Opinion Article

Collective Responsibility for Indigenous Health: A Philosophical Inquiry

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Abstract

The improvement of Indigenous people's health and the closing of the gap with non-Indigenous peoples is a collective responsibility of a society, drawing from various philosophical perspectives. Bentham's utilitarianism will prioritise actions that maximise overall health outcomes *via* allocating resources and interventions in a way that produces the greatest overall benefit for the largest number of people, which could be at the expense of minority groups, such as Indigenous people. Kant's philosophy of moral duty and categorical imperative recognise the inherent worth and dignity of every individual. The principle is treating people as ends in themselves, rather than mere means to an end. It calls for respecting Indigenous autonomy, cultural values, and right to self-determination in healthcare decision-making. Aristotle's virtue ethics focuses on the cultivation of virtuous character and the pursuit of the common good. The society's virtues include social justice, compassion and solidarity. Michael Sandel's moral reasoning reinforces the idea of collective responsibility for Indigenous health by highlighting the importance of social justice. A just society, according to Sandel, ensures fair distribution of goods and services, including healthcare, and actively works to rectify inequities.

It is the collective responsibility of the whole society to address the health inequities for Indigenous peoples by acknowledging the historical injustices and systemic factors while paying full respect to Indigenous self-governance and self-determination. Collectively, we can and should foster a morally just, equitable, inclusive, and thriving society where we promote the health of Indigenous peoples and the society as a whole.

Main Text

Inequities in health status and healthcare are among the greatest challenges facing the international community today. This problem raises fundamental questions for healthcare planners, policy makers, researchers, and community leaders. With the differences in health systems in different countries, the discussion on health equity at the philosophical level is increasingly relevant and urgent.

Health equity is one of the principal elements in healthcare research. It aims to address and eliminate the unjust and avoidable health disparities, but it is not just about the distribution of health, not the even narrower focus on the distribution of healthcare. Health equity as a consideration has an enormously wide reach and relevance [1]. It is the measure of the society's fair distribution of healthcare resources, opportunities, and outcomes, which grips with the larger issues of fairness and justice in social arrangements, including economic allocations, paying appropriate attention to the role of health in human life.

The underlying value of health equity is that the society needs to ensure that all individuals have equal access to and use of quality healthcare regardless of their socio-economic status, gender, ethnicity, and race, such as Aboriginal and Torres Strait

Islanders (hereafter, respectively Indigenous) peoples in Australia. Australian's life expectancy at birth was 71.6 years for Indigenous males and 75.6 years for Indigenous females in 2015-2017. The gap between Indigenous and non-Indigenous Australians was 8.6 years for males and 7.8 years for females [2].

There is also a disparity in the death rates from some specific diseases for Indigenous Australians, including endocrine, nutritional and metabolic diseases (3.7 times as high as for non-Indigenous Australians, 86 compared with 23 deaths per 100,000 population), injury and poisoning (79 compared with 40 per 100,000 population), respiratory disease (106 compared with 52 per 100,000 population), and chronic obstructive pulmonary disease (3 times as high as for non-Indigenous Australians, 70 compared with 24 deaths per 100,000 population) [2].

There have been enough data and reports about health disparities between Indigenous and non-Indigenous peoples in various countries in the world. We also acknowledge the need for academic research that takes data-driven approaches, evidence-based strategies, and rigorous evaluation to monitor progress in reducing disparities. However, for this article, we will take a philosophical approach to argue that Indigenous health is the collective responsibility of the whole society, using four philosophers' theories as a starting point, Jeremy Bentham, Immanuel Kant, Aristotle, and Michael J Sandel.

Jeremy Bentham (1748-1832)

Bentham was an influential British philosopher whose philosophy laid the foundation for the ethical theory of utilitarianism. It is often described as the greatest happiness for the greatest number of people, focusing on the outcomes or consequences of actions. Bentham believed that human beings are fundamentally motivated by the pursuit of pleasure and the avoidance of pain. Therefore, a principle of utility should guide moral, legal, political, and social decision-making.

When applied to healthcare, utilitarianism will prioritise actions that maximise overall health outcomes via allocating resources, treatments, and interventions in a way that produces the greatest overall benefit for the largest number of people. For example, utilitarianism supports public health interventions that prevent diseases at a population level (rather than treating diseases at an individual level), such as vaccination campaigns, health education, health promotion, and disease prevention.

However, due to its focus on outcomes at the population level, utilitarianism may overlook or neglect the interests and rights of minority or marginalised groups, including Indigenous communities.

For utilitarianism, it does not make sense that the health expenditure for Indigenous people is higher than that for non-

Indigenous people. For example, healthcare expenditure was $7,995 per Indigenous Australian, compared with $5,437 per non-Indigenous Australian in 2010-11 [3]; in 2012-13, government expenditure on welfare for Indigenous Australians was an estimated $9.8 billion, $13,968 per Indigenous Australian, compared with $6,019 per non-Indigenous Australian [3].

Therefore, utilitarianism might prioritise the majority's health and wellbeing at the expense of minority groups. It may fail to consider the unique cultural, spiritual, and holistic dimensions of health that are important to Indigenous peoples, potentially leading to more disparities and health inequity.

Immanuel Kant (1724-1804)

Health equity is a matter of human rights, rooted in the principles of social justice. The Lancet Global Health Commission on High-Quality Health Systems in the SDG Era [4] emphasises that achieving health equity is fundamental for advancing social justice. This is the core value of our second philosopher, Immanuel Kant.

Kant was a prominent German philosopher whose philosophy is known for its rigorous rationality and its emphasis on human autonomy. It centres on the categorical imperative, a universal moral law that applies to all rational beings. Kant believed that individuals have inherent worth and should be treated as ends in themselves, rather than means to an end. This requires individuals to act in accordance with reason and universal principles, regardless of personal desires or consequences.

Kant's philosophy emphasises the inherent dignity and worth of each individual, regardless of his/her age, gender, ethnicity, race, social economic status, sexuality, political positions, and religious belief. By treating Indigenous peoples as ends in themselves rather than a means to an end, Kant's philosophy calls for respecting their autonomy, cultural values, and right to self-determination in healthcare decision-making. This approach aligns with the principles of cultural safety, reconciliation, self-governance, and Indigenous rights. Therefore, it is a common sense that culturally safe and community-led health initiatives are more likely to be effective and sustainable.

Additionally, historical experiences of colonisation, marginalisation, and systemic injustices have led to a loss of trust in external entities and a desire for self-governance and self-determination in addressing health issues within Indigenous communities. It stems from a deep sense of cultural pride, and the recognition that Indigenous knowledge systems and traditional healing practices hold intrinsic value in promoting health and well-being, reflecting a larger movement toward decolonisation and the assertion of cultural identity [5].

Here is an example of the process of decolonisation.

An Applied Decolonial Framework for Health Promotion that integrates decolonial processes into health promotion practice was developed. It will help health promotion stakeholders attend to colonising structures within the field and engage with communities to achieve social justice and health equity [6].

However, there are also potential risks in applying Kant's philosophy in the context of Indigenous health blindly. Kant's theories might overly prioritise individual autonomy and fail to adequately address systemic and structural injustices that contribute to health disparities among Indigenous peoples in the first place. People could argue that individuals and communities should be responsible for their own health and well-being, and that healthcare services should be delivered and funded based on market principles. They could advocate for a reduced role of the government in healthcare provision, emphasising the importance of individual choices, private investments, and market-driven competition to address health needs. This perspective is like neoliberal ideologies, prioritising limited government intervention and promoting individual responsibility and market forces in shaping healthcare systems [7].

This perspective might inadvertently reinforce existing power imbalances in the healthcare system. Drawing upon Foucault's power theory, the healthcare system, as a site of power, operates through mechanisms of medical knowledge, professional authority, and institutional structures. This power can control and shape the experiences and outcomes of marginalised groups including Indigenous peoples, who are particularly vulnerable to these power dynamics [8].

In addition to the power imbalance, this perspective might neglect the responsibilities of the broader society in addressing health disparities faced by Indigenous peoples. It risks absolving governments, healthcare institutions, and non-Indigenous individuals from their obligations to uphold social justice, provide equitable resources, and address systemic barriers that contribute to Indigenous health inequities. This could perpetuate the marginalisation of Indigenous voices and overlook the need for collaborative approaches that involve meaningful engagement and partnerships with every sector of the society.

Therefore, Kant's emphasis on moral duties rather than consequences might not fully account for our collective responsibilities and obligations to address the complex and multifaceted challenges faced by Indigenous communities as a whole society.

Aristotle (384-322 BCE)

Aristotle was an ancient Greek philosopher. His philosophy centres around the concept of virtue ethics. He believed that the ultimate goal of human life is eudaimonia, often translated as "flourishing" or "well-being." Eudaimonia is achieved through the cultivation of virtues and the development of character. Virtues are acquired through moral education and practice, enabling individuals to lead a fulfilling and virtuous life. Therefore, they aim to promote the common good and facilitate the development of virtuous citizens.

In a general sense, virtues include justice, compassion, and cultural sensitivity. Applying Aristotle's philosophy to address Indigenous health encourages healthcare providers and policymakers to engage with Indigenous communities respectfully and empathetically. Aristotle's philosophy can foster culturally appropriate healthcare practices that promote holistic well-being by recognising the unique cultural values, traditions, and relational aspects that are important to Indigenous peoples. This will also facilitate a collaborative approach to Indigenous health that respects people's autonomy, knowledge systems, and self-determination.

Like Kant's philosophy, in the context of Indigenous health, Aristotle's philosophy might not adequately address structural and systemic injustices that contribute to health disparities among Indigenous populations. The focus on individual virtues may overlook the broader social and political factors that shape Indigenous health outcomes. In Australia, Indigenous communities have experienced generations of colonisation, marginalisation, and systemic injustices which are historical and structural factors that contribute to health disparities faced by Indigenous populations [9].

Additionally, Aristotle's philosophy might not provide clear guidance on prioritising competing values and interests. It can be challenging to navigate situations where virtues clash or when there is a tension between cultural values and universal ethical principles. One example of the competing values and interest is the market-oriented solutions (market reasoning) which often prioritises cost-effectiveness and efficiency over the principles of social justice and equitable distribution of resources.

Michael J Sandel (1953)

Market reasoning and moral reasoning are two distinct approaches to decision-making and value judgments. Market reasoning, rooted in economic principles, emphasises efficiency, individual choices, and market forces in shaping outcomes. On the other hand, moral reasoning focuses on ethical principles, justice, and the well-being of individuals and communities. Prof Michael Sandel, an American political philosopher at Harvard Law School, has analysed these two different approaches in-depth. His Justice course was the university's first course to be made freely available online and on television, and tens of millions of people viewed his teachings.

Sandel argues that market reasoning can sometimes clash with moral reasoning, leading to ethical dilemmas and conflicts. For instance, using market reasoning to allocate essential resources like healthcare can result in inequitable access to care, as it may prioritise those who can afford it over those in need [10]. Market reasoning can neglect the historical and systemic factors that contribute to health disparities faced by Indigenous communities [9]. By adopting moral reasoning, we recognise the Indigenous peoples' inherent value and their right to equitable access to healthcare and well-being [10], which agrees with Kant's philosophy.

The tension between market-driven efficiency and the moral obligation to ensure equal access to basic needs must be addressed as a society. Sandel has tried to show that economics is a poor guide when it comes to deciding whether this or that good/service should be allocated by the market or nonmarket principles. Deciding which social practices should be governed by market mechanisms requires a form of market reasoning that is "bound up" with moral reasoning [11].

This "bound-up" may be able to reason that using moral reasoning to address Indigenous health benefits Indigenous communities and the entire society [12]. Health inequities and disparities can erode social cohesion, the overall social fabric, and the sense of solidarity and collective well-being for a thriving society. Solidarity and equity can generally be and even traditionally accepted as being equally fundamental values in some countries [13]. Additionally, health inequities can compromise the overall health of the population via reduced productivity, and further strains on healthcare systems via increased healthcare expenditure. Consequently, promoting health equity in healthcare will lead to human flourishing, justice as a disposition not a process, and solidarity, and vice versa [14]. Finally, health disparities indicate underlying social and structural factors that impact health, such as poverty, education, employment, and environmental conditions [15]. These social factors influence not only the marginalised groups' health but also the entire population's health.

Research has constantly demonstrated the vital importance of social determinants of health. For example, an analysis of the pre-retirement adult mortality in the United States showed that broader social economic status measures including wealth, are significant for understanding adult mortality; lower asset holdings among blacks, compared to whites, affects their financial well-being and survival prospects. Therefore, social policies aiming to close health disparities in the United States might be poorly conceived if they ignore the impact of wealth on premature adult mortality [16].

Similarly, improving the social determinants of health leads to an improved health outcome, almost always in some respects. For example, from 2010 to 2019, the age-standardised death rate for Indigenous Australians due to cardiovascular disease decreased by 18%, which coincided with reductions in smoking rates and an increase in hospitalisations for cardiovascular-related procedures; and the age-standardised rate of death due to kidney disease declined by 36% [2]. It is reasonable to argue that the improved health outcome among the Indigenous Australians, directly or indirectly, is influenced by the improvement of education, income, housing, and access to healthcare. Indeed, this year's report from the Australian Institute of Health and Welfare [2] showed exactly this.

Education: *Over the period from 2012 to 2021, the proportion of Indigenous Year 3 students meeting the national minimum standards for reading increased by 11% (the gap with non-Indigenous students narrowed by 33%). The proportion of Indigenous Australians aged 20-24 who had a Year 12 or equivalent qualification increased from 45% in 2008 to 66% in 2018. The rate at which Indigenous adults completed higher education courses increased from 38 to 67 per 10,000 between 2001 and 2018.*

Income: *Household incomes of Indigenous adults increased in real terms (that is, after adjusting for inflation) from $544 to $802 per week between 1996 and 2016 (AIHW, 2023). Other Australian adults experienced a weekly increase in household income of $801 to $1,096 over the same period.*

Housing: *In 2018-19, 31% of Indigenous adults lived in household that were owned or being purchased – an increase from 27% in 2002. The proportion of Indigenous Australians who lived in overcrowded households fell from 27% in 2004-2005 to 18% in 2018-19.*

Accessing healthcare: *The rate of health assessments for Indigenous Australians increased fourfold between 2009-10 and 2018-19 from 68 checks per 1,000 population to 297 checks per 1,000 population.*

Contribution: *A large part of the disparity in health outcomes between Indigenous Australians and non-Indigenous Australians is explained by disparities in social determinants, in particular income, employment and education. ... Socioeconomic factors (social determinants) explained 34% of the total health gap between Indigenous and non-Indigenous Australians. The leading social determinants that accounted for the health gap include household income (explained 14% of the total health gap) and employment and hours worked (12%). Individual health risk factors explained 19% of the total health gap between Indigenous and non-Indigenous Australians (10% from smoking, and 7.2% from overweight or obesity.*

These practical achievement of improved health outcome and advanced social determinants for Indigenous Australians needs to be acknowledged and celebrated, as well as its society's underlying value of social justice. However, we still have a long way to go in

Closing the Gap, an Australian national strategy announced over a decade ago. One of the research evidence confronting us is the increased mental health issues [2]. For Indigenous Australians, the age-standardised rate of death due to suicide increased by 30% from 2010 to 2019; similarly, over the period from 2009-10 to 2018-19, the hospitalisation rate for intentional self-harm increased by 63%; mental and substance use disorders were the leading cause for the total disease burden in 2018 (23% or 54,263 DALY).

To close the gap in mental health for Indigenous people, it takes the whole society to achieve it. One of the series of actions in the whole society is research which can generate scientific evidence to guide practice. However, for Western researchers, we need to be careful in considering our research approaches and our underlying epistemologies when conducting health research involving Indigenous communities. We must align with the distinct Indigenous values and goals of the communities involved, and the Indigenous ways of knowing. It has been recommended that realist approaches might work as "they are based on a wholistic approach congruent with Indigenous ontologies, anchored in local knowledge, process-oriented and dynamic". The use of realistic approaches could link diverse knowledge systems (including the western and eastern knowledge system) into action that is meaningful for the Indigenous communities [17].

Summary

To improve Indigenous people's health and close the gap with non-Indigenous peoples, this philosophical inquiry demonstrates that it is a collective responsibility of the society, including collective efforts of Indigenous and non-Indigenous peoples, collective policy and strategies in health system and non-health sectors, collective activities to address individual and structural and systemic factors, and collective principles and values in social justice in the whole society.

Several areas in this field require in-depth research and further discussions, such as the relationship between an individual and a community regarding rights and responsibilities, operationalising the moral duty to decrease health inequity, and the understanding and interpretation of human rights regarding healthcare services [18]. In some cases, the choice of a healthcare system may not centre on moral principles and values, such as fairness, justice and compassion. It may hinge primarily on that country's political culture, as reported in the USA [19] and China [20].

Health is not only an individual concern but also a public common good. By promoting health equity and improving Indigenous peoples' health, we create a society that upholds the value and principles of justice, fairness, and solidarity. Recognising the rights and well-being of Indigenous peoples does contribute to the overall social cohesion, inclusivity, and collective well-being of the society as a whole.

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