Where are the opportunities to address system barriers preventing equitable cardiovascular outcomes for indigenous populations?

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The health and wellbeing of indigenous communities across the globe are affected by the substantial burden of cardiovascular disease.[1–3] Burden disproportionally sits with younger indigenous people compared with non-indigenous populations, affecting the cultural, social, and economic strength of communities.

Despite a reduction in cardiovascular mortality for both Aboriginal and Torres Strait Islander and non-indigenous Australians, the disparity between the two populations has not reduced.[4] Numerous studies have identified gaps in provision of evidence-based acute treatment for coronary heart disease for Aboriginal and Torres Strait Islander people, with demonstration of disparities spanning different jurisdictions and timeframes.[4] Evidence also exists of disparities in outcomes.[5] In *The Lancet Global Health*, Luke Dawson and coworkers[6] provide contemporary data on short-term, medium-term, and long-term outcomes following percutaneous coronary intervention (PCI) in Victoria, Australia. They report 2·5 times greater long-term mortality following PCI for Aboriginal and Torres Strait Islander people than in non-indigenous counterparts, and a similar disparity for 30 day mortality and major adverse cardiac events.[6]

Of great concern in the Article's findings is the continued difference in long-term mortality over time, with virtually no change in the hazard ratio between the periods of 2005–09 and 2015–18.[6] This continued trend is despite in-hospital cardiac disparities for Aboriginal and Torres Strait Islander people being a national priority since 2014.[7] Targeted efforts over the past decade to increase culturally appropriate, clinically competent cardiac care in selected hospitals through addressing on-the-ground gaps seem not to have made any difference to disparities and outcomes more broadly.[8]

There is persistent evidence of health-system failure to meet its obligation to address unacceptable disparities in indigenous populations. Specifically for those with an acute episode of coronary heart disease, but also across the board for most health outcomes.[4] As stated by Dawson and coworkers,[6] there is a need to have a solutions-focused approach. It is not enough to continue to report the extent of the disparity. So where are the opportunities for transformation?

Health promotion and disease prevention are crucial areas of opportunity to delay and prevent heart disease. Fundamentally, indigenous communities should be able to access culturally responsive programmes that integrate spiritual, emotional, social, and environmental wellbeing.[9] Development and delivery of such programmes requires redistribution of resources away from disease-focused interventions. A coordinated approach to increase uptake of risk assessment and delivery of evidence-based management is required. Health-promotion strategies also need to address social determinants of health that affect indigenous people from a young age.

Institutionalised racism perpetuates the disparities described in the Article. There is failure to consistently provide evidence-based acute cardiac care. Biased clinical preconceptions around patient morbidity and adherence to treatments that favour conservative management must be challenged. Communication and engagement by health-care workers with indigenous clients needs substantial improvement and the provision of culturally competent care should be an expectation throughout the health system.[10] In Australia, national hospital standards are seeking to address cultural safety.[10] However, these standards need to be implemented into practice, requiring organisational change and the calling out of individual and institutional racism.

Addressing long-term post-acute outcomes requires action beyond the hospital. Care continuity and long-term management is largely overlooked. Dawson and coworkers'[6] finding of high rates of optimal medical therapy is encouraging. Improvement in the provision of coordinated, integrated pathways out of hospital with ongoing support across the range of primary and specialist services is needed. Providing care that supports healthy living with multimorbidity is crucial. Cardiac rehabilitation programmes need reorienting

to meet the social, emotional, and cultural needs of clients.[9] Furthermore, opportunities exist to increase uptake of rehabilitation through alternative modes of delivery to enhance access and cater to younger clients. Coordinated pathways should ideally be provided within integrated regional networks spanning the care continuum.

Monitoring and reporting of disparities continues to highlight the need for action but it will not fix the problem. Identification of indigenous clients within the system is far from accurate, resulting in missed opportunities to provide care that meets patient need.[6,10] The study provides a picture for six public hospitals in one jurisdiction, but we do not have broader understanding across jurisdictions, sectors, and remoteness.[6] Focus on the gap remains, but we need to focus on what is driving disparities so that evidence-based solutions are implemented.

Unacceptable disparities in cardiovascular outcomes are evidenced across the globe for indigenous people. The underlying drivers of systemic racism, the effects of continuing colonisation and historical trauma, and a failure to provide care that acknowledges a holistic approach to health and wellbeing all perpetuate disparities. The under-resourcing of indigenous health solutions, and the disconnect between sectors within and beyond the health system need to be addressed at a national level.[1–3] If we seek to highlight gaps and disparities, then we must also provide direction and actions that challenge the causative-system structures. Providing support for health workers to unlearn behaviours and beliefs about indigenous people and their health, which drives the bias in decision making and care provision, is also essential for change.

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