

# Māori Health Review™



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Issue 77 – 2019

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### Abbreviations used in this issue

aOR = adjusted odds ratio  
 CVD = cardiovascular disease  
 HBV = hepatitis B virus  
 HCC = hepatocellular carcinoma  
 ID = infectious disease  
 OR = odds ratio  
 PoCI = process of care indicator  
 RT = radiotherapy

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Ngā mihi

**Matire**

Dr Matire Harwood

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## Distress in informal carers of the elderly in New Zealand

**Authors:** Swain N et al.

**Summary:** Findings are described from this investigation into informal, unpaid care of the elderly in New Zealand. Forty-eight carers of elderly relatives participated in telephone interviews that explored their psychological experiences, their motivations for providing care, the costs involved and their experience of aggression. Analysis of the transcripts revealed high rates of anxiety and depression amongst the carers, most of whom were partners or offspring of the carees. The carers reported a sense of feeling personally and socially restricted as a result of their caring duties, which impacted adversely on their physical and emotional health, and were reportedly the most burdensome aspect of the caring experience. Most cited love as being the driving force that motivated them to care for their relative. Economic costs involved were substantial. The study researchers note that the health system needs to provide much higher levels of emotional support for these carers to be able to continue their work.

**Comment:** I think the issues raised here are particularly relevant and important for Māori health. Whānau provide care to whānau for many wonderful reasons, including aroha. And although the study highlighted the issues for younger people providing care of older adults, I think there are similar issues at the other end of the spectrum with grandparents looking after grandchildren. As well as the financial burden, there are important health concerns including mental illness, heart disease and back injuries. Screening for common physical, emotional and social health issues with whānau caregivers, at each clinical (and often opportunistic) interaction, is recommended.

**Reference:** *N Z Med J.* 2018;131(1485):60-6

[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.



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

on Wednesday 13 February 2019, closing Wednesday 27 March 2019

## Māori living and dying with cardiovascular disease in Aotearoa New Zealand

**Authors:** Mason K et al.

**Summary:** CVD is the leading cause of mortality and morbidity for Māori, whose high burden of CVD risk factors is expected to contribute markedly to an increase in older Māori deaths within the next 30 years. This has important consequences for health and palliative care service provision in New Zealand. As discussed in this article, Māori currently face many obstacles that prevent them from easily accessing quality palliative care services. Māori families are the major caregivers at end-of-life, but can become fatigued with the challenges that accompany long-term progressive illnesses, such as CVD. Importantly, families are often burdened with the high financial costs associated with end-of-life care, in addition to the need to engage with the Western model of care at end-of-life. The Western biomedical approach represents a major barrier when holistic care is preferable. Moreover, low health literacy among many Māori is compounded by their experiences of poor relationship building and a lack of good communication with health professionals. This article calls for cultural safety training to support health professionals to work successfully with Māori. Increasing understanding of Māori cultural traditions and their holistic end-of-life preferences would help to strengthen rapport between the health sector and Māori, as well as create the respectful communication that is necessary for effective informational exchanges. Another effective way to support Māori preferences and outcomes at end-of-life would be to increase the Māori palliative care workforce. Encouragingly, a study that is currently collecting information on traditional care customs will make this information available as an online resource for whānau and the health and palliative care sectors. In future, Māori whānau experiences of caregiving could benefit greatly from palliative care services.

**Comment:** Following on from the previous article, and further evidence supporting the need for excellent research with whānau as caregivers. I look forward to seeing, and referring people to, the resource being proposed here.

**Reference:** *Curr Opin Support Palliat Care.* 2018 Nov 13. [Epub ahead of print]

[Abstract](#)

## Hepatitis B virus-related hepatocellular carcinoma presenting at an advanced stage: is it preventable?

**Authors:** Mules T et al.

**Summary:** This retrospective analysis included medical records from 368 patients diagnosed with late-stage/incurable HBV-related hepatocellular carcinoma (HCC) in New Zealand between 2003 and 2017. All were positive for hepatitis B surface antigen (HBsAg). The researchers sought to determine which factors contribute to the late presentation of HBV-related HCC. The patients were categorised into 1 of 4 groups, according to potential reasons for late presentation: no previous diagnosis of HBV infection (Group A; 40% of patients); known HBV diagnosis but not under HCC surveillance (Group B; 26%); known HBV diagnosis and under suboptimal HCC surveillance, defined as serum  $\alpha$ -fetoprotein alone (without liver ultrasound) in patients with cirrhosis or who had a positive family history of HCC, or who were under surveillance outside the recommended timeframe (Group C; 12%); or known HBV diagnosis and under optimised HCC surveillance (Group D; 23%). The median age of death was 59 years. Ethnicity was most often Māori (39%), Pacific (34%), or Asian (20%). The incidence of patients presenting with HBV-related advanced HCC increased from 4.5 cases per million people between 2003 and 2007 (Era 1) to 6.0 cases per million people between 2008 and 2012 (Era 2), then to 6.3 cases per million people between 2013 and 2017 (Era 3). The overall median survival was 138 days and did not differ significantly from survival values calculated for Eras 1, 2 and 3, respectively. Mean survival time was significantly prolonged for patients under optimised surveillance (Group D) as compared with those in Groups A, B, or C (469 days vs 90, 145 and 152 days, respectively;  $p < 0.05$  for all comparisons). A significantly higher proportion of patients in Group D compared with those in Groups A, B or C received transarterial chemoembolisation (40% vs 11%, 22% and 18%;  $p < 0.05$  for all comparisons).

**Comment:** HCC or liver cancer is the fourth most common cancer (after prostate, lung and bowel) in Māori men and Hep B is an important modifiable risk factor. If you or someone you know has had Hep B and would like to receive optimal surveillance, please register with the Hepatitis Foundation <https://www.hepatitisfoundation.org.nz> to get more information.

**Reference:** *N Z Med J.* 2018;131(1486):27-35

[Abstract](#)

## Understanding the structure and processes of primary health care for young indigenous children

**Authors:** Strobel NA et al.

**Summary:** These researchers audited records from 1,554 annual child health records that included quality of care data from 74 remote, rural and urban primary health care services throughout Queensland, the Northern Territory, South Australia and Western Australia participating in Australia's Audit and Best Practice for Chronic Disease (ABCD) programme (a continuous quality improvement programme) between 2012 and 2014. All services completed the Systems Assessment Tool (SAT), developed in 2005 as a way for indigenous health services to assess their health care systems and improve their quality of care. The analysis sought to determine whether an association exists between social and emotional wellbeing, anaemia and child neurodevelopment process of care indicators (PoCIs) for young indigenous children (aged between 3 months and 14 years at the audit date) and (i) primary health care service and child characteristics, and (ii) organisational health service structures. Approximately one-third (32%) of the records had a social and emotional wellbeing PoCI, over half (56.6%) had an anaemia PoCI and almost half (49.3%) had a child neurodevelopment PoCI. When adjusted logistic regression models were fitted to the data and clustered for health services, it was found that children aged 12–23 months were significantly more likely to receive all PoCIs compared with children aged 24–59 months. The analysis also revealed that certain items in the SAT delivery system design component were associated with the process of care provided for anaemia: every 1-point increase in assessment scores for team structure and function (aOR 1.14; 95% CI, 1.01 to 1.27) and care planning (aOR 1.14; 95% CI, 1.01 to 1.29) items increased the odds of having an anaemia PoCI by 14%. In contrast, system assessment scores were not associated with social and emotional wellbeing PoCIs or child neurodevelopment PoCIs.

**Comment:** An important paper for my primary care colleagues, supporting the need for organisational level measures to monitor process and quality of care, as well as equity (in this case there were clear differences by age) in receipt of service and health outcomes.

**Reference:** *J Prim Health Care.* 2018;10(3):267-78

[Abstract](#)

## Receipt of radiotherapy after mastectomy in women with breast cancer: population-based cohort study in New Zealand

**Authors:** Latt PM et al.

**Summary:** This analysis included data from 1,455 New Zealand women diagnosed with stage 2–3 breast cancer, all of whom satisfied the "strong recommendation" criteria for postmastectomy radiotherapy (RT) in current New Zealand National Guidelines. A total of 1,195 women (82%) underwent postmastectomy RT. In logistic regression analyses, the following factors lowered the likelihood of receiving postmastectomy RT; increasing age, residing in a rural area or a more deprived neighbourhood, being of Māori or Pacific ethnicity, having comorbidities, receiving primary cancer care in a public facility, and being diagnosed with stage 3 cancer. When analyses factored in data from only the 1,325 patients with stage disease and the 422 women diagnosed since 2010, after the current guidelines were published in 2009, the findings did not differ much from those for the entire study population.

**Comment:** This particular group has been at the forefront of monitoring unequal treatment and inequitable outcomes in breast cancer. Importantly, the evidence is driving change both regionally and nationally.

**Reference:** *Asia Pac J Clin Oncol.* 2018 Nov 15. [Epub ahead of print]

[Abstract](#)

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## Using codesign to develop a culturally tailored, behavior change mHealth intervention for indigenous and other priority communities: a case study in New Zealand

**Authors:** Verbiest MEA et al.

**Summary:** This paper describes the co-design process used to develop a lifestyle support mobile health (mHealth) programme tailored to the cultural needs and context of Māori and Pasifika in New Zealand. The co-design partnership-building process involved Māori and Pasifika partners and an academic research team that worked with communities to co-create the intervention. Focus groups were held with the end users of the mHealth programme (members of Māori and/or Pasifika communities) to understand what aspects of health and wellbeing were wanted by the community and what they considered to be important. The participatory framework of the co-design process determined how the end users envisaged the mHealth tool; this information led to prototype testing and a process of refinement based on input from the community partners regarding the final content, features and functionalities of the smartphone app, which was deemed to be the optimal vehicle for the intervention. The app was developed in both Māori and Pasifika versions so that the features and functionalities would be culturally tailored and appealing to users.

**Comment:** See next paper.

**Reference:** *Transl Behav Med.* 2018 Nov 2. [Epub ahead of print]

[Abstract](#)

## Mana Tū: a whānau ora approach to type 2 diabetes

**Authors:** Harwood M et al.

**Summary:** This article describes the rationale underlying the development of an evidence-based kaupapa Māori programme for diabetes in primary care – *Mana Tū: a whānau ora approach to type 2 diabetes*. *Mana Tū* was designed by the National Hauora Coalition, a Māori-led Primary Health Organisation (PHO) based in Auckland, in response to current ethnic and social inequities in type 2 diabetes rates, outcomes and wider determinants. This unique model of care supports people with poorly-controlled type 2 diabetes to successfully self-manage their condition. In 2017, the National Hauora Coalition was awarded a Long-Term Conditions Partnership Research grant to test the effectiveness of *Mana Tū*. The programme incorporates input from patients with type 2 diabetes and primary care doctors, and aims to address system, service and patient factors that prevent whānau to 'stand with authority', or 'mana tū', when living with a long-term condition. *Mana Tū* focuses on the wider determinants for health by identifying both health barriers (including lack of knowledge around healthy eating, what medications do and physical activity) and social barriers (including financial, housing and transport issues). Over the next 2 years, clinical, implementation and cost-effectiveness data will be collected and analysed.

**Comment:** A couple of papers from studies funded in the 'Healthier Lives He Oranga Hauora National Science Challenge'. Fantastic to see Māori and community leadership in the development of innovative solutions to long-term conditions.

**Reference:** *N Z Med J.* 2018;131(1485):76-83

[Abstract](#)



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## How differing methods of ascribing ethnicity and socio-economic status affect risk estimates for hospitalisation with infectious disease

**Authors:** Hobbs MR et al.

**Summary:** This study was conducted within the *Growing Up in New Zealand* (GUINZ) longitudinal birth cohort, which enrolled 6,822 pregnant women in the Auckland, Counties-Manukau and Waikato District Health Board areas due to deliver in 2009 or 2010. The GUINZ cohort includes representative proportions of Māori, Pacific, and socioeconomically deprived families. This analysis of GUINZ data reports rates of hospitalisation for an infectious disease (ID) within the first 5 years of life, an outcome that is known to be linked to greater socioeconomic deprivation. Using only cross-sectional data at 4.5 years of child age, this analysis included 5,602 children and compared different methods of ethnicity and socioeconomic deprivation, to determine the most accurate measures. Primary caregivers assigned the children to either a self-prioritised ethnicity (i.e. the *main* ethnic group with which their child identified), a total response ethnicity (i.e. the ethnic group or groups their child belonged to), or single-combined ethnic groups (i.e. assigning the child to a single or combination ethnic group matching their combination of ethnicities). Socioeconomic status was measured using household income, census-derived and survey-derived deprivation indices. The easiest category of child ethnicity to analyse was the self-prioritisation group. Total response was complicated by mixed ethnicity allowing overlap between groups. The researchers had to aggregate small groups for the single-combined ethnicity cohort to maintain statistical power, but this measure offered greater detail. Whichever method was used to ascribe ethnicity, Māori and Pacific children were at greater risk of ID hospitalisation, as were children in the most socioeconomically deprived households. The magnitude of these effects differed according to whichever methodology was used. Household income was affected by non-random missing data. The census-derived deprivation index offered a high level of completeness with some risk of multicollinearity and concerns regarding the ecological fallacy (i.e. making assumptions about individuals within a given decile). The survey-derived index contained an additional 8 questions but proved acceptable to participants and provided individualised data, so largely avoided the ecological fallacy concerns affecting the census-derived deprivation index.

**Comment:** One of the strengths of *Growing Up in New Zealand* is its monitoring of ethnicity, and how it is ascribed to tamariki, over time. This paper provides valuable and pragmatic information about the collection and reporting of ethnicity and socioeconomic status and the impacts on analysis and results.

**Reference:** *Epidemiol Infect.* 2018;147:e40

[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](#)

## Restricting tobacco sales to only pharmacies combined with cessation advice: a modelling study of the future smoking prevalence, health and cost impacts

**Authors:** Petrović-van der Deen FS et al.

**Summary:** These researchers used two peer-reviewed simulation models, 1) a dynamic population forecasting model for smoking prevalence and 2) a closed cohort multi-state life-table model for future health gains and costs by sex, age and ethnicity, to analyse the impacts of restricting tobacco sales to only pharmacies providing cessation advice, an intervention that could arguably accelerate progress towards the tobacco endgame in New Zealand. Compared with no such action, this intervention was associated with reductions in future smoking prevalence among both Māori and non-Māori by 2025. Moreover, this intervention accrued an estimated 41,700 discounted quality-adjusted life-years (QALYs) over the remainder of the lives of the New Zealand population projected from 2011. The majority (74%) of QALYs gained were linked to the provision of cessation advice over and above the limiting of sales to pharmacies.

**Comment:** We'd all love to see a smokefree Aotearoa by 2025, but despite great gains, there remains much more to be done. Great to see 'outside of the box' ideas like this coming through with modelling of the potential impacts/benefits.

**Reference:** *Tobacco Control*. 2018 Nov 9. [Epub ahead of print]

[Abstract](#)

## Te Oranga Hinengaro: report on Māori mental wellbeing. Results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey

**Author:** Russell L

**Summary:** Using Māori mental health data from 3 population surveys, *Te Oranga Hinengaro* discusses findings about whanaungatanga and belonging, cultural connectedness and reconnection, and cultural identity for Māori mental wellbeing. The publication describes lower levels of mental distress among Māori with a secure cultural and social identity derived from ready access to Māori culture, which encourages a sense of belonging or whanaungatanga. Those reporting stronger relationships with whānau and friends have better mental health and they feel better about life in general than Māori lacking such support, who are significantly more likely to experience symptoms of psychological distress and feel isolated. The findings highlight areas where gains in Māori mental health can be made, showing that cultural connectedness fosters social inclusion among Māori.

**Comment:** I showed this paper to my son during an argument about the time he spends on his screen. Even trying to strike up a conversation at the bus stop with other travellers is challenging these days, with most people attached to their phone. I hope this paper motivates you all to look up away from your screens and connect with people around you – because it's good for you!

**Reference:** *Health Promotion Agency/Te Hīringa Hauo, Wellington, 2018.*

[Abstract](#)

## Māori and Pasifika leaders' experiences of government health advisory groups in New Zealand

**Authors:** Came H et al.

**Summary:** This qualitative investigation explored the experiences of 6 Māori and Pasifika public health leaders with extensive experience on health policy-making advisory committees. In semi-structured interviews, the respondents reported a lack of appreciation by these committees for the knowledge and interests offered by these leaders. They described experiences of racism and tokenistic engagement in the meetings, where some struggled to be considered seriously, have a voice and make an impact. The respondents felt that their inputs were marginalised. These findings underscore how inequalities in the New Zealand health system are also present in advisory committees.

**Comment:** Many of us have been in this position – appointed to a committee for our expertise but then feeling 'unsafe'. I wish I'd had access to something like this when I was just starting, and had been able to send it to my non-Māori colleagues. Perhaps we should encourage organisations to include this paper in their governance/advisory group orientation programmes.

**Reference:** *Kōtuitui: New Zealand Journal of Social Sciences Online*. 2019;1-10

[Abstract](#)

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