

Closing the gap in cardiovascular risk for Aboriginal and Torres Strait Islander Australians

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High absolute cardiovascular risk in young Aboriginal and Torres Strait Islander people urgently requires action



The recent 10-year review of the Closing the Gap Strategy, which aims to eliminate the difference in life expectancy between Aboriginals and Torres Strait Islanders and other Australians by 2031, found that the life expectancy of both Indigenous and non-Indigenous Australians increased between 2005–2007 and 2010–2012, but the gap has not closed significantly, and is still about 10 years.¹ As reiterated by Sir Michael Marmot in his recent *MJA* editorial,² the Close the Gap campaign highlights the importance of addressing underlying social determinants of health, engaging with Aboriginal and Torres Strait Islander leaders, increasing the emphasis on chronic disease, enhancing primary health service capacity, and shifting to a preventive health focus.³



The research reported by Calabria and her colleagues in this issue of the *Journal* is an exemplar of these approaches.⁴ Overseen by an Aboriginal Reference Group and undertaken in cooperation with Aboriginal co-authors, this study provides evidence regarding deficiencies that undermine preventing cardiovascular disease in Aboriginal and Torres Strait Islander people. Overseen by an Aboriginal Reference Group and including Aboriginal co-authors, this study provides evidence relevant to preventing cardiovascular disease in Aboriginal and Torres Strait Islander people.

Ischaemic heart disease remains the leading cause of death among Aboriginal and Torres Strait Islander Australians, with a population rate 1.8 times that for non-Indigenous Australians; the ratio is even higher in young people, with 12.0% of deaths in 30–39-year-old Indigenous Australians caused by heart disease, compared with 3.8% for non-Indigenous people in this age group.⁵ While screening for risk factors is recommended for Aboriginal and Torres Strait Islander peoples from 12 years of age, calculating absolute cardiovascular risk in those not already known to be at high risk is currently recommended only from 30 years of age.⁶ Adding 5% to the calculated 5-year risk score is recommended in communities with a high prevalence of cardiovascular risk factors and disease.⁶

Until now we have lacked the evidence provided by Calabria and her co-authors with their analysis of population data from the

Australian Aboriginal and Torres Strait Islander Health Survey. The authors quantified the risk of cardiovascular disease and the use of lipid-lowering medication by Indigenous Australians. They found that 4.7% of participants aged 25–34 years without pre-existing cardiovascular disease were at high absolute risk of cardiovascular disease, larger than the proportion of 45–54-year-old non-Indigenous Australians at high absolute risk (4.0%).⁷ The authors also found that only 53% of Indigenous Australians aged 35–75 years with established cardiovascular disease and 42% of those at high risk were receiving lipid-lowering therapy. These findings highlight the importance of ensuring that Aboriginal and Torres Strait Islander Australians have access to treatment known to reduce cardiovascular risk. Limitations of the study included undersampling of people living in non-private dwellings, the higher rates of biological samples from remote areas, and data on medication use more likely to be missing for smokers and participants at greater disadvantage, meaning that the study may have overestimated the rate of treatment.⁴

Further research is required to quantify the contribution that appropriate management of cardiovascular risk would make to closing the gap in life expectancy. However, a focus on primary health care, including prevention, was included in a comprehensive range of strategies that are yet to be fully implemented in response to the high rates of cardiovascular disease in Aboriginal and Torres Strait Islander peoples.⁸

Cardiovascular screening guidelines should be revised to reflect the new evidence of higher risk at younger age in Aboriginal and Torres Strait Islander people. Primary care professionals should identify Indigenous Australian patients and be aware of their increased risk and the lower age of onset of cardiovascular disease. We need to ensure all health facilities provide culturally safe, trauma-informed, supportive environments in which to work with patients and communities.⁹ Aboriginal Community Controlled Health Services provide many lessons in best practice.¹⁰ Access of Aboriginal and Torres Strait Islander people to recommended therapy should be facilitated through programs, such as the Pharmaceutical Benefits Scheme co-payments made within the Closing the Gap framework, or we will continue to fail to ensure equity of life expectancy.

As well as concentrating on risk factors, such as lack of access to affordable, healthy food and higher smoking rates, we need to consider the “causes of the causes”, as Marmot has termed them:¹¹ social marginalisation, educational and employment inequities, and the racism and trauma that are too often the experience of Aboriginal and Torres Strait Islander Australians. Employment of Indigenous people in the health sector not only creates jobs, but facilitates delivery of culturally appropriate health care. As leaders in their communities, health practitioners are well positioned to influence opinion and advocate policies that tackle these antecedents of illness,¹² with benefits that extend beyond cardiovascular disease.

The findings of Calabria and her colleagues indicate the importance of working alongside Aboriginal and Torres Strait Islander

people. Similarly, closing the gap in life expectancy needs a fresh approach, including genuine engagement with Aboriginal and Torres Strait Islander leaders (as recommended in the Uluru Statement from the Heart¹³), and a strong, shared focus on social determinants of health.

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