Title page

Health and society

Introduction

There is a significant level of inequality among indigenous and non-indigenous Australians. The gap is wider in the healthcare facilities for indigenous and non-indigenous populations. The inequality can be observed in the shorter life expectancy, high rates of infant mortality, poor health and low levels of education. Such gaps have undermined the health opportunities for indigenous Australians. Two prominent factors that cause a disparity in healthcare among indigenous and non-indigenous populations include discrimination and economic deprivation. The prevalence of coronary heart disease is high among Aboriginals and Torre Islanders. The argument claims that the indigenous population suffers the consequences of the health gap because of lack of knowledge and because of their insensitivity to discuss their health problem. These causes are considered as the social determinants of health. Facts also indicate that the aboriginals and Torre islanders are political, culturally and economically disadvantaged in Australia. The coronary disparities can be removed by addressing the social indicators (Thompson, et al., 2016). It is crucial to identify the barriers that discourage the adoption of timely treatment for coronary heart disease and improve future health prospects.

Discussion

The primary reason that causes disparity among indigenous and non-indigenous populations include a lack of knowledge. It is revealed that majority of the aboriginals and Torres Islanders lacks awareness about the canary heart disease (Markwick, Ansari, Sullivan, Parsons, & McNeil, 2014). This has adverse impacts on their decision of seeking timely treatment. This is also linked to the social determinants of health including low literacy. The facts indicate that the ingenious Australians have low educations that result in lack of knowledge and awareness regarding coronary heart disease and its causes. They ignore the factors that increase the likelihood of heart attacks. It is thus important to provide adequate information to the indigenous population about the causes and treatments for coronary heart disease (Lucero, et al., 2014). Lack of knowledge discourage people of minority populations from visiting the hospital or seeking medical advice. This reflects their negative attitudes regarding treatments and intervention (Reath & O'Mara, 2018).

Lack of knowledge undermines the patient's level of a corporation that is required during treatment or intervention. These patients exhibit a high level of fears related to the procedures such as tests, screening and diagnosis. Lack of support from the indigenous populations affects the quality of care because it has negative impacts on the healthcare providers. This factor also influences the relationship between the healthcare provider and the patient (Brown, 2012). This indicates that the social indicates acts as barriers for the provision of adequate healthcare to the minority population in Australia. The research findings indicate that a sub-optimal level of awareness remains a dominant cause of high mortality rates linked with the deaths of the indigenous population associated with coronary heart disease. (Brown & Kritharides, 2017).

Another cause of the gap in the coronary heart disease among indigenous and non-indigenous populations include sensitive attitude. The facts reveal that aboriginals and Torres Strait Islanders exhibit more sensitive behaviours towards the coronary disease that undermines them from seeking appropriate care. this reflects that these patients are sensitive to discuss their health issues with the healthcare professionals. It also reflects their lack of trust towards the doctors and staff. Sometimes they are even convinced to hide their health problems that delay the possibilities of diagnosis and treatment implementation. This increases the mortality rates due to heart disease because aboriginals are inclined to conceal their health issues. Their resistance to sharing the information with doctors results in the deterioration of their health (Hamilton, Mills, McRae, & Thompson, 2016). Such behaviours have negative impacts on the treatment plan because the professionals don't receive the required level of coordination from the patients.

The indigenous population is more likely to become victims of coronary heart disease. The evidence suggests that young indigenous Australians are diagnosed with chronic disease at a very young age. The inability of indigenous people to get access to better healthcare services is due to their socio-economic situations. It is revealed that the majority of the indigenous people in Australia are poor and are unable to invest in healthcare services. This undermines their ability to maintain adequate health standards. Low economic status also affects the ability of the indigenous people to pay for healthcare (Mathur, Moon, & Leigh, 2006). Statistics reveal that “in 2011-13, Indigenous Australians were 1.6 times more likely to report CVD and their rate of acute coronary events was 2.5 times higher than non-Indigenous Australians” (Hamilton, Mills, McRae, & Thompson, 2016). Economic disparity is recognized as a significant factor that prevents the indigenous population from visiting healthcare institutes of clinics.

Facts indicate that "the difference was slightly greater for males, with Indigenous life expectancy estimated to be 69.1 years compared with 79.7 years for non-Indigenous males, a gap of 10.6 years” (Mathur, Moon, & Leigh, 2006). The death rates of aboriginals and Torre Islanders are also high among people who develop coronary disease. This condition is most commonly witnessed in the form of heart attacks, causing the death of the patients. it is also revealed that these two populations receive less treatment compared to the non-indigenous populations. The findings of the studies conducted on evaluating the prevalence of the coronary disease among these populations depict that aboriginals and Torre Islanders are more likely to die who suffer from heart attacks. The disparity is also visible because the death rates of the indigenous population from a heart attack are 1.4 times high compared to the non-indigenous population. These rates are associated with patients who experience out-of-hospital deaths. These facts indicate that healthcare institutes don't treat indigenous populations on a priority basis (Graham, 'Connor, Chamberlain, & Hocking, 2017).

Interventions

An effective intervention used for improving the health of the indigenous population is lifestyle intervention. This approach stresses on altering the parents of an unhealthy lifestyle and replacing them with the healthy ones. This will require aboriginals and Islanders to get rid of their risky behaviours that contribute to the high likelihood of heart disease such as heart attacks. The facts indicate that aboriginals and Islanders are addicted to smoking and alcohol that contributes to the high risks of a heart attack. They also consume unhealthy food resulting in high-cholesterol and obesity. The intervention will thus stress on changing the unhealthy lifestyle by taking healthy food such as vegetables, grains, milk and fish. The intervention will also provide information about the significance of physical activity such as exercise and workout (Reath & Brown, 2010).

To remove the health disparity among indigenous and non-indigenous population suggests adopting adequate interventions. The most crucial need for eliminating the health gap include the provision of complete information to the minority population. Ensuring better information for the aboriginals and Torres Islanders will increase the probability of providing timely treatment. This will improve the participation of the patients that is linked to the positive outcomes of healthcare and recovery. This is an effective strategy that leads to early diagnosis of heart disease and also improves the likelihood of adopting interventions in a timely manner. Knowledge on the causes of heart disease such as smoking, poor hygiene, high cholesterol, obesity and no physical exercise improve the awareness of aboriginals and Torres Islanders about the risks of the disease. Their improved knowledge of the causes of disease will allow them to avoid things that increase the risks of heart attacks and other related diseases (Stoner, Stoner, Young, & Fryer, 2012). Goals are set for addressing the health problems of the indigenous population associated with coronary disease. They are provided information about the dietary plan, physical activity and self-management. This encourages them to follow the instructions and attain their health goals.

Behavioural strategies are adopted for removing the sensitive attitudes of patients towards coronary heart disease. This involves building a relationship of trust between the patient and the physician. The Aboriginal and Islanders are explained that the process of diagnosis and treatment (Stuart-Shor E. M., Berra, Kamau, & Kumanyika, 2012). They are encouraged to share their health-related issues and problems. they are convinced that their disease can be treated if they adopt corporating behaviours and share their health-related issues (Stuart-Shor, Berra, Kamau, & Kumanyika, 2012). Patient care interventions are required for ensuring the provision of adequate health and welfare. (Kazdin, 2008). Patients are encouraged to trust the healthcare provider and are ensured that the information is kept confidential. This is used for helping patients in overcoming their resistance against diagnosis and healthcare treatment.

Conclusion

The paper explains that the risks of coronary heart disease are high among aboriginals and Torres Strait Islanders in Australia. The two dominant factors that contribute to such risks include lack of knowledge and sensitive attitudes of the indigenous people towards heart disease. Such attitudes discourage them from visiting hospitals and taking timely treatment. Patients are convinced to hide their health problems that delay the possibilities of diagnosis and treatment implementation. The possible interventions that are effective in eliminating such attitudes include behavioural strategies and lifestyle interventions. Their improved knowledge of the causes of disease will allow them to avoid things that increase the risks of heart attacks and other related diseases.

References

Brown, A. 2012. Addressing cardiovascular inequalities among indigenous Australians. *Glob Cardiol Sci Pract, 1* (2).

Brown, A., & Kritharides, L. 2017. Overcoming cardiovascular disease in Indigenous Australians. *South Australian Health and Medical Research Institute, 205* (1).

Crump, C., Sundquist, J., Winkleby, M. A., & Sundquist, K. 2017. Interactive Effects of Obesity and Physical Fitness on Risk of Ischemic Heart Disease. *International Journal of Obesity*.

Graham, S., 'Connor, S., Chamberlain, S. M., & Hocking, J. 2017. Prevalence of HIV among Aboriginal and Torres Strait Islander Australians: a systematic review and meta-analysis. *Send to Sex Health.* *, 14* (3), 201-207.

Ivy, W., Miles, I., Le, B., & Paz-Bailey, G. 2014. Correlates of HIV Infection Among African American Women from 20 Cities in the United States. *AIDS Behav, 18* (3), 266–275.

Hamilton, S., Mills, B., McRae, S., & Thompson, S. 2016. Cardiac Rehabilitation for Aboriginal and Torres Strait Islander people in Western Australia. *BMC Cardiovasc Disord, 16* (150).

Kazdin, A. E. 2008. Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist, 63* (3), 146-159.

Lucero, A. A., Lambrick, D. M., James A. Faulkner, 1. S., Tarrant, M. A., Poudevigne, M., Williams, 5. M., et al. 2014. Modifiable Cardiovascular Disease Risk Factors among Indigenous Populations. *Advances in Preventive Medicine*.

Norcross, J. C., & Wampold, B. E. 2011. Evidence-based therapy relationships: Research conclusions and clinical practices... *=Psychotherapy, 48* (1), 98-102.

Markwick, A., Ansari, Z., Sullivan, M., Parsons, L., & McNeil, J. 2014. Inequalities in the social determinants of health of Aboriginal and Torres Strait Islander People: a cross-sectional population-based study in the Australian state of Victoria. *Int J EquityHealth, 31* (91).

Mathur, S., Moon, L., & Leigh, S. 2006. *Aboriginal and Torres Strait Islander people with coronary heart disease: further perspectives on health status and treatment.* AIHW.

Stuart-Shor, E. M., Berra, K. A., Kamau, M. W., & Kumanyika, S. K. 2012. Behavioural Strategies for Cardiovascular Risk Reduction in Diverse and Underserved Racial/Ethnic Groups. *Circulation, 125*, 171–184.

Stuart-Shor, E. M., Berra, K., Kamau, M. W., & Kumanyika, S. 2012. Behavioural Strategies for Cardiovascular Risk Reduction in Diverse and Underserved Racial/Ethnic Groups. *Circulation, 125* (1), 171–184.

Stoner, L., Stoner, K. R., Young, J. M., & Fryer, S. 2012. Preventing a Cardiovascular Disease Epidemic among Indigenous Populations through Lifestyle Changes. *Int J Prev Med, 3* (4), 230–240.

Reath, J. S., & O'Mara, P. 2018. Closing the gap in cardiovascular risk for Aboriginal and Torres Strait Islander Australians. *Med J Aust, 209* (1), 17-18.

Reath, J., & Brown, N. 2010. Managing cardiovascular disease in Aboriginal and Torres Strait Islander people. *Aust Prescr, 34*, 4-5.

Thompson, S. C., Haynes, E., Woods, J. A., Bessarab, D. C., Dimer, L. A., Wood, M. M., et al. 2016. Improving cardiovascular outcomes among Aboriginal Australians: Lessons from research for primary care. *SAGE Open Med.* *, 4*.