

Indigenous health disparities: a challenge and an opportunity

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See also the review by Bonneau et al. on page 305.

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SUMMARY

Clinical Indigenous health research is sparse and often not patient-centred. Despite a broad acknowledgement that Indigenous patients have unique clinical considerations, specific interventional research in Indigenous health is lacking.

The practice of medicine is both science and art. It's a science because we apply research, guidelines and personal expertise in a conscientious, explicit and judicious way. It's an art because our patients' circumstances, values and goals recalibrate where science directs us. A recent response to an editorial in *BMJ* states this succinctly: "evidence-based medicine as a concept goes beyond solely the appraisal and use of published research evidence. It is the practice that integrates 'the best research evidence with our clinical expertise and our patient's unique values and circumstances.'"¹ What happens when scientific evidence is sparse, however, or when the circumstances, values and goals of patients are systemically devalued?

Thought leaders have argued that Indigenous health has both these deficiencies.² In my own review of the literature, I have come to conclude that contemporary Indigenous health research has paid some attention to the latter, exploring themes of racism, discrimination and cultural safety. It has also unpacked the social determinants of health in ways that have articulated the complex interplay between social circumstances and health outcomes. However, the space between the social determinants and health outcomes remains unexplored. Specifically, what happens to Indigenous patients who receive medical or surgical treatment in specific clinical contexts? The research done by Bonneau and colleagues³ and published in this issue of *CJS* holds value, as it constitutes a first step in filling in this knowledge gap.

There is considerable value in researchers' directing their minds toward unpacking these specific disease contexts. Indigenous peoples self-report poorer health than non-Indigenous Canadians, and epidemiologic data show disease burdens several times higher among the former in most cases.⁴ In the case of tuberculosis, for example, rates are almost 300 times higher for Inuit living in Inuit Nunangat than for non-Indigenous Canadians.⁵

These are not uncommon diseases with poorly understood causes. These are common chronic diseases, such as hypertension, chronic obstructive pulmonary disease, tuberculosis and diabetes. We have a history of confronting these diseases directly and with great success. We lack a clear understanding of the unique contexts that Indigenous patients bring to the patient care experience and how they inform the way we should optimally provide care to this population.

In a critical review of Indigenous health publications in Australia, Canada, New Zealand and the United States in various periods from 1987 to 2003, Sanson-Fisher and colleagues⁶ reported that most (88%–94%) Canadian-specific publications were descriptive, with very few interventional studies

published (2%–6%). Descriptive research describes the characteristics of a population or phenomenon but does not answer the how, when or why those characteristics occurred. In contrast, interventional research provides a comparison between treatments and guidance on the reasons behind the results. Sanson-Fisher and colleagues⁶ go on to state that these discrepancies may be accounted for by cost, ease of patient engagement, speed of completion, likelihood of publication, design and ethical issues.

I echo many of these reasons. Historically, Indigenous health research has had lower rates of funding, or funding was tied to specific diseases that may have excluded certain research questions. Data sets for Indigenous patients are woefully inadequate or nonexistent, which creates unique challenges and additional costs in addressing disease in a context-specific way.⁷ Historical racism and dehumanization of Indigenous patients in health research⁸ creates additional barriers when developing research relationships, practising trauma-informed research and considering what value patients derive from research projects. Owing to the ongoing disparities experienced by Indigenous populations, there can be a misconception that many of these problems are intractable, with little opportunity for impact (or low likelihood of publication).

I encourage Canadian researchers to reconsider interventional research in Indigenous health, however. After years of funding Indigenous health research at levels less than 2% of its total budget, the Canadian Institutes of Health Research increased such funding to 3% of total budget in 2017/18, with a goal to grow its commitment to 4.6% in certain key action areas.⁹ Provincial health care systems are exploring new ways to track and publish Indigenous-specific data. *C7S* has recently featured Indigenous health submissions,³ as has its sister publication, *CMAJ*.^{10,11}

Research forms a pillar for resolving the ongoing health disparities between Indigenous and non-Indigenous Canadians. Balancing the art and science of medicine, focusing on disease-specific contexts and rebalancing the ratio of descriptive to interventional research questions that we pursue will improve the quality and

utility of the research we produce. This is reflected in the impact we have had in improving the health outcomes of other, non-Indigenous patient populations in a wide range of diseases. We can have the same effect in Indigenous health if we apply the same principles, tailored toward Indigenous patients.

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