

# Māori Health Review™



Making Education Easy

Issue 80 – 2019

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### Abbreviations used in this issue

**CA-MRSA** = community-acquired methicillin-resistant *Staphylococcus aureus*  
**DHB** = District Health Board  
**OHCA** = out-of-hospital cardiac arrest  
**OR** = odds ratio  
**POC** = point-of-care

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Ngā mihi

**Matire**

Dr Matire Harwood

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## Incidence and outcomes of major trauma in New Zealand: findings from a feasibility study of New Zealand's first national trauma registry

**Authors:** Czuba KJ et al.

**Summary:** Findings are reported from the Outcomes after Trauma Study (OATS) investigation, which was conducted in Auckland between June 2015 and December 2016 and involved 112 adults who had survived significant physical trauma, defined as an Injury Severity Score (ISS) of  $\geq 12$ . The study researchers sought to explore the feasibility of monitoring long-term disability and functional outcomes in such patient populations in New Zealand. Data were evaluable from all participants at baseline (on discharge following their injury), from 100 at 6 months and 83 at 12 months of follow-up. Most participants (72%) were male and aged <65 years (84%). The cohort was marked by a disproportionately higher number of Māori (23%) compared with their representation in Auckland's population (10.7%). At 6 months of follow-up, 37% of the cohort were experiencing moderate disability, while 42% were categorised as having good recovery. Moderate pain was reported by 50% of the cohort at 6 months post-injury and by 52% at 12 months post-injury. A little over half (51%) reported problems with their usual activities at 6 months' follow-up.

**Comment:** Registries can be useful, particularly in terms of understanding and addressing inequities in risks, processes and outcomes. We have them for 'diseases' (e.g. the Cancer Register) and trauma/injury registries have been lauded in resource-poor nations of similar size to Aotearoa. Any benefit for Māori will require accurate ethnicity data and Māori governance.

**Reference:** *N Z Med J 2019;132(1494):26-40*

[Abstract](#)

## Predictors of non-attendance at outpatient endoscopy: a five-year multi-centre observational study from New Zealand

**Authors:** Lamba M et al.

**Summary:** This analysis of endoscopy non-attendance rates and associated factors examined data from 58,434 consecutive endoscopy appointments at the Canterbury (n=33,697) and Auckland (n= 24,737) DHBs during a 5-year period (1 April 2012 to 31 March 2017). The following procedures were included: gastroscopy, colonoscopy and endoscopic retrograde cholangiopancreatography. Overall, 2,694 (4.6%) appointments were not attended. In multivariate analysis, Māori (OR 3.0; 95% CI, 2.63 to 3.42) and Pacific Peoples (OR 3.1; 95% CI, 2.7 to 3.55) were significantly more likely than Europeans to miss appointments. Patients residing in the socioeconomically most deprived areas (NZDep decile 10) had higher rates of non-attendance compared with those from NZDep decile 1 (OR 2.13; 95% CI, 1.72 to 2.63). Non-attendance rates were also higher among males (OR 1.43; 95% CI, 1.32 to 1.56) and among the Auckland DHB patients (2.28; 2.08 to 2.50).

**Comment:** One point that stood out for me was that most of the geographic difference was explained by different patient reminder systems. A systematic approach is therefore required.

**Reference:** *N Z Med J 2019;132(1496):31-8*

[Abstract](#)

## Insiders' insight: discrimination against Indigenous peoples through the eyes of health care professionals

**Authors:** Wylie L, McConkey S

**Summary:** This Canadian investigation invited healthcare providers and decision-makers to identify any challenges that they see facing Indigenous patients and families when accessing health services in a large city in southern Ontario. The respondents identified widespread discrimination against Indigenous people as a major challenge for the healthcare system. Analyses of the interview data highlighted 3 key discrimination subthemes: (1) an unwelcoming environment; (2) stereotyping and stigma and; (3) practice informed by racism. The study researchers state that these findings highlight the importance of going beyond simply making health services more welcoming and inclusive, if healthcare access is to be meaningfully improved for Indigenous peoples. Moreover, they note that practice norms shaped by biases informed by discrimination against Indigenous people are widespread and compromise standards of care. The researchers call for a quality improvement strategy designed to address the problem throughout the healthcare system. As they note, addressing the problem in this way will require not only a significant shift in the attitudes, knowledge, and skills of healthcare providers, but also, healthcare organisations will need to establish accountabilities to ensure equitable health services for Indigenous peoples.

**Comment:** Please read the whole paper, especially the quotes from health professional participants, who were forthright, open and challenging.

**Reference:** *J Racial Ethn Health Disparities* 2019;6(1):37-45

[Abstract](#)



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## Factors across life associated with remaining free from functional limitations despite lifelong exposure to socioeconomic adversity

**Authors:** Kok AAL et al.

**Summary:** These researchers sought to determine which specific factors across life may protect some older-aged individuals from developing functional limitations despite exposure to socioeconomic adversity. The study analysed data from 1,973 participants in the UK Medical Research Council National Survey of Health and Development, followed from birth until age 60–64 years. Functional limitations were defined as reporting difficulty with  $\geq 1$  of 16 activities at age 60–64 years. Lifetime socioeconomic adversity was based on socioeconomic trajectories, categorised into 3 adversity levels (low, intermediate and high). Functional limitations in the low, intermediate and high adversity groups affected 23%, 30% and 44% of men, respectively, and 49%, 55% and 61% of women, respectively. A 'Resilient' group was identified that consisted of 196 participants, all of whom had a high level of adversity but no functional limitations. Analyses compared psychosocial factors and health-related behaviours between the 'Resilient' group and 5 groups with other combinations of adversity and limitations. Compared with the 'Resilient' group, people with high adversity/limitations were more likely to have childhood illness (19% vs 12%) and to be obese between the ages of 43 and 64 years (70% vs 55%). Other factors that were also associated with resilience included higher adolescent self-management, lower neuroticism, engaging in volunteer work and physical activity (age 60–64 years) and not smoking. There was no evidence that marital status and contact frequency were associated with resilience.

**Comment:** I think we all agree that the prevention of childhood adversity is paramount. However, there are a couple of key points here. As clinicians, we must do what we can to prevent/manage childhood illness (immunisations, best practice) and support children into physical activity. As citizens, we need to acknowledge the cumulative impacts of stigma associated with chronic illness, obesity, poverty and adversity.

**Reference:** *J Epidemiol Community Health* 2019;73(6):529-36

[Abstract](#)

# Ministry of Health developing a new Māori Health Action Plan

*“He manako te koura e kore ai.”*

He Korowai Oranga: Māori Health Strategy sets the overarching framework to guide the Government and the health and disability sector to achieve the best health outcomes for Māori. Refreshed in 2014 with the new direction of pae ora (healthy futures), He Korowai Oranga continues to provide a strong platform for Māori health for the future. However, despite some improvements in Māori health in recent years, there is more work to be done.

To support and further embed He Korowai Oranga, the Ministry of Health are developing a new Māori Health Action Plan (the Action Plan). This presents new opportunities to strengthen the Ministry and health and disability system's focus to better respond to Māori.

The vision for He Korowai Oranga is to achieve pae ora – healthy futures, which includes three interconnected elements: mauri ora – healthy individuals; whānau ora – healthy families; and wai ora – healthy environments. This vision will be achieved by creating a cultural and system shift that enables partnership and participation of Māori at all levels of the health and disability system.

It is important the new Action Plan is developed through engagement with Māori communities and the health and disability sector. This feedback will help to shape the priorities and actions included in the final Action Plan. The Ministry are currently finalising the details of engagement with the health sector to take place across the country in the second half of August. There will also be opportunities to provide feedback via an online survey and written submissions.

The online Māori health action plan hub will go-live on the Ministry website in early August. Please visit [www.health.govt.nz/HKO](http://www.health.govt.nz/HKO) to find out more.





## Relationship between socioeconomic factors, distribution of public access defibrillators and incidence of out-of-hospital cardiac arrest

**Authors:** Dicker B et al.

**Summary:** These researchers sought to determine whether relationships exist between socioeconomic factors, geospatial distribution of public access defibrillators (PADs) and incidence of out-of-hospital cardiac arrest (OHCA) within New Zealand. The analyses revealed that cardiac arrest incidence increases with increasing sociodemographic deprivation. Between 1 October 2013 and 30 June 2016, the incidence of OHCA events per 100,000 person-years in the most deprived areas of the NZDep2013 decile was double that of the least deprived areas (156.5 vs 78.0). Analyses of the 2013 Census data revealed that for every 1% increase in the proportion of Māori within a specific census area unit (CAU), the OHCA rate increased significantly by 1.0% ( $p=0.001$ ); similarly, OHCA rates within a CAU increased significantly with each 1% increase in the proportion of Pacific Peoples (an increase of 0.6%;  $p=0.005$ ), over 65-year-olds (3.7%;  $p<0.001$ ) and males (3.7%;  $p<0.001$ ). An analysis of data obtained from a registry containing all registered PAD locations throughout New Zealand in 2018 revealed that NZDep decile 10 areas had the lowest coverage of PADs compared with less deprived areas (a median 81% of these areas contained PADs vs 65% of NZDep decile 10 areas).

**Comment:** The findings are consistent with institutionalised or systematic “processes, attitudes and behavior which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping” (see [The Stephen Lawrence Inquiry](#)). People are dying as a result. Please check on the availability of PADs in your communities. For example, there has been a push to have them at marae in Te Tai Tokerau, with St John staff providing the training.

**Reference:** *Resuscitation* 2019;138:53-8

[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.



## 2019 DIETITIANS NZ CONFERENCE

Monday 2nd & Tuesday 3rd September

University of Auckland (Grafton Campus)

<https://event.dietitians.org.nz/>

2019 theme ‘Closing the Gap’ focuses on our most vulnerable communities and the equity challenge that currently exists within the NZ health sector.

With a speaker line-up that includes 2014 New Zealander of the Year, Dr Lance O’Sullivan and business leader & entrepreneur Laura Humphreys.



## Did New Zealand’s new alcohol legislation achieve its object of facilitating public input? Qualitative study of Māori communities

**Authors:** Kyri K et al.

**Summary:** The introduction of alcohol legislation in 2012 by the New Zealand government was proclaimed as being designed to facilitate community input on decisions concerning alcohol. These researchers investigated the experience of Māori communities with the new law, by obtaining submissions made to local governments and submitters from iwi (tribes), hapū (sub-tribes/clan groups) and Māori service providers who were invited to participate in semi-structured interviews with Māori researchers. Analyses of the interview transcripts revealed that the respondents had invested heavily in human resources to write submissions informed by technical knowledge of liquor licensing and relevant research. In their experience, local governments had not meaningfully engaged with the content of their submissions, and on multiple occasions had not updated participants on how the consultation was progressing. In the opinion of some respondents, the fact that the alcohol industry had easier access to local politicians was likely to mean that outcomes would reflect industry interests.

**Comment:** Disappointing, but perhaps not surprising.

**Reference:** *Drug Alcohol Rev* 2019;38(4):331-8

[Abstract](#)

## The impact of the introduction of a point-of-care haematology analyser in a New Zealand rural hospital with no onsite laboratory

**Authors:** Blattner K et al.

**Summary:** This evaluation assessed the impact of introducing point-of-care (POC) haematology testing in Hokianga Hospital, a small rural hospital in the far north of New Zealand serving a predominantly Māori population of 6,500 people. POC biochemistry has been available at the hospital since 2010, but it lacks an onsite laboratory. This 3-part investigation was conducted at Hokianga Hospital over 4 months in 2016. In Part 1, hospital doctors completed a form before and after POC haematology testing, recording test indication, differential diagnosis, planned patient disposition and impact on patient treatment. In Part 2, focus group interviews were conducted with hospital doctors, nurses and a cultural advisor. Part 3 of the study involved an analysis of cost versus tangible benefits. Analysis of the 97 POC haematology tests (97% were performed during the acute clinical presentation; 72% were performed out of hours) revealed a significant reduction in the average number of differential diagnoses, from 2.43 pre-testing to 1.7 post-testing ( $p<0.05$ ). Haematology POC testing was also associated with significant reductions in the number of patients transferred and significantly increased the number of patients discharged home (both  $p<0.05$ ). Analyses of the interview transcripts revealed 3 key themes: impact on patient management, challenges, and the commitment to ‘make it work’. POC haematology positively impacted patient management and clinician confidence, mainly by increasing diagnostic certainty. Respondents cited challenges surrounding the testing as issues relating to the hidden costs of implementing the analyser and its associated quality assurance programme in a remote-from-laboratory setting. A cost-benefit analysis demonstrated savings in healthcare costs.

**Comment:** Useful for those of you considering, or arguing for, POC in your areas.

**Reference:** *Rural Remote Health* 2019;19(2):4934

[Abstract](#)

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## Evolving threat of community acquired methicillin resistant *Staphylococcus aureus* upper extremity infections in the South Pacific: 2011–2015

**Authors:** Abeysekera N et al.

**Summary:** This analysis examined data from 1,252 patients with upper extremity infections requiring operative management between 2011 and 2015 at the Auckland Regional Hand Unit; culture-positive community-acquired methicillin-resistant *Staphylococcus aureus* (CA-MRSA) upper extremity infections were identified in 150 (12%) patients. An increasing annual trend was observed. Notably, in 2014 and 2015, CA-MRSA rates in Māori and Pacific Islander populations exceeded 15%, satisfying the US Center for Disease Control (CDC) threshold for empiric antimicrobial cover.

**Comment:** I think more work needs to be done in this area. Our clinic is seeing higher than anticipated numbers of children and adults with MRSA. A small audit showed that at least half had been treated in hospital only, that is, they had not been seen in primary care. As the authors suggest, a review against best practice is warranted.

**Reference:** *J Hand Surg Asian Pac* 2019;24(2):129-37

[Abstract](#)

## Factors supporting retention of Aboriginal Health and Wellbeing staff in Aboriginal health services: a comprehensive review of the literature

**Authors:** Derooy S, Schütze H

**Summary:** This Australian research identified 26 English-language papers published between 2002 and 2017 that focused on retention of Aboriginal Health and Wellbeing staff, or health staff in comparable roles working in Aboriginal health services. The work of Aboriginal Health and Wellbeing staff is essential for successful primary healthcare for Aboriginal communities, but is often compromised by high rates of stress, burnout, and staff turnover, impacting on primary healthcare delivery to Aboriginal peoples. This investigation explored organisational factors that help support the retention of Aboriginal Health and Wellbeing staff in Aboriginal Health services. Five key themes were found to contribute to the retention of Aboriginal Health and Wellbeing staff in Aboriginal Health Services: (1) feeling culturally safe and secure within the workplace; (2) teamwork and collaboration; (3) supervision (internal or external supervision with a counsellor outside the organisation), with strong managerial leadership and support from peers (to debrief, reflect, receive emotional support and strengthen coping mechanisms); (4) professional development (the opportunity for skill development and role progression), and; (5) recognition (of work load, quality of work performed, being trusted to work autonomously, with financial remuneration reflecting the high pressure of the role).

**Comment:** Being well aware of the issues recruiting and retaining Māori and Pacific staff at clinics serving Māori and Pacific communities, I thought this paper provided an excellent review of the potential solutions. I was particularly interested in two points made by the authors to reduce turnover – formal peer support (as staff/management may think that informal is enough) and recognition (both fiscal and other forms of ‘sponsorship’).

**Reference:** *Int J Equity Health* 2019;18:70

[Abstract](#)

## Bringing a health equity perspective to the prevention of child abuse and neglect

**Authors:** Klevens J, Metzler M

**Summary:** These researchers contend that it is possible to reduce persistent inequities in risk for child abuse and neglect (CAN) by using a health equity perspective, giving all children the opportunity to reach their full health and life potential. The chapter describes how the World Health Organization’s Commission on the Social Determinants of Health framework supports this goal. The researchers use the framework to explore possible mechanisms and pathways that contribute to current inequities in risk for CAN, within their US-based experience. They then discuss how this framework has been used to guide and monitor activities in the Centers for Disease Control and Prevention’s Essentials for Childhood Initiative. The chapter concludes with suggestions as to how this work can successfully prevent child abuse and neglect, and other childhood adversities by assuring safe, stable, nurturing environments for all children and families.

**Comment:** I recently attended the hui for the Māori Inquiry into Oranga Tamariki and was asked by a reporter why health professionals had been invited. I recalled this paper, which is just one chapter of a book called *Re-visioning public health approaches for protecting children*. The entire book is excellent, but I found this chapter a useful reminder for clinicians on why and how we are part of the problem, and the solution. It is not Kaupapa Māori, but I think much of it aligns with the recommendations John Rangihau and others made some 30+ years ago (<https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/archive/1988-puaoteatatu.pdf>).

**Reference:** In Lonne, B., Scott, D., Higgins, D., & Herrenkohl, T. (Eds.) *Re-visioning public health approaches for protecting children*. Springer, 2019: pp. 197-220.

[Abstract](#)

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