Closing the Gap: where to now?

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Let us move our focus to building health care relationships and partnerships that optimise care for every Indigenous patient

In 1978, the International Conference on Primary Health Care declared that "governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures."[1] In 2007, *Closing the Gap* was heralded by the Australian government as a shift in health policy for Indigenous Australians, proposing drastic action that would be measured against clear benchmarks.[2] The flaw in this policy was the assumption that a homogenous approach, unaccompanied by deep, meaningful engagement with Indigenous people, communities, and health care services would be sufficient. Fourteen years later, the goal of closing the gap in life expectancy between Indigenous and non-Indigenous Australians by 2031 "is not on track".[3] In 2020, the incorporation of Indigenous perspectives into health care, and greater control of health-related targets and programs by Indigenous-led organisations promised change, despite risks, including peak Indigenous health care bodies being "held responsible for any future policy failings."[4]

General practice links the disparate components of the Australian health care network. Primary health care "is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."[1] General practitioners, nurses, and other primary health care practitioners triage, treat, refer, educate, and help patients, families and communities navigate the health care system.

General practice must be the cornerstone for restructuring Indigenous health policy, and this must include reforming Medicare.

Primary health care practitioners have long understood that "health … is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity."[1] As GPs, we see how health care in Australia fails to adequately serve Aboriginal and Torres Strait Islander Australians. We see the risks associated with the new *Closing the Gap* policies in community primary health care. The focus of these policies is the individual and their behaviour, failing to acknowledge "a strong evidence base that suggests … conditions can be prevented by addressing the socio-economic and environmental factors that make Indigenous peoples more susceptible."[4] Referrals by GPs need to extend beyond referrals to other health care practitioners. The social determinants of health have long been clear,[5] but the model of care expected of Australian GPs does not acknowledge that housing, food security, and protection from the effects of climate change are as important as a referral to a podiatrist when managing someone with diabetes.

Characterising Indigenous ethnicity as a risk factor for poor health[4] continues the emphasis on individuals' behaviour and homogenises the experiences of Aboriginal and Torres Strait Islander Australians — as does the *Closing the Gap* program. Drive-through, 12-minute consultations are never going to serve the many Aboriginal and Torres Strait Islanders who seek the opportunity to be listened to and heard, and to have their histories and their needs understood[6] rather than "solved". We need a reformed Medicare that ensures listening time is valued.

Whereas a "conceptual grasp of race … should frame our thinking about how to close the gap",[4] the racism experienced by Indigenous Australians who present to health care facilities is not widely acknowledged. While we choose our colleagues carefully when possible, referrals of patients are often to health organisations, such as hospitals, and choices are more restricted. Referring patients to the care of another is an act of trust that they will care for them as we would. That trust, however, is frequently betrayed. For example, "Indigenous and minoritised ethnic groups [across the globe] experience longer wait times, differential pain management and less evaluation and treatment for acute conditions within emergency medicine care",[7] and racism has been recognised as a major impediment to Aboriginal and Torres Strait Islander Australians receiving optimal health care.[8] Racialised social structures, internalised racism, and power differentials in health care have a detrimental impact on Indigenous people.[9] We need a Medicare reform which ensures that advocacy for Aboriginal and Torres Strait Islander patients is supported, encouraged, and valued.

We urge a move from the paternalistic nature of the current *Closing the Gap* initiatives. Move from its emphasis on counting and on individuals and their behaviour. Move to working on health care relationships and partnerships that empower us to get the details of care right for every Indigenous patient. Social and cultural determinants are fundamental to health care, and are as important as ensuring good blood pressure control. We should aim to provide a flexible, engaged health care system, easily negotiated both by ourselves as practitioners and by Aboriginal and Torres Strait Islander patients, families, and communities.

The benefits in closing these gaps go beyond fulfilling a policy agenda, providing new health services, or establishing new

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Podcast with Talila Milroy and Lilon Bandler available at mja.com.au/podcasts programs. It means future generations of Indigenous Australians who live longer, who thrive rather than survive, and who are recognised as valued members of the society and country they own.

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