment, laboratory tests, pharmaceuticals, hospitalisations and mortality) were linked anonymously to identify adults aged ≥25 years without cardiovascular disease or diabetes who had their lipids tested in 2006–2010. Age, gender, ethnicity, area of residence and area-level deprivation were obtained for each person. Of the 627,907 participants included in this study, 415,992 people (66.3%) had at least one lipid test between 2006 and 2010. Annual testing increased from 24.7% in 2006 to 35.1% in 2010. Lipid test frequency increased linearly by age in a similar fashion for men and women. Indian people were 87% more likely than New Zealand European and Others (NZEO) to be tested, Pacific people 8% more likely, but rates for Māori were similar to NZEO. There was marked variation within the region, with residents of the most deprived areas less likely to be tested than residents in least deprived areas.

Comment: Further evidence of disparities in the provision of primary prevention of cardiovascular disease, by ethnicity and neighbourhood deprivation.

Reference: *J Prim Health Care.* 2015;7(3):182-91

[Abstract](#)



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TATAU KAHUKURA: MĀORI HEALTH CHART BOOK 2015 (3RD EDITION)

The Ministry of Health released *Tatau Kahukura: Māori Health Chart Book 2015 (3rd Edition)* on 9th October. The chart book provides a snapshot of Māori health in the early 2010s. This chart book, like previous editions, presents key indicators relating to the socioeconomic determinants of health, risk and protective factors for health, health status, health service use and the health system. The most recent data available for each indicator was used. The indicators align to those used in more general annual monitoring at a national level.

The chart book shows that Māori have higher rates than non-Māori for many health conditions and chronic diseases, including cancer, diabetes, cardiovascular disease and asthma. Māori also experience higher disability rates.

The Ministry intends to continue to update this profile of Māori health regularly (every three to five years).



Hard copies of the chart book can be ordered from the Ministry website www.health.govt.nz.

The publication is also available to download with the full suite of data tables.

The Green Prescription Active Families programme in Taranaki, New Zealand 2007-2009: Did it reach children in need?

Authors: Anderson YC et al.

Summary: The Green Prescription Active Families (GRxAF) programme is an intensive intervention that focuses on overweight/obese children and adolescents, and is family/whānau-based. GRxAF supports lifestyle changes through weekly sessions (nutrition advice and/or physical activity), and goal setting for the family/whānau for up to 12 months. Outcomes are reported from an audit of the GRxAF programme in Taranaki, which reviewed participant files for each referred child from May 2007 to December 2009. Ethnic affiliations for the 109 participants during the audit period were Māori (39%), New Zealand European (NZE; 58%), Pacific (3%), and Other ethnicity (1%). Mean age at entry was 10 years. Mean duration of programme involvement was 5 months. Overall, 33/60 (55%) of the participants completing the programme during the audit period graduated, having made steps towards healthy lifestyle change. Notably, fewer Māori than NZE successfully graduated (40% vs 68%; $p=0.04$). In comparison with those who attended no sessions, attendance at any activity sessions was associated with a higher likelihood of graduating (OR 3.65; 95% CI, 1.24 to 10.8).

Comment: This research answers a lot of the 'frequently asked questions' for providers and whānau. Three messages that I'll take into practice – one session is better than none; identify ways that support whānau to be 'ready'; look beyond the surface to the root causes.

Reference: *J Prim Health Care.* 2015;7(3):192-7

[Abstract](#)

Culturally and linguistically diverse patients' views of multimorbidity and general practice care

Authors: McKinlay E et al.

Summary: These researchers explain that scant data are available as to how culturally and linguistically diverse (CALD) patients experience multimorbidity and their views of care delivery in New Zealand general practice. This qualitative investigation therefore examined the views of multimorbid CALD patients about multimorbidity and the health care available in a Very Low Cost Access general practice. Ten patients were recruited from a subgroup of those on the diabetes register aged between 45 and 64 years, who had more than 3 other long-term conditions. Ethnicities were recorded as Samoan, Cook Island Māori, and Cambodian. They participated in either individual interviews or language-specific focus groups. Participants described multimorbidity as having considerable impact on their life. They reported feeling responsible for supporting their own health and many detailed self-management techniques. However, they also expressed confusion, lack of information and limited understanding of multimorbidity, particularly in relation to managing medication. Not all patients were aware of the range of available general practice services and some described difficulties in accessing general practice care.

Comment: The finding, that "despite being motivated to self-manage, this . . . group reports challenges. . ." confirms my observations. I also wonder if clinicians would benefit from strategies that improve their knowledge of, and access to, 'available services'.

Reference: *J Prim Health Care.* 2015;7(3):228-35

[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 Rangira and Waimarie.



Enhancing Māori food security using traditional kai

Authors: Mc Kerchar C et al.

Summary: This paper explores the role of Māori in enhancing Māori food security through revitalising traditional kai (food) gathering places and practices. The researchers undertook a narrative literature review of peer-reviewed and grey literature, which revealed a range of activities that are available for improving food security for Māori through the revitalising of traditional kai. Māori are now significant players in New Zealand's fishing industry, and are developing their horticultural resources. Gardening initiatives have also grown considerably in Māori communities. Enabling factors include: the return of traditional kai resources by the Crown, and successful pursuit by Māori of the legal rights to develop them; development of Māori models of governance; government policy around Māori economic development and healthy eating; and Māori leadership on the issue. Remaining barriers to revitalising traditional kai include: tensions between Government and Māori goals and models of resource management; economic pressures resulting in severely depleted fishing stocks; and pollution of marine and freshwater fish.

Comment: A great review of the literature regarding the cultural, political, historical, economical and health-related relationships between Māori and traditional kai.

Reference: *Glob Health Promot.* 2015;22(3):15-24

[Abstract](#)

Support needs of families living with children with autism spectrum disorder

Authors: Searing BM et al.

Summary: The aim of this investigation was to determine how caregivers of children with autism spectrum disorder (ASD) in New Zealand perceive the availability and helpfulness of supports used, with a particular focus on caregivers who are Māori, and who live rurally. The study recruited 92 caregivers, all of whom completed the Family Support Scale (a widely used screening tool that details a client's social networks; Hanley et al., 1998). Free text comments were invited. More support was perceived as available by non-Māori than Māori. Spouses were rated as the most helpful support. Professional helpers were rated as 'somewhat helpful'. Helpful support emphasised caring, knowledge and accessibility.

Comment: A number of whānau have described the difficulties and challenges experienced when accessing services to help with the diagnosis, and management, of ASD for their tamariki. Importantly, this research builds on previous work undertaken with Māori living with ASD to focus on the impacts on, and needs of, whānau.

Reference: *J Autism Dev Disord.* 2015;45(11):3693-702

[Abstract](#)



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