Conclusion

Everything has been said before, but since nobody listens we have to keep going back and beginning all over again.

André Gide, (Nobel Laureate)

The information presented in this Report is based on many sources. Its substantial and diverse research component presents a picture of what was occurring in Aboriginal heart health at the time the data were collected. Although all research has limitations, our quantitative results enhance understanding of the frequency, causes and outcomes of disease as well as the patterns of health service utilisation, allowing comparisons across different groups. The qualitative data add the rich insights needed to understand diverse perspectives and issues.

The data from this Report, and elsewhere, clearly indicate not only that cardiovascular disease is the biggest killer of Aboriginal people, but also that Aboriginal people are experiencing both illness and death from heart disease at a much earlier age than non-Aboriginal people. It matters little which particular cardiovascular condition we consider—heart attacks, atrial fibrillation, heart failure, stroke—the common pattern pertains.

Furthermore, the Report highlights that people living in rural and remote areas are generally more disadvantaged than those in urban areas in terms of service access. In this regard, many Aboriginal people suffer from a ‘double whammy’—the overlay of living at a distance from urban centres (where primary and specialist services are concentrated) along with the cluster of disadvantages arising from discrimination that has been perpetuated over time, lack of material resources, exposure to high risk environments and the ensuing burden of grief and trauma, along with limited education and health literacy.

A key message arising from these observations is the urgency to direct efforts ‘upstream’ towards primary prevention, as well as the need for earlier, community-based detection and intervention, recognising that these are every bit as important in extending people’s lives in good health as are acute/hospital-based care. This is a hard message to get across but an important one to make, time and time again.

‘By the time you get into a coronary care unit, it’s too late; you’ve damaged your heart. If we could have got you 10 years ago, stopped you smoking, got you to exercise a bit and controlled your diabetes, maybe you wouldn’t have ended up in coronary care. But politically you can’t prove that. I can’t employ 5 AHWs and say they’ve prevented 30 heart attacks; you can’t measure that … but I can employ 5 nurses in the hospital and say we treated 30 heart attacks, aren’t we good? … So politically, it’s easier to spend the money in a tertiary centre because you can say, “Look at all these patients I treated!”’

(Participant in health care worker study, tertiary hospital)

Another important message is that a seamless, integrated health care system with linkages between primary, tertiary and follow-up care has not been achieved, despite this being given attention as a necessity in many policy documents. There is little point in developing endless strategies and models of care while glaring inadequacies in the fundamentals of the system, such as patient information systems and co-ordinated pathways, have not been addressed.
The data underscore the importance of more holistic approaches to addressing health problems. To ensure that Aboriginal patients receive the best possible health management and advice, access to high quality primary health care is imperative. Improved integration and continuity of care are likewise important; the role of multidisciplinary teams must be enhanced and—where practicable—‘one-stop shop’ service provision is recommended. This is particularly important for some Aboriginal people who may not have the financial means, health literacy or experience to navigate their way through the complex health service environment. Specialist care is also important in modern diagnosis and management. Outreach clinics, videoconferencing and telephone support providing good communication and timely support for patients and primary health care providers are necessary for better integrated care with specialist input. Almost all of these changes will improve care provision for other population groups who experience similar challenges and also want holistic care.

Critically, there is much that can be done to overcome the many barriers that Aboriginal people encounter in accessing good health care. Part II of the Report has provided examples of progress in improving services and of special initiatives developed to improve access and acceptability. They demonstrate the efforts of talented and committed individuals, who nevertheless almost always function as part of dedicated groups, strategizing, planning and working together. Substantial change rarely occurs as the result of single person or initiative. In order to deliver the best possible outcomes, efforts need to be sustainable and founded on partnerships incorporating the broader Aboriginal community as well as linking organisations. This Report encourages readers, including health care providers, to think carefully about the ways in which—both as individuals and by working with others at an organisational and societal level—they can help reduce Aboriginal cardiovascular (and other health) disparities. There is no quick fix, but small changes can ultimately effect sizable improvements, and through the exchange of knowledge, successful approaches developed in one place can inform the efforts of people elsewhere. We hope that the practical strategies proposed in our workshops will serve as inspiration to others in this regard.

We must consciously regard data as the basis for directing our efforts for improvement in the health of Aboriginal people. We have more than enough high quality information to inform the development of interventions at individual, community, organisational and policy levels. It is important in this work that we go beyond rhetoric to look at data to ascertain what is happening and to assess progress. Ongoing monitoring and evaluation will help to inform our progress and refine our approaches into the future.

We thank the many people—Aboriginal and non-Aboriginal—who generously shared their wisdom and experience, particularly in regard to what has worked and what has failed. By exchanging knowledge in this manner, we can be catalysts for improvements in health care. Research generates information that helps build our understanding, but the information in itself is not enough to effect change without a commitment that it be used to educate individuals and to guide program and policy development. Change generally requires evidence and/or political will to catalyse action; we certainly encourage a tight nexus between the two. This report brings together the information from research to identify priority areas for action.

We will take forward the partnerships developed in our research to implement the ideas and address the issues discussed in this Report. The establishment of the Poche Centre at the University of Western Australia through the generous donation of Greg and Kay Poche provides an opportunity to build on the momentum achieved through this Report. Join us in working towards making a difference to Aboriginal heart health in WA.