language of the Aboriginal and Torres Strait Islander people is disappearing or has disappeared.

In Australia, there is currently a debate about symbolic versus practical reconciliation—the latter approach suggesting that it is best not to acknowledge the history and its influence on current outcomes, and that to move forward to improve living conditions and other activities that enhance wellbeing is in effect ignoring the root causes.[9 10] However, evidence shows that the most effective programmes are those which acknowledge the devastating impact of removing people from their land, removing children from their families and from their culture, and marginalising people so that they cannot access any of the advantages of the dominant culture, such as education and employment, which would have enabled them to participate and control their own lives.[11–13] This is evidence of the importance of the social determinants of health and how they have had an impact on generations of these populations—seen repeatedly in all colonised indigenous groups. We believe that sustainable solutions to indigenous health problems must address and acknowledge this history and the links these people have with nature.

Increasingly, we witness approaches to health research and health service provision led by indigenous people and based on indigenous methodologies and world views. Some approaches incorporate many contemporary and Western developments; still others prefer a return to more authentic cultural delivery, using traditional medicines and practices such as spiritual and traditional healing approaches.

August 2004 will mark the end of the United Nations decade for indigenous people, and a recent report reflects the views of less well researched indigenous peoples from Laos, Cambodia, Guatemala, Burma, and Namibia.[14] Unfortunately, it concludes: "Very little has been achieved on the ground, and [our] experience is that the threats to indigenous people are growing rather than diminishing."

The indigenous experience is distinct yet diverse; many similarities are obvious yet significant differences can be identified. That this pattern is so similar across all colonised indigenous groups is one reason for having a theme issue devoted to their health. This issue is an opportunity to share these similarities and differences and to learn from the ways used to improve outcomes. This sharing of experiences needs to be transferred among nations to move rhetoric into urgently needed action.

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The health status of indigenous peoples and others

The gap is narrowing in the United States, Canada, and New Zealand, but a lot more is needed

Indigenous populations differ in levels, patterns, and trends of health. What is common is the unacceptably large differences between the health of indigenous and non-indigenous populations in developed nations. Durie recently outlined the explanations for these disparities and proposed a broad spectrum of interventions to improve the health of indigenous people.[1] Within that spectrum, health professionals can have a major role in contributing to dramatic reductions in mortality and morbidity through high quality primary healthcare services for prevention and early treatment.

The gap in life expectancy between indigenous and non-indigenous populations is estimated to be 19-21 years in Australia, 8 years in New Zealand, 5-7 years in Canada, and 4-5 years in the United States.[2–5] These continuing disparities in health are a matter of major concern, but it is none the less important to recognise the substantial narrowing of the gap in health between indigenous and non-indigenous people in the United

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States, Canada, and New Zealand.[4–6] In Australia the gap in median age at death seems to have widened.[2]

Much of the reduction in mortality in North American indigenous populations has been the result of fewer deaths from injury. The Maori population has had major reductions in circulatory conditions. Diabetes seems to be an increasing problem in indigenous populations generally.[7]

Although indigenous peoples tend to have higher mortality right across the disease spectrum, much of the excess arises from chronic disease. In all four countries, circulatory conditions, external causes, respiratory disease, endocrine illnesses (mainly diabetes), and neoplasms account for most of the excess deaths among indigenous people. These conditions collectively can account for 70% or more of excess mortality in indigenous people.[8]

A large proportion of chronic disease in populations throughout the world is regarded as avoidable through primary, secondary, or tertiary services. Rates of avoidable deaths among indigenous people tend to be much higher than for non-indigenous people. Avoidable death rates among the Maori, for example, are estimated to be almost double those of Europeans or other New Zealanders.[3] Many indigenous people have one or more of a complex set of interlocking chronic diseases from a comparatively early age.[9] Although these diseases are diagnosable and treatable, at least some of this avoidable mortality remains underdiagnosed and undertreated. Death rates for chronic disease can be halved for some aboriginal communities in just over three years through high quality, systematic diagnosis and treatment services.[10] Cardiovascular disease, which is central to the high mortality among indigenous people in several countries, may largely be avoided through therapeutic measures.[11]

The similarities and contrasts between the different indigenous peoples—for example, the higher levels of injury in North American Indians and the higher burden of circulatory conditions in Maoris and Australian Aboriginal populations—suggest the value to be had from exchange of information and developing research through international links between indigenous peoples, and such initiatives are currently under way.[12]

Durie's prescription is for capacity building, research, cultural education for health professionals, appropriate (needs based) funding and resources for indigenous health, and constitutional and legislative changes.[1] He also emphasised the importance of an indigenous health workforce and indigenous health perspectives and the central role of socioeconomic and macropolitical interventions. We endorse those views.

Change in the culture of medicine itself is necessary. Tertiary institutions and colleges need to acknowledge their responsibility to produce competent and responsive clinicians, and government agencies and funding bodies need to support the delivery of appropriate services.

Efforts continue to educate the policy makers that improving health outcomes is also about process. If governments are to truly contribute to positive change, they need to make the commitment that will transcend political vagaries and election cycles and strip away the racism that remains a barrier to progress in health of indigenous people.

We also need to acknowledge the contribution that indigenous practitioners make to the workforce. Indigenous health staff may be trained primarily in a Western model of healthcare delivery, but their cultural insight and community grounding provide a valuable opportunity to enrich the medical profession generally.

Tacit acceptance of continuing disparities in health for indigenous peoples is not appropriate when the causes of those disparities and the remedies are well understood. We urge national efforts, led by indigenous people, to implement Durie's broad approach and within that approach to use the knowledge that is already available to effectively diagnose and treat the conditions that cause most of the excess mortality. Regardless of the differences in health patterns of the individual indigenous populations, the critical health service issue is one of adequate primary healthcare services for prevention and for early diagnosis and treatment of the high levels of illness and illness precursors that are already present in much of the indigenous populations. This could best be achieved through national programmes to further develop community controlled primary healthcare services at a funding level, which is indexed proportionately to the higher level of need, and through national training programmes to produce indigenous health professionals to deliver these services as well as to train culturally competent non-indigenous practitioners. The aim should be to use the knowledge we have to eliminate current differences in health service provision and health status within the next 10 years.

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