Indigenous health: burden or opportunity?

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Solutions for Indigenous health problems may hold the key to solving those of other disadvantaged groups in our society

There is a substantial and chronic shortage in the health care workforce for Indigenous Australians.[1] Of the many factors that contribute to this, one is the lack of suitably trained and willing doctors. In the past 25 years, there have been major efforts to improve medical education to address this problem. As shown by Paul et al in this issue of the Journal (*page 522*)[2] and others,[3,4] medical schools have slowly changed their curricula to include material specific to Indigenous health, several Australian medical schools have introduced recruitment and support programs for Indigenous and rural students and, more recently, clinical colleges and other medical organisations have promoted cultural awareness activities.[5,6]

These initiatives rely largely on providing information to a (presumably receptive) profession, based on the underlying premise that most Australian doctors are not aware of the cultural mores and the socioeconomic and health problems of Aboriginal and Torres Strait Islander peoples. It seems to be assumed that informing them will be enough to change their attitudes and behaviours, and that this will improve access to health care for Indigenous Australians.

However, despite these and many other initiatives, as several articles in this issue of the Journal (Hayman et al [*page 485*],[7] Zhao and Dempsey [*page 490*],[8] Ho et al [*page 496*],[9] and Harrington et al [*page 507*][10]) indicate, lack of timely access to quality medical care continues to be a major problem. The ongoing inertia suggests that despite current educational efforts, the medical profession may still have poorly conceived attitudes and beliefs about Indigenous peoples' health that are unrelated to the realities of Indigenous life, and an impediment to overcoming the workforce shortages. Three separate but related issues — competing priorities, victim-blaming and individualism — stand out.

We all prioritise information. As we know from our attempts to help patients change unhealthy lifestyle practices, raising awareness is only a part of what is needed to change behaviour. Few smokers believe that smoking is healthy but, for many, smoking cessation is not at the top of the list of their personal priorities, as they have other pressing issues which seem much more acute than dealing with nicotine addiction.[11] It may be that Indigenous health is just not high on the list of many doctors' priorities.

Victim-blaming is still prevalent in community attitudes,[12] and may also be reflected in the beliefs of some doctors.[13] Why should doctors, whose central focus is to alleviate suffering, harbour attitudes that are less than helpful for marginalised and disenfranchised Australians? A paradoxical explanation may be our reverence for those who overcome adversity. Since the Enlightenment, people of European descent have been enthralled with the concept of struggle. This is demonstrated in Australian political campaigns, in which all the candidates vie for underdog status. Two sentinel publications that irrevocably changed the 20th century focused on struggle — Darwin's *The Origin of Species* (1859; struggle for life) and Marx and Engel's tract *The Communist Manifesto* (1848, struggle of classes). In our modern age of plenty, we seem to have a deep-seated need to have our own struggles acknowledged. Unfortunately, many of those who have struggled successfully show disdain for those who have, in their judgement, not struggled hard enough to overcome adversity.

Another societal attitude that may find expression among medical professionals and diminish their interest in Indigenous Australians is individualism. The more we progress and the more individualistic we become, the less we show concern for those who are most unlike "us" (see McDermott [*page 519*[14]). Recently, in Queensland, an Aboriginal Elder who had a stroke at a bus stop outside the tertiary institution at which she is an "Elder-In-Residence" was left to suffer on the footpath by other Australians.[15] Ironically, the people who eventually stopped to help her were Japanese students. In their own "otherness", the foreign students were unencumbered by the prejudices and racial stereotypes that afflicted the many other bypassers.

Can we continue to perceive the problems of Indigenous Australians with dispassionate disinterest? The causes of Indigenous morbidity and mortality are now dominated by non-communicable chronic diseases (see Zhao and Dempsey [*page 490*][8]), such as diabetes and heart disease; these conditions are also the major causes of morbidity and mortality in the non-Indigenous population. It is possible that if health professionals work with Indigenous communities to find solutions for chronic disease in Indigenous populations, they will be repaid with solutions for epidemics of the same diseases among non-Indigenous Australians. This point was made last year in a keynote address by Professor John Hamilton (former Dean of Newcastle medical school in New South Wales) to the *Towards Unity For Health* conference in Vietnam. He recalled a public statement made by our first author (LGP), that if non-Indigenous Australians would walk with Indigenous Australians to find solutions for the health problems of Indigenous people, their gift in return will be a better understanding of non-Indigenous people who are marginalised and disenfranchised. Professor Hamilton later bore witness to this phenomenon when he was able to apply the lessons he had learned from the recruitment program for Indigenous Australians at the Newcastle medical school to the creation of a new medical school in his native England, which needed a program to reach out to a group of disadvantaged young people.

We can look on the terrible state of Indigenous health in Australia, and see a burden for health care, or we can see an opportunity. We know that simple and relatively inexpensive measures in Indigenous health can make substantial differences.[16] In many Indigenous communities, grandparents are the primary carers for young children. An extra 5 years of life for a "nanna" can mean that these children do not have to lose the single most important adult figure in their life during the vulnerable adolescent years; this would translate into many more years of health for future generations.

As a profession, we are confronted with an opportunity to give Indigenous health priority, upskill ourselves with appropriate

cultural and clinical training, cease to blame the victims, and acknowledge that "their" health problems are actually "our" problems. We can loose the bonds of individualism and recover an understanding of what it means to live in a community. The state of Indigenous health ought to matter to all Australians, and it should be regarded as an opportunity rather than a burden. Let us not miss the opportunity.

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