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Editorial

Improving health outcomes for Indigenous peoples: what are the challenges?

Noel Hayman, Papaarangi MJ Reid, Malcolm King
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This editorial accompanies a series of Cochrane Library Special Collections on the health of Indigenous peoples in Australia, Canada, and New Zealand, focusing on diabetes, fetal alcohol syndrome disorders, and suicide prevention. A second editorial asks Can Cochrane Reviews inform decisions to improve Indigenous people’s health?

The International Day of the World’s Indigenous Peoples (www.un.org/en/events/indigenousday) is commemorated on 9 August each year. This day reminds us all to pause and question what progress has been achieved from the previous year. This year’s theme, "Post 2015 agenda: Ensuring Indigenous peoples’ health and well-being", is important for us all.

Internationally, the health of Indigenous peoples continues to be inequitable. The International Working Group on Indigenous Affairs reported that: "Indigenous peoples remain on the margins of society: they are poorer, less educated, die at a younger age, are much more likely to commit suicide, and are generally in worse health than the rest of the population."[1]

Since 2002, Australia's National Health and Medical Research Council (NHMRC), the Canadian Institutes of Health Research (CIHR), and the Health Research Council of New Zealand (HRC) have been signatories to an agreement on trilateral cooperation to improve Indigenous people's health.[2] Regularly updated, the agreement commits the three agencies to working collaboratively to improve the health of Indigenous peoples through sharing of best practice, information, and expertise. Priorities for research identified in the current agreement include fetal alcohol spectrum disorder (FASD) and suicide prevention, both the focus of Cochrane Library Special Collections. A third Special Collection on diabetes reflects the burden of disease attributable to this chronic condition on Indigenous peoples worldwide and its status within the Global Alliance for Chronic Disease as a research priority.[3]

There are 713,600 Aboriginal and Torres Strait Islander people, comprising about 3% of the Australian population.[4] Over one-third are less than 15 years of age. In Aotearoa New Zealand, with a total population of around 4.25 million at the 2013 census, nearly 600,000 (15%) identified Māori as one or only ethnicity, with a
comparatively youthful median age of 24 years.[5] Canada's First Peoples comprise approximately 1.4 million First Nations, Inuit, and Métis, representing 4.3% of the total Canadian population.[6] These three groups, like their counterparts in Australia and New Zealand, are young and growing compared with non-Indigenous populations. The median age for First Nations people is 26 years of age and for Métis, age 31, while Inuit are the youngest of the three groups, with a median age of 23 years.[6]

In Australia and Aotearoa New Zealand average life expectancy of Indigenous people continues to lag behind non-Indigenous counterparts by 10 and 7 years, respectively.[7,8] In Canada, the life expectancy for First Nations and Métis is on average 5 to 6 years less; and for Inuit, the lag is 10 to 15 years, whereby Inuit have the lowest projected life expectancy of all groups in Canada.[9] These numbers underplay the human and economic costs, loss of potential, and cultural impact of this life expectancy gap. Eliminating ethnic inequities is documented as a priority in almost every jurisdiction but remains a challenge.

Research has a mixed reputation among Indigenous communities, who have considered research harmful, damaging, insensitive, and exploitative.[10] A large number of research projects have been implemented to serve the professional, political, and academic needs of non-Indigenous researchers, with little or no translation into improving health outcomes.

Keeping community interests and priorities central in research is paramount to addressing the factors that impact health in Indigenous communities. These factors are unique to and vary between each group and cannot be compared to the same factors affecting the health of non-Indigenous citizens.

In our developed and wealthy nations such health inequities justify inquiry and action. In the past, research often resulted in harm as well as lost opportunity for mutual learning and development. Furthermore this 'done to' approach inevitably fosters 'victim-blame' analyses and discourses that are unable to encompass the broader determinants and root causes of inequity. These include structural and societal features, including the historic and contemporary effects of colonisation and racism.

Systematic reviews of good-quality studies have provided the foundation for evidence-based guidelines for clinical practice and improved health outcomes for specific conditions, and therefore may be useful in eliminating Indigenous health disparities. But alternative research approaches are also needed. To be relevant to decision-making in countries with disparities in health outcomes among Indigenous peoples it is particularly important that the authors of Cochrane Reviews interpret their results through the lens of the broader determinants of inequity. This will more readily facilitate the introduction of healthcare practices, policies, and systems that will ultimately enable Indigenous health development.

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