

Enduring dilemmas of Indigenous health

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Recognising the tensions inherent in all efforts to bring about change in Indigenous health outcomes

Health promotion and illness prevention in Aboriginal and Torres Strait Islander communities remain central to closing the gap between Indigenous and non-Indigenous health outcomes. The National Indigenous Health Equality Targets identify the need for effective health promotion activities targeting smoking, alcohol consumption, oral health, chronic disease, nutrition, exercise, mental health, and social and emotional wellbeing.¹ An expanding body of research considers the barriers to effective health promotion and illness prevention in Indigenous contexts.²⁻⁶

In this issue of the Journal (page 602), Taylor and colleagues present findings from their study of Indigenous participation in cardiac rehabilitation,⁷ an important form of secondary prevention. Their study identified many barriers to participation, including the challenges associated with extended family responsibilities, the sociocultural inappropriateness of cardiac rehabilitation programs, and historical barriers to using mainstream services. The barriers they identified are recurring themes in many evaluations of Indigenous health promotion and health care services.²⁻⁶ At the heart of these recurring themes are two central tensions of Indigenous development: the tension between cultural difference and statistical equality, and the problem of marginalised identities.

For a range of historical, geographical, socioeconomic and cultural reasons, the conditions required for a “healthy life” as defined by Western society (including nutritious food, smoking cessation, and accessing mainstream health services) are found less often in Indigenous than non-Indigenous populations. While many Indigenous communities and individuals see this as a major problem, for others, unhealthy behaviour and conditions are a normal part of life. For some Indigenous people, the environments and behaviour linked to good health are associated with non-Indigenous society and akin to a “foreign” culture. They may even be seen as antithetical to an Indigenous identity.

Medical anthropologist Kate Senior’s research at Ngukurr in the Northern Territory provides one example of this. In this Indigenous community, hygiene practices are associated with the missionaries who required mission residents to keep their houses spotless. One older woman told Senior that, “I tell my own daughter how to do it, but all she says is ‘we’re not *Munanga* [white] — we don’t want to live *Munanga* way’”.⁸ Walking for exercise is similarly considered a *Munanga* behaviour and regarded with amusement. Others have also noted that the approach taken to hygiene interventions in Indigenous communities in the past promoted resistance to, rather than adoption of, health-promoting behaviour.⁹

Taylor et al suggest that attitudes such as these may be due to social exclusion. As one of the Aboriginal patients in their study commented in regard to health services, the legacy of colonisation and discrimination is that “it remain[s] in the psyche of the Aboriginal people that mainstream services are only there for other people”.⁷ In addition to social exclusion, others have argued that cultural difference plays a role in the “foreignness” of health services and healthy behaviour. A study of smoking in an Aborigi-

nal community describes how integral the practice is to family interaction and ceremonial exchange, and how refusing to smoke can produce unbearable social isolation and friction — the “passing around and sharing of cigarettes is part of the social fabric of the community”.¹⁰ Anthropologist Maggie Brady has shown that alcohol misuse is similarly integrated into Indigenous social practices and identities.¹¹

Such findings imply that calling for health-promoting change may mean changing the “social fabric” of some Indigenous communities. While some working in Indigenous health see this as a necessary and positive change, others are troubled by the thought that certain cultural practices may be compromised in the pursuit of good health. For example, there is debate over the role of “demand sharing”¹² (where Indigenous people are obliged to accommodate even unreasonable demands from their kin) in preventing improvements in health behaviour and socioeconomic status. An anthropological study found that some non-Indigenous researchers working in Indigenous health expressed concern that healthy lifestyles may require a rejection of such kinship obligations.¹³ The overarching tension here is between respecting cultural difference and addressing disadvantage.¹⁴ Regardless of whether one believes that aspects of Indigenous culture will be changed by efforts to improve health, many non-Indigenous people working in Indigenous health harbour fears of eroding Indigenous culture and repeating the mistakes of the assimilation era.¹³

Taylor et al also report that, paradoxically, the widespread dissemination of Indigenous health statistics in the media reduces the likelihood of Indigenous people accessing cardiac rehabilitation services.⁷ They found that knowledge of the poor health status of the Indigenous population was disempowering and reduced Indigenous people’s motivation to engage with health promotion, an effect also found by others.¹⁰ This is one aspect of the broader problem of marginalised identities. When we recognise a distinct and disadvantaged group within the general population, we inadvertently and unavoidably label that population as inherently disadvantaged, even in the act of trying to address this disadvantage.¹⁵

The publication of Indigenous health statistics draws attention to health problems and attracts resources to deal with them. However, for Indigenous Australians, it also creates a sense that an Indigenous identity is tied to inevitable ill health, homogenising the varied health and wellbeing of individual Indigenous people. This effect may contribute to the reluctance of Indigenous Australians in the Australian Capital Territory to identify as Indigenous when accessing mainstream health services, as reported by Scotney and colleagues in this issue of the Journal (page 609).¹⁶ The notion of the statistical “gap” between Indigenous and non-Indigenous health outcomes that forms the centrepiece of current Indigenous policy is an illustrative example. Even when Indigenous health is improving at the same rate as non-Indigenous health, the gap remains constant. In fact, if measured as a relative proportion, the



gap will *increase* as the absolute health of the Indigenous population steadily improves.

Recognising these tensions does not mean that we should cease any form of intervention for Indigenous health — which would be unethical — or enter into a state of “paralysis by analysis”. Instead, health practitioners should accept that such tensions are inherent in all efforts to bring about change in Indigenous health contexts. We should be aware of the wider debates concerning cultural difference and statistical equality, and the dilemma of marginalised identities. Such awareness helps us to recognise these issues as they arise across the many diverse contexts of Indigenous affairs. It also makes explicit the ongoing need to manage these tensions in our work with Indigenous people.

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