

# Māori Health Review™



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Issue 66 – 2017

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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 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.

### Matire

Dr Matire Harwood  
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## Realising the rhetoric: refreshing public health providers' efforts to honour Te Tiriti o Waitangi in New Zealand

**Authors:** Came HA et al.

**Summary:** This paper details results from a nationwide telephone survey undertaken in 2014–2015 involving 162 primary health providers who were asked about the effectiveness and monitoring of their service delivery to Māori. Public health units (PHUs) reported that they actively work with Māori and Te Tiriti o Waitangi (the Treaty of Waitangi) to reduce health disparities. Furthermore, they view direct Māori engagement with development and delivery of programmes as essential. Their strategies include the appointment of designated PHU staff to positions of responsibility, establishing formal partnerships with Māori, and providing operational and strategic guidance. Some PHUs actively support the development of cultural competencies. Non-governmental organisations (NGOs) reported variable responsiveness to Māori; some stated that they prioritise service delivery and programmes for Māori, while others focus their services on European or other non-Māori ethnicities. Cited barriers included lack of resources or past difficulties engaging with Māori.

**Comment:** I recently attended the fantastic Diabetes Symposium (<http://www.otago.ac.nz/diabetes/news/otago629593.html>), at which there were a number of excellent national and international presenters. The thing that struck me was that most of them called for a 'rights-based approach' to health promotion and clinical interventions. This paper provides a similar message for public health activities.

**Reference:** *Ethn Health*. 2017;22(2):105-18

[Abstract](#)

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## Looking like a smoker, a smokescreen to racism? Māori perceived appearance linked to smoking status

**Authors:** Muriwai E et al.

**Summary:** This investigation into the factors that perpetuate Māori smoking examined links between subjective elements of Māori identity, demographic factors and perceived discrimination with smoking status. The analysis used a national probability sample of 667 individuals who self-identified as Māori. According to the results, there is no apparent significant link between smoking and core aspects of Māori identity and cultural engagement. However, the extent to which participants felt they were perceived as prototypically Māori (measured as Perceived Appearance) was reliably associated with smoking. The effect of Perceived Appearance persisted in analyses that took into account perceived experiences of discrimination and other standard demographic indicators.

**Comment:** See below.

**Reference:** *Ethn Health. 2016;1-14*

[Abstract](#)

## Changes to smoking habits and addiction following tobacco excise tax increases: a comparison of Māori, Pacific and New Zealand European smokers

**Authors:** Tucker MR et al.

**Summary:** These researchers sought to determine changes in smoking habit and psychological addiction among Māori/Pacific and New Zealand European smokers following excise tax increases. In this survey, smokers from New Zealand cities completed questionnaires at three time points before and after two annual excise tax increases from 2012 to 2014. At baseline, the ethnic groups did not differ significantly on measures of cigarettes per day or psychological addiction. However, both measures declined in a linear fashion among Māori/Pacific and NZ European smokers; daily cigarette consumption reduced at a greater rate in Māori/Pacific than NZ European smokers but dependence did not.

**Comment:** I've chosen to reflect on these two papers together, given the commonality – racism. There has been a lot in the media recently about tobacco (and others, including sugar) taxes potentially disadvantaging Māori and therefore being racist. These papers suggest that Dame Tariana was right to introduce, and then increase, tobacco taxes as they have had a positive impact on Māori smoking rates and this has shown leadership in terms of tackling an issue that many have placed in the too-hard basket. International evidence recommends careful monitoring of the impacts that taxes have on the Indigenous or peoples of non-dominant ethnicity (such as African Americans in the US), as there appears to be a point when the harm outweighs benefit.

**Reference:** *Aust N Z J Public Health. 2017;41(1):92-8*

[Abstract](#)



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## Health care experiences of Indigenous people living with type 2 diabetes in Canada

**Authors:** Jacklin KM et al.

**Summary:** It is acknowledged that specific determinants contribute to inflated rates of diabetes and other illnesses among colonised peoples, negatively affecting disease management and outcomes in unique ways. These researchers explored the health care experiences of Indigenous people with type 2 diabetes, in an attempt to clarify how such determinants are embodied and enacted during clinical encounters. This study is part of a larger investigation known as "Educating for Equity" and forms one component of an international research collaboration between New Zealand, Australia and Canada. Five Indigenous organisations from the provinces of British Columbia, Alberta and Ontario were invited to participate in sequential focus groups and interviews concerning diabetes care. Participants self-identified as Indigenous, were aged ≥18 years, had type 2 diabetes, had received care from the same physician for the previous 12 months and spoke English. A phenomenological thematic analysis framework categorised patient experiences according to 4 themes: the colonial legacy of health care; the perpetuation of inequities; structural barriers to care; and the role of the health care relationship in mitigating harm.

**Comment:** An important paper. Data shows that the greatest inequities in diabetes rates and outcomes exist between Indigenous and non-Indigenous peoples living in Australia and Canada. As I tell students, the common factor for Indigenous peoples' poor health is not our genes but colonisation. The authors suggest a potential pathway from colonisation to health outcomes, with guidance on how to intervene at each step of the path.

**Reference:** *CMAJ. 2017;189(3):E106-E112*

[Abstract](#)

## Changes in the age pattern of New Zealand suicide rates

**Author:** Snowdon J

**Summary:** This paper describes marked changes in the age patterns of male and female suicide rates in New Zealand and Australia over the last 50 years. In both countries in the 1950s and 1960s, suicide rates of male youths were low, but progressively increased across the age-range to reach a peak in old age. Between the 1960s and 1990s, suicide rates of New Zealand males in their late teens and early twenties increased three-fold. There was a comparable but smaller increase in suicide rates of young Australian males. Since the late 1990s, the suicide rates of young males have fallen in both countries. However, New Zealand youth suicide rates (Māori much more than non-Māori) in 2009–2013 were double those in Australia. Since the 1980s, similar and substantial falls in late-life suicide rates of males and females have occurred in both countries. Notably, the Māori suicide rate is almost zero in old age.

**Comment:** What more is there to say? Suicide remains one of THE most important health issues for our young Tāne, and therefore MUST remain on our health and research agenda.

**Reference:** *N Z Med J. 2017;130(148):18-26*

[Abstract](#)

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## Screening for diabetes in pregnancy in a regional area with a high Māori population

**Authors:** Daly B et al.

**Summary:** Outcomes are reported from an audit performed on routine hospital data collected from 656 women who gave birth over two 6-month periods (June to December in 2013 and 2014) in two Mid-North Island hospitals in the Bay of Plenty region, an area with a high Māori population. Just 416 (63%) women were screened for diabetes in pregnancy, including 390 (60%) for gestational diabetes mellitus (GDM) later in pregnancy. Significantly higher proportions of New Zealand European/Other and Asian women were screened compared with Māori women (75% and 77% vs 56%, respectively;  $p < 0.0001$ ). After controlling for ethnicity, women aged 35–40 years were more likely to be screened compared with those aged 25–29 years (77% vs 61%;  $p = 0.02$ ). Screening was associated with longer hospital stays following birth; screened women were more likely to stay  $>5$  days than  $<1$  day, compared with unscreened women (84% vs 56%;  $p < 0.0001$ ). A significantly higher proportion of women were screened in 2014 than in 2013 (68% vs 58%;  $p = 0.008$ ).

**Comment:** Given the higher rates of GDM, and poor antenatal outcomes associated with it, amongst Māori women, I cannot believe that only 56% of Māori women were screened for it. A major positive to take from this study is that rates improved in one year, suggesting that the audit itself may have had a positive impact on clinical care.

**Reference:** *N Z Med J.* 2017;130(1450):25-31

[Abstract](#)



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## Ethnic and geographic variations in the incidence of pancreatitis and post-pancreatitis diabetes mellitus in New Zealand: a nationwide population-based study

**Authors:** Pendharkar SA et al.

**Summary:** This analysis of data from all district health boards in New Zealand investigated the incidence of acute pancreatitis (AP), chronic pancreatitis (CP), and post-pancreatitis diabetes mellitus (DP) and the effect of ethnic and geographic variations. The study period was from 1 January 2006 to 31 October 2015. On average, 2,072 new cases of AP, CP and DP were diagnosed in New Zealand every year. Crude incidence rates (per 100,000 population per year) were 58.42 for AP, 3.97 for CP, and 7.95 for DP. Māori had the highest incidence of AP (95.21 per 100,000 population per year), CP (6.27 per 100,000 population per year), and DP (18.23 per 100,000 population per year). Across all age groups, the incidence of AP and DP was at least 1.8 and 2.6 times higher in Māori than in New Zealand Europeans, and Pacific people were more likely to develop DP than New Zealand Europeans in every age group, ranging from 1.90 times in the 45–49 group to 6.86 in the  $\geq 75$  group. Auckland/Northland had the highest incidence of AP (135.25 per 100,000 population), and CP (9.03 per 100,000 population), while Lakes/Waikato had the highest incidence of DP (20.64 per 100,000 population) in New Zealand.

**Comment:** I thought this provided very important information, and the fact that we can have such comprehensive data reflects the excellent quality of health information, particularly ethnicity data, here in Aotearoa. Yes, we could do better, as ethnicity audits show, but I look at research like this and can't help thinking that we are world leaders in terms of having access to exceptional ethnicity data to monitor health outcomes.

**Reference:** *N Z Med J.* 2017;130(1450):55-68

[Abstract](#)

## The contribution of *Helicobacter pylori* to excess gastric cancer in Indigenous and Pacific men: a birth cohort estimate

**Authors:** Teng AM et al.

**Summary:** This paper quantifies the contribution of *Helicobacter pylori* to excess gastric cancer among Māori and Pacific men in New Zealand. The study researchers calculated age-standardised gastric cancer rate ratios for 1981–2004 in Māori and Pacific men as well as European/Other men born between 1926 and 1940 (Cohort One) and between 1941 and 1955 (Cohort Two). Analyses comparing these rate ratios with those restricted to *H. pylori* prevalent populations revealed that *H. pylori* contributed substantially to excess gastric cancer incidence in Māori men (50% in Cohort One and 61% in Cohort Two) and Pacific men (71% in Cohort One and 82% in Cohort Two).

**Comment:** See below.

**Reference:** *Gastric Cancer.* 2016 Nov 16. [Epub ahead of print]

[Abstract](#)

## A screening program to test and treat for *Helicobacter pylori* infection: Cost-utility analysis by age, sex and ethnicity

**Authors:** Teng AM et al.

**Summary:** These researchers developed a Markov macrosimulation model using life-tables and morbidity data from a national burden of disease study, in order to evaluate cost-effectiveness of a *H. pylori* serology-based screening programme in New Zealand in 2011 compared with current medical practice. The cost of the screening programme was estimated at NZ\$24,600 per quality-adjusted life year (QALY) gained for the total population. The targeted screening program for Māori was more cost effective at \$11,985 per QALY gained. Compared to current practice, the total net cost of a one-off total population *H. pylori* screening programme for the 25–69-year age group was \$293 million, with estimated health gains of 14,200 QALYs over the cohort's lifetime, corresponding to a 17% reduction in the expected future gastric cancer cases and deaths.

**Comment:** Interesting and significant that these two papers were published around the same time. Hopefully, policy makers and funders take notice of the combined results.

**Reference:** *BMC Infect Dis.* 2017;17(1):156

[Abstract](#)

## Demographic and regional disparities in insulin pump utilization in a setting of universal funding: a New Zealand nationwide study

**Authors:** McKergow E et al.

**Summary:** These researchers analysed data from the New Zealand Virtual Diabetes Register and national demographic, health, and pharmaceutical dispensing data from the Ministry of Health, in order to identify patients with type 1 diabetes and assess patterns of funded insulin pump use between 2012 and 2014. Among the 13,727 patients included in this analysis, funded pump use increased from 1.8% in 2012 to 93% in 2014; uptake differed according to demographic characteristics and region. In 2014, proportionate pump use was significantly higher in females compared with males (adjusted OR 2.0; 95% CI, 1.8 to 2.3), in those aged <20 years, and in some regions. Compared with New Zealand Europeans, pumps were significantly less likely to be used by Māori (OR 0.30; 95% CI, 0.23 to 0.41), Pacific (OR 0.26; 95% CI, 0.14 to 0.46), and Asian patients (OR 0.22; 95% CI, 0.14 to 0.35). Similarly, pump uptake was lower in the most deprived socioeconomic decile compared with the least deprived areas (OR 0.36; 95% CI, 0.25 to 0.52).

**Comment:** Another example of when 'public funding' may work for some and not others; and in this case, potentially contribute to inequities in diabetes outcomes between Māori and non-Māori people with diabetes. There are similar examples of inequities in the provision of 'best practice' care in other areas including asthma, cardiovascular disease and gout. Efforts to address these issues have focused on 'service factors', with good results.

**Reference:** *Acta Diabetol.* 2017;54(1):63-71  
[Abstract](#)

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### 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.



## Māori patients' experiences and perspectives of chronic kidney disease: a New Zealand qualitative interview study

**Authors:** Walker RC et al.

**Summary:** This paper describes Māori patients' experiences and perspectives of chronic kidney disease (CKD). Thirteen Māori patients (aged 22–72 years) with CKD and who were either nearing the need for dialysis or had started dialysis within the previous 12 months participated in in-depth face-to-face semi-structured interviews at 3 dialysis centres in New Zealand, all of which offered all forms of dialysis modalities. The Māori concepts of whakamā (disempowerment and embarrassment) and whakamana (enhanced self-esteem and self-determination) provided an overarching framework for interpreting the themes identified: disempowered by delayed CKD diagnosis (resentment of late diagnosis; missed opportunities for preventive care; regret and self-blame); confronting the stigma of kidney disease (multigenerational trepidation; shame and embarrassment; fear and denial); developing and sustaining relationships to support treatment decision-making (importance of family/whānau; valuing peer support; building clinician-patient trust); and maintaining cultural identity (spiritual connection to land; and upholding inner strength/manā).

**Comment:** This research is giving patient voice to a really important health issue affecting many of us and/or our whānau. The theme around 'feeling disempowered by delayed diagnosis' is particularly concerning, and yet it is a place that we clinicians can start to work on immediately.

**Reference:** *BMJ Open.* 2017;7:e013829  
[Abstract](#)

## The prevalence of symptoms of depression and anxiety, and the level of life stress and worry in New Zealand Māori and non-Māori women in late pregnancy

**Authors:** Signal TL et al.

**Summary:** This study involved 406 Māori women (mean age, 27.6 years) and 738 non-Māori women (mean age, 31.6 years), who all completed a questionnaire in late pregnancy recording their prior history of mood disorders; self-reported current depressive symptoms ( $\geq 13$  on the Edinburgh Postnatal Depression Scale), current anxiety symptoms ( $\geq 6$  on the anxiety items from the Edinburgh Postnatal Depression Scale), significant life stress ( $\geq 2$  items on the Life Stress Scale) and dysfunctional worry ( $> 12$  on the Brief Measure of Worry Scale). Compared with non-Māori women, Māori women were more likely to report depressive symptoms (15% vs 22%), anxiety symptoms (20% vs 25%), significant life stress (30% vs 55%) and a period of poor mood during the current pregnancy (14% vs 18%). Of those who had experienced  $\geq 2$  weeks of poor mood during the current pregnancy, less than half had sought help. Younger age independently predicted depressive symptoms, significant life stress and dysfunctional worry. Women with a prior history of depression were more likely to experience negative affect in pregnancy.

**Comment:** As a GP I know that I tend to focus on postnatal depression and stress, and fail to screen for depression, stress and anxiety during the pregnancy. Reflecting on my practice, there are certainly signs of stress in the young Māori mums-to-be whether it be hormonal, sleep-related or external including financial, housing and relationship strain. I'll certainly look to identify and manage these better.

**Reference:** *Aust N Z J Psychiatry.* 2017;51(2):168-76  
[Abstract](#)

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