

# Māori Health Review™



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Issue 57 – 2015

## In this issue:

- > *Acute admissions for otitis media in NZ*
- > *Epilepsy is a major health issue for Māori*
- > *Adoption of the wahakura (flax bassinet) for infants*
- > *The financial costs of family caregiving at the end of life*
- > *Ethnic disparities for lower limb amputation in type 2 diabetes*
- > *Ethnicity impacts upon adolescent uptake of oral health services*
- > *Health promotion funding, workforce recruitment and turnover*
- > *Timeliness of Lead Maternity Carer engagement in NZ*
- > *Indigenous inequities in stomach cancer in NZ*
- > *Awareness of stroke risk in an urban NZ population*



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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.

Nga mihi

**Matire**

Dr Matire Harwood

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## Ethnic differences in acute hospitalisations for otitis media and elective hospitalisations for ventilation tubes in New Zealand children aged 0–14 years

**Authors:** McCallum J et al.

**Summary:** These researchers investigated ethnic differences in acute hospital admissions for otitis media (OM) and elective admissions for ventilation tubes in New Zealand children aged 0–14 years. They also reviewed first attendances at Ear Nose and Throat (ENT) Outpatient appointments during 2007–2008 by ethnicity. Records were examined from all hospital admissions of children aged 0–14 years during 2002–2008 that met the following criteria: acute admissions with an ICD-10-AM primary diagnosis code of OM; elective admissions with a primary procedure code of ventilation tube insertion. Among 0–4 year olds, acute admissions for OM were more likely among Māori and Pacific children than European children. In contrast, both Māori and Pacific children had lower rates of elective admissions for ventilation tube insertion, with ethnic differences being most marked for children from the most deprived areas. In those aged 5–14 years, Māori and Pacific children again had higher acute OM admission rates than European children. However, in contrast to the younger age group, they also had higher rates of ventilation tube insertion. ENT outpatient data for children 0–4 years revealed similar first appointment rates for European and Māori children, but lower rates for Pacific and Asian children. For the 5–14 age group, first appointment rates were higher for Māori and Pacific children than for European children. However, Māori and Pacific children in both age groups had higher rates of non-attendance at their first ENT appointments than European children.

**Comment:** The findings suggest potential barriers in access at the primary care level and to outpatient clinics (e.g. travel, parking costs, time off work, receipt of appointment) but a better understanding of the pathways in and through 'otitis media management' is required.

**Reference:** *N Z Med J. 2015;128(1416):10-20*

[Abstract](#)

## 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](http://www.health.govt.nz).

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



## Inequities in provision of seizure care across the Wellington Region

**Authors:** Joshi P et al.

**Summary:** These researchers conducted a retrospective review of 250 consecutive adult patients (aged ≥16 years) presenting to Wellington Hospital and Hutt Hospital Emergency Departments (EDs) with the primary diagnosis of a seizure between 11 February 2013 and 30 December 2013. Patient electronic records were examined to determine the proportion of patients discussed with the inpatient neurology team and referred to the neurology outpatient clinic. A significantly higher proportion of the patients presenting to Wellington Hospital ED with a seizure were referred to neurology, compared with those presenting to Hutt Hospital ED (52% vs 13.6%;  $p < 0.0001$ ). Similarly, the proportion of 'first seizure' patients referred to neurology was 63.2% for Wellington Hospital versus 9.8% for Hutt Hospital ( $p < 0.0001$ ). The difference in referral rates was primarily attributable to the difference in inpatient referrals. Māori were over-represented in the patients presenting to ED with a seizure, compared to their population composition: 16% of the seizure patients presenting to Wellington Hospital were Māori, compared to the population composition of 11.1%; 22% of the seizure patients presenting to Hutt Hospital were Māori, compared to the population composition of 17.8%.

**Comment:** I've included this paper as this is the first study I'm aware of that has looked at epilepsy and Māori. These findings and the fact that risk factors for epilepsy are higher for Māori than non-Māori (such as brain injury) would suggest that epilepsy is a major health issue for Māori. The impacts on work, school, driving and quality of life deserve further investigation.

**Reference:** *N Z Med J. 2015;128(1417):30-5*

[Abstract](#)

## The wahakura: a qualitative study of the flax bassinet as a sleep location for New Zealand Māori infants

**Authors:** Abel S et al.

**Summary:** The wahakura, a simple woven flax bassinet-like structure capable of being used in the parental bed, enables a separate sleeping surface in the bedsharing environment and is being promoted as a means to minimise the risk of sudden unexpected death in infancy (SUDI) amongst Māori. In this study, 12 Māori mothers and 10 key informants who had wahakura experience participated in face-to-face, semi-structured interviews, following Māori cultural protocols, which explored their experiences and views on the wahakura. The data were analysed using thematic analysis. The wahakura was valued for its practical appeal: its portability, for enabling bedsharing and making breastfeeding easier. It also had considerable cultural and spiritual appeal because of its native flax composition and traditional origin. Moreover, health professionals found that it facilitated antenatal engagement of Māori women. The study affirmed the acceptability of the wahakura in engaging Māori mothers and families in reducing SUDI risk.

**Comment:** The wahakura are beautiful on so many levels – to look upon; to know that they are protecting our babies; and that they are made with aroha and support wairuatanga.

**Reference:** *N Z Med J. 2015;128(1413):12-9*

[Abstract](#)

## Māori Health Review and Ministry Publications A-Z GUIDE

An **A to Z** guide is now available on the Māori Health website:  
[www.maorihealthreview.co.nz](http://www.maorihealthreview.co.nz)

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## 'No matter what the cost': A qualitative study of the financial costs faced by family and whānau caregivers within a palliative care context

**Authors:** Gott M et al.

**Summary:** This Auckland-based group of researchers explored family and whānau carers' experiences of the financial impact of caring within a palliative care context. Semi-structured interviews were held with 30 family/whānau caregivers who were either currently caring for a person with palliative care needs or had done so in the past year. The data were analysed using narrative analysis, which identified impacts and costs at the personal, interpersonal, sociocultural and structural levels. Participants reported significant costs involved in caregiving, resulting in debt for some people or even bankruptcy. A range of direct (transport, food and medication) and indirect costs (related to employment, cultural needs and own health) were reported. A multi-level qualitative analysis revealed how costs operated at a number of levels (personal, interpersonal, sociocultural and structural). The palliative care context increased costs, as meeting needs were prioritised over cost. In addition, there was confusion among caregivers as to what statutory (government) help was available in the context of 'being palliative'.

**Comment:** A really important and considered description of the wider ripples of impact that caregiving has for whānau.

**Reference:** *Palliat Med.* 2015;29(6):518-28

[Abstract](#)

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Time spent reading this publication has been approved for CNE by The College of Nurses Aotearoa (NZ) for RNs and NPs. For more information on how to claim CNE hours please [CLICK HERE](#)

## Ethnicity and risk of lower limb amputation in people with Type 2 diabetes: a prospective cohort study

**Authors:** Robinson TE et al.

**Summary:** For this study, primary care data were examined from a large national multi-ethnic cohort of patients with type 2 diabetes in New Zealand and linked hospital records. The primary outcome was time from initial data collection to first lower limb amputation. There were 892 lower limb amputations recorded among 62,002 patients (2.11 amputations per 1000 person-years), followed for a median of 7.14 years (422,357 person-years). In Cox proportional hazards analyses that adjusted for demographic and socioeconomic variables, Māori had the highest risk of lower limb amputation in comparison with Europeans (hazard ratio [HR] 1.84; 95% CI, 1.54 to 2.19), whereas East Asians (HR 0.18; 95% CI, 0.08 to 0.44) and South Asians (HR 0.39; 95% CI, 0.22 to 0.67) had the lowest risk. Adjusting for available clinical variables (smoking status, height and weight, blood pressure, HbA1c, total cholesterol/HDL ratio and albuminuria) reduced the differences but they remained substantial (HRs of 1.61, 0.23 and 0.48, respectively).

**Comment:** Ethnic disparities for diabetic complications (renal failure, lower limb amputations, eye problems and heart disease) are disproportionately higher than for prevalence; that is, Māori with diabetes are more likely to have more severe disease. There are many reasons but evidence suggests that ethnic inequalities in access to, and the quality of, diabetes care plays a role. Programmes that screen for and aggressively manage complications must prioritise Māori. However, tackling root causes is also required in any effort to eliminate disparities.

**Reference:** *Diabet Med.* 2015 May 16. [Epub ahead of print]

[Abstract](#)

## Factors influencing the use of oral health services among adolescents in New Zealand

**Authors:** Børsting T et al.

**Summary:** Cross-sectional data from the 2009 New Zealand Oral Health Survey were examined in this investigation, which sought to determine the impact of parental use of dental services, ethnicity and socioeconomic background on adolescents' recent use of dental services. The study sample consisted of 509 participants aged 12–17 years. Four in five adolescents reported having visited a dental provider within the last year (79.9%); almost half had last visited a private general dental practice (46.6%). No significant associations were found for either outcome with the primary caregiver exposure factor: most recent dental visit outcome fully adjusted odds ratio [OR] (primary caregiver not visited) 0.93 (95% CI, 0.32 to 2.72); visited provider other than private general dental practice outcome fully adjusted OR (primary caregiver not visited) 1.60 (95% CI, 0.39 to 6.57). Compared to European/Other adolescents, Māori and Pacific adolescents were significantly more likely to have not visited in the last year (Māori 12–14 years fully adjusted OR 4.20; 95% CI, 1.54 to 11.50; Pacific 12–17 years fully adjusted OR 2.61; 95% CI, 0.84 to 8.07 – the latter was not significant after adjusting for socioeconomic deprivation), and significantly less likely to have last visited a private general dental practice (Māori 12–17 years fully adjusted OR 2.16; 95% CI, 1.13 to 4.12; Pacific 12–17 years fully adjusted OR 5.15; 95% CI, 1.69 to 15.74).

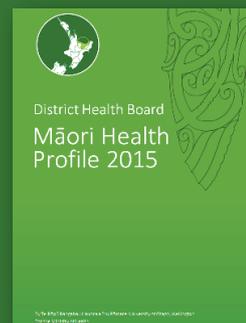
**Comment:** A significant health issue for our tai tamariki. I think cost, and even perceived costs, are major barriers here.

**Reference:** *N Z Dent J.* 2015;111(2):49-57

[Abstract](#)

## 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](http://www.otago.ac.nz/MHP2015)**

## Health promotion funding, workforce recruitment and turnover in New Zealand

**Authors:** Lovell SA et al.

**Summary:** This nationwide survey of health promotion providers sought to identify trends in recruitment and turnover in New Zealand's health promotion workforce. Surveys were sent to 160 organisations identified as having a health focus and employing one or more health promoter. Respondents, primarily health promotion managers, were asked to report budget, retention and hiring data for the period 1 July 2009 through 1 July 2010. Responses were received from 53% of organisations. Among respondents, government funding for health promotion declined by 6.3% in the year ended July 2010 and health promoter positions decreased by 7.5% (equalling 36.6 full-time equivalent positions). Among staff who left their roles, 79% also left the field of health promotion. Forty-two organisations (52%) reported employing health promoters on time-limited contracts lasting  $\leq 3$  years; this employment arrangement was particularly common in public health units (80%) and primary health organisations (57%). Among new hires, 46% (n=55) were identified as Māori.

**Comment:** There has been a lot of focus recently on personally mediated racism in the health workforce recently, particularly for medical students. This paper and the recently highlighted inequities in midwives' salaries provide good examples of institutionalised racism and sexism that exist for our health workforce.

**Reference:** *J Prim Health Care.* 2015;7(2):153-7

[Abstract](#)

## Early engagement with a Lead Maternity Carer: Results from Growing Up in New Zealand

**Authors:** Bartholomew K et al.

**Summary:** This paper describes the timeliness of lead maternity carer (LMC) engagement and discusses factors associated with timely engagement, using data from the *Growing Up in New Zealand* longitudinal study, which enrolled a diverse sample of 6822 pregnant women during 2009 and 2010. Timely engagement was defined as before 10 weeks' gestation. Of 6661 women (98%) who stated they had a LMC, 6012 (90%) reported the time taken to engage a LMC. Eighty-six to 92% of women engaged a LMC in a timely manner, depending upon the estimate of gestational time used. Factors independently associated with delayed engagement were Māori (OR 0.59; 95% CI, 0.44 to 0.80), Pacific (OR 0.63; 95% CI, 0.46 to 0.86), or Asian (OR 0.51; 95% CI, 0.39 to 0.67) ethnicity; first pregnancy (OR 0.71; 95% CI, 0.58 to 0.88); age  $< 20$  years (OR 0.62; 95% CI, 0.41 to 0.94); socioeconomic deprivation (OR 0.69; 95% CI, 0.52 to 0.92); and LMC type being a hospital midwife (OR 0.47; 95% CI, 0.38 to 0.60), or a combination of care providers (OR 0.60; 95% CI, 0.42 to 0.90).

**Comment:** As stated in the introduction of this paper, antenatal care is critical to the 'best start to life' for our tamariki, and its status reflects the level or quality of a health care system. The fact that Māori, Pacifica, Asian, young and first-time mums living in areas of social deprivation are missing out speaks volumes to the (under)valuing of these groups of women, and their pēpi, by our health system.

**Reference:** *Aust N Z J Obstet Gynaecol.* 2015;55(3):227-32

[Abstract](#)



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## Indigenous inequities in the presentation and management of stomach cancer in New Zealand: a country with universal health care coverage

**Authors:** Signal V et al.

**Summary:** These researchers investigated the presentation, management and survival of stomach cancer in a cohort of newly diagnosed Māori and non-Māori patients. They reviewed the clinical notes of all Māori from the North Island diagnosed between 2006 and 2008, and a random equivalent sample of non-Māori (final cohort n=335). Compared to non-Māori, Māori patients had a younger average age at diagnosis, a higher prevalence of congestive heart failure and renal disease, and were more likely to be diagnosed with distal disease (43% Māori vs 26% non-Māori; p=0.004). Stage and grade distributions were similar between ethnic groups. Two-thirds (66%) of stage I-III patients had definitive surgery; rates were similar between Māori and non-Māori (71% vs 68%). Māori were less likely to have surgery performed by a specialist upper gastrointestinal surgeon (38% Māori vs 79% non-Māori; p<0.01) and less likely to be treated in a main centre (44% Māori vs 87% non-Māori; p<0.01). In multivariate analyses adjusted for age, sex, stage, tumour site and comorbidity, survival was poorer among Māori (hazard ratio 1.27; 95% CI, 0.96 to 1.68).

**Comment:** Another example of unequal treatment and inequities in cancer outcomes between Māori and non-Māori in Aotearoa. I liked that the authors have highlighted the fact that this is supposedly 'a country with universal health care'!

**Reference:** *Gastric Cancer.* 2015;18(3):571-9

[Abstract](#)

## Stroke awareness and knowledge in an urban New Zealand population

**Authors:** Bay JL et al.

**Summary:** This study used a structured oral questionnaire to assess the awareness of stroke risk, symptoms, detection, and prevention behaviours in an urban New Zealand population. Although personal experience of stroke increased awareness of symptoms and their likelihood to indicate the need for urgent medical attention, only 42.7% of the respondents (n=850) identified stroke as involving both blood and the brain. Higher educational achievement (at or above a trade certificate, apprenticeship, or diploma) was associated with an increased level of awareness of stroke symptoms compared with not having any formal education. Pacific Island respondents were less likely than New Zealand Europeans to identify a number of stroke risk factors. Māori, Pacific Island, and Asian respondents were less likely to identify symptoms of stroke and indicate the need for urgent medical attention.

**Comment:** For those people that know me, stroke prevention and management is a major area of research interest. What stood out for me were the findings showing a lower likelihood of having knowledge about stroke symptoms and importance of acute stroke care amongst the Māori respondents. I asked my aunty, who'd had a major stroke but stayed home, would she have done differently if someone had explained to her that acute treatment (such as stroke unit care) is associated with better outcomes – her answer was 'yes but no one ever did!'.

**Reference:** *J Stroke Cerebrovasc Dis.* 2015;24(6):1153-62

[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 Rangiuira and Waimarie.

