



Chapter 16:

Culture in Health Research and Practice

Heather McDonald (Australian Institute of Aboriginal and Torres Strait Islander Studies)

Acknowledgments: I thank Janelle White for research assistance in the initial stages of this project. Thanks to the two anonymous reviewers for their critical comments on an earlier draft of this chapter.

Introduction

People's concepts of health and illness relate to their ways of being in the world. The Western mind reifies ways of being and knowing as 'culture'. However, cultures are not *sui generis* and independent of socio-political and economic practices. Ways of being and knowing are continually subject to innovation and change. The term 'culture', like that of politics or economics, is a product of a peculiarly Western compartmentalisation of life. Because 'culture' is not separate from socio-political practices and trends, it would perhaps be better to talk of socio-cultural determinants of health and illness. Traditionally, Aboriginal views of health and illness derived from hunter-gatherer ways of being, and Western views derived from industrialised and post-industrialised city-state and nation-state cultures. Although Aboriginal and Western people today inhabit common space and time, in northern Australia there are major differences between Aboriginal concepts of health and illness and Western health professionals' views (Cass *et al.* 2002; Devitt & McMasters 1998; McDonald 2006b; Trudgeon 2000).

Within public health practice, the role of culture has largely been confined to the production of negative stereotypes and lists of health risks and behaviours (Brough 2000). These limited understandings support racist assumptions, which fail to acknowledge the reality of 'culture' as lived experience (Bhopal 1997). The literature around social determinants of health, including cultural identity, social status, social exclusion, support, isolation and autonomy, suggests the need within public health to understand the concept of culture more dynamically. In urban settings, supporting and strengthening cultural identity has been identified as an important factor in improving Aboriginal health (Bond 2003). This chapter examines the relationship between culture and health in Western and Indigenous health research and practice.

The concept of culture

In the mid-nineteenth century research into contemporary human societies diverged from social philosophy and natural history. Economics, political science, sociology and anthropology emerged as highly specialised and narrowly defined academic disciplines with claims to scientific status. They carved out distinct academic domains for themselves, with separate modes of inquiry, methods and goals (Acker 2005). American anthropologists adopted the notion of 'culture' from the German Romantic tradition and developed it into a theoretical concept, displacing more fluid concepts such as 'customs' and 'practices'. Boaz, reacting against evolutionary theories of human societies, promoted ahistorical studies of small-scale societies that were believed to live within bounded cultures (Stocking 1996).

Geertz (1973) shifted the theoretical focus from ahistorical cultures to human agency and creativity. Humans do not simply transmit culture but create meanings and generate new cultural practices through social interaction. Sahlins' historical anthropology and Wolf's (1982) Marxist historiography swept away the notion of self-contained, integrated cultures uncontaminated by world history (Whitehead 2004). Gramsci and Foucault brought the issues of power and hegemony into theoretical focus (Woost 2005). For Clifford and Marcus (1986) culture is composed of dynamic and contested codes. Cultural practice, and ethnography, are political and ethical, and are as much processes of invention as of description (Szczelkun 2002).

'Culture' remains a core concept in some fields of anthropology, but it has lost its foundational power.

As a theoretical concept, it has become as slippery as 'identity', which shifts and changes according to context (Szczelkun 2002).

However, the concept of culture has spilled over into other disciplines including history, sociology and social work. It has emerged within diverse discourses including Indigenous discourses (see Committee on Indigenous Health 2002). Some theorists would do away with the concept altogether, as it has become more of a liability than an asset (Park 2005). For others, it is now such a ubiquitous term that they must continue to engage with it.

Health systems as cultural domains

Western medicine claims to be neutral, disinterested, abstract and objective. However, Australian health services and programs derive from Eurocentric forms and practices. The majority of health administrators and medical practitioners are white. The biomedical model appears monolithic and objective; its historically and culturally contingent nature is concealed (Coulehan *et al.* 2005). Western healthcare providers are seen to be the norm and the recipients of services are believed to be deficient in knowledge and practice. Target groups are seen as needing help from the mainstream. Indigenous people in particular become objects of power and the objects of services, while the cultural norm of whiteness is ignored (Shore 2000). Eurocentric structures and programs marginalise Indigenous cultural practices. By providing only a Western understanding of health, illness and treatment, Indigenous people are made strangers to their experiences of sickness and health (Heil 2003; Paul 2000).

Airhihenbuwa (1995) argues that health practitioners and researchers should be educated to recognise the cultural dimension in health for all people regardless of ethnicity. Health professionals can become aware of the cultural paradigms that underlie health programs, and understand that their cultural values influence their own attitudes and actions. Australia's Eurocentric heritage imposes barriers to information-exchange with people of other cultures. Health education does not have to be equated with Westernisation or whiteness (Loustanau & Sobo 1997; Lupton 1995; Taylor J. S. 2003; Wright & Treacher 1982).

In some Aboriginal Medical Services (AMSs) community control is well developed and there is commitment to Indigenous cultural values at all levels of service delivery. Poliness (2004) says that at Wurli Wurlinjang, the Aboriginal health service in Katherine, unlike most general practice, clinics do not run to timed appointments. Rather, the doctors, patients and health workers work together to build relationships and help solve underlying problems. Aboriginal health workers see patients first, before inviting the doctor to come and join them as part of the treatment team. Aboriginal health workers focus on the spiritual and cultural wellbeing of patients, not just their physical problems. Their unique insight into community life plays a critical role in helping doctors understand patients' illnesses. However, this service did not use Aboriginal health interpreters.

The Aboriginal Medical Services Alliance, Northern Territory (AMSANT), the peak body of the Aboriginal community-controlled health services in the Northern Territory, believes that the community-controlled model delivers a critique of Western medicine and the relations of power and authority between the patient and healthcare provider. In the AMSANT services the role of non-Aboriginal health staff is consultative rather than directive (AMSANT 2001:6). However, in some AMSs, community control, Indigenous involvement in management processes, commitment to Aboriginal cultural values, and development of shared understandings of health and illness are not well developed:

When I first came here I got told by the management that we were to hover in the background. I was told to let the Aboriginal health workers do all the basic care and they would come and see and consult with me if they feel they need to. Alright I was doing that. Then at the last meeting the health workers said, 'Oh, we want the Sister right next to us all the time'. But I have found that when I am in that clinic, nine times out of ten the health workers disappear. You can't find them (Nurse practitioner, in Cramer 2005:185).

Recommendation: Aboriginal health workers and nurses from AMSs, such as the above, should spend some time in AMSs such as Wurli Wurlijang, perhaps in the context of an exchange program, to observe and participate in the community-controlled model of health services management.

Culture in architectural design

Western architectural values are encoded in Australian hospitals, medical centres and health clinics. Australian health institutions are white intellectual spaces. The organisation of space in buildings sends crucial messages to clients regarding power relationships. As yet, few Aboriginal community-controlled health organisations have managed to influence architects to design AMS facilities in ways that reflect Aboriginal cultural values. Nunkuwarrin Yunti AMS in Adelaide is a custom-built Aboriginal health centre. A number of community-based clinics that were built after consultation with local people provide culturally appropriate features such as separate men's and women's entrances and areas. Some mainstream health clinics provide an outdoor circular sitting area around a fireplace in order to make Aboriginal clients feel comfortable. However, the majority of AMS buildings in Australia reflect hierarchical Western values. Space is sharply demarcated to protect medical specialists from the

masses and to allow for privacy in the health provider–client relationship. A reception desk is normally positioned between sick people and the doctors' rooms. Receptionists face the crowds and organise them into controllable units to present to the doctor. However, in remote areas, an important cultural factor in the healing process is not privacy in the doctor–patient relationship, or patient confidentiality, but community witnessing.

Witnessing is more than attesting to events. Witnesses consent to, and participate in, a performance (Sansom 1980:96–102). Healing events require witnesses to ensure that the healer performs his or her task correctly and does not harm the patient. If things go wrong, and the patient is harmed, the witnesses will be implicated in the blame because they did not intervene to save the patient. Both healer and witnesses are required to constitute the healing performance (McDonald 2006a). For Minyintiri, an Anangu traditional healer, '[Nurses and doctors] work inside the clinic buildings inside private rooms, so I can't say what they do. Their work is hidden' (Minyintiri, in NPY Women's Council 2003:25). In some remote community clinics, Aboriginal people are able to be witnesses to healing practices despite the architectural construction of the healthcare facility:

People all come in at once and crowd into the clinic. I thought, 'Hang on a minute, there is a waiting room'. No-one wanted to leave and wait in the waiting room. So I saw them one by one while they all sat together (Nurse practitioner, in Cramer 2005:99).

In matters of sexual health, however, Western codes of privacy and patient confidentiality are valued.

Memmott and colleagues (Memmott & Reser 1998; Memmott & Eckermann 1999) suggest that designers of Aboriginal public buildings work with culturally specific design knowledge based on Indigenous socio-spatial principles, preference for external orientation, concepts of respect and privacy, and values and attitudes about shared space. Aboriginalising of healthcare facilities can be directed and monitored by Indigenous community members. Indigenous involvement in architectural brief preparation can be drawn from Indigenous organisational representatives, local leaders, health staff and client representatives. In remote areas special care needs to be taken with the location of mortuary facilities. In Alice Springs many old people are reluctant to enter the hospital because of the collective presence of spirits of the many people who have died there.

Whiteness studies

Whiteness studies can contribute to an analysis of health systems as cultural domains. Whiteness operates as a social norm in Australia. This is the basis of its power (Shore 2000). White professional discourses, including discourses about Indigenous health, conceal white privilege and are complicit in perpetuating racial inequality. One of the insidious properties of the dominance of whiteness, and of white racial privilege in Australia, is its structured invisibility (Stephenson 1997). Whiteness studies investigate the economic and political histories behind the invention of whiteness. The purpose is to expose this fiction, to deconstruct the notion of a 'white race', and to make visible the history and practices of white superiority found in social life and institutions.

Whiteness studies (Moreton-Robinson 1999, 2000, 2001; Nakayama & Krizek 1995; Shore 1998, 2000) have been readily taken up by education and feminist researchers as a way to critique their disciplines and practices but not, thus far, by health researchers. This is a potentially fruitful area of research and one that could increase our understanding of Western institutions as cultural domains.

The biomedical model

The biomedical model of illness and healing is assumed to be cultureless (Taylor, J. S. 2003). However, Heil's (2003) research shows that the biomedical ideology is based on Western concepts of the self, that is, on the self-contained individual who is defined independently of family or community. This notion of the self influences the planning and delivery of Western healthcare.

Treatment regimes are designed for patients who prioritise individualised bodily health over social health. In central western New South Wales, Aboriginal people have difficulty adhering to individualised treatment and preventative health programs. Health practitioners complain that Aboriginal patients do not look after their bodies and do not comply with healthcare recommendations. Disjunctures between biomedical requirements and Aboriginal compliance are grounded in the relational nature of Aboriginal cultures (Heil 2003).

Aboriginal people in many parts of Australia espouse a relational–moral aetiology of illness (McDonald 2006a). But the biomedical model of illness strips away social contexts of meaning and diminishes awareness of the socio-political causes of disease. Complex social and moral processes are reduced to narrow cause-and-effect relationships (Mishler 1981; Riessman 1989:193). Diseases are interpreted in terms of a mechanical aetiology. The biomedical model privileges the health professional as expert on the patient's health and teaches diagnosis and treatment in isolation from wider social, historical and politico-economic considerations (AMSANT 2001:6) Health professionals, who work within a biomedical framework, tend to ignore global relational–moral causality, for example, the effects of economic globalism, world trade agreements and neoliberal politics on Indigenous people's health.

Racist attitudes within health services

Contemporary Australia was formed by colonisation, and racist ideologies were used to rationalise Indigenous dispossession and displacement. Racism involves the practices of exclusion, oppression and marginalisation, as well as the stereotypes and symbols required by these processes (Stephenson 1997). Institutional and structural racism manifests itself in the laws, policies and practices of governments, institutions, public service sectors and transnational organisations. In Western countries political elites lead the way in articulating racist discourses against otherness (Wodak & van Dijk 2000). The Australian Government and dominant political forces are currently in breach of the International Convention on the Elimination of All Forms of Racial Discrimination (Malezer 2004:9).

Institutional racism

Institutional racism consists of the organisational policies and practices that reflect the cultural assumptions of the dominant group. These policies and practices serve to advantage the dominant group while disadvantaging and marginalising others. The practices of the dominant group, which are sanctioned by political elites, are seen as the norm to which other cultural practices should conform. In Australia, Western culture is taken to be the norm against which other cultures and practices are measured. Institutional racism in this way becomes hidden and subconscious even to those who practise it. Anti-racist education is needed to expose

hidden and subconscious racist practices and to provide professionals with the intellectual tools to develop a critical understanding of their own cultural practices and values (RacismNoWay 2002).

Institutionalised racism in healthcare systems is characterised by inadequate funding for community health services, stereotypical views held by health professionals, language barriers, lack of cultural sensitivity and absence of cultural competences (Galabuzi 2002; King 1996). Institutional racism within Australian health services includes lack of interpreting services in regions where English is spoken as a second language, failure to fund cultural awareness programs for Western health professionals working in Indigenous communities, failure to give priority to preventative health programs in Indigenous Australia (that is, allocating the majority of funds to secondary and tertiary care programs), and failure of policy makers to incorporate health programs into community development and self-determination frameworks. Saggars and Gray (1991) argue that the emphasis on curative medicine is not only ineffective in combating Aboriginal ill health, but actually promotes it by diverting funds away from Aboriginal capacity-building and community development.

AMSANT (2001) found that some sections of the nursing workforce, including nurses' professional and representative bodies and individual nurses in remote communities, have been reluctant to acknowledge the greater authority of Aboriginal leadership to address Aboriginal health issues. Some nurses bring a paternalistic approach to their work with Aboriginal clients and attempt to undermine or obstruct the community's steps to take greater control. However, at the Council of Remote Area Nurses of Australia (CRANA) Conference 2000, CRANA responded positively to AMSANT's challenge to support the Aboriginal model of healthcare with a request to discuss opportunities for collaboration with AMSANT.

Intersectionality

Intersectionality has emerged as a research agenda mainly within Black Women's Studies (Corbie-Smith *et al.* 2000; Crenshaw 1996; Hine 1993; Zambrana 2001). Marginalised groups do not only inhabit racialised identities. They live at the intersection of multiple identifying factors, which serve to disempower them. These include race or ethnicity, language, gender, sexual orientation, educational achievement, socio-economic status, age or disability. Intersectional analysis

is a way of understanding people's multiple identities, and the multiple forms of oppression that marginalised people attract. It is also a way of analysing the complexities of power relations. People can be both the oppressor and the oppressed. Intersectional analysis has yet to be taken up by education researchers or health researchers.

Colonised identities

Cultural identities are historical, fluid and dependent on context. As subjects we occupy different identities at different points of time (Hall, Held & McGrew 1992; Gergen 1991). We construct narratives of the self in order to produce coherent and continuous identities (Hall, Held & McGrew 1992:277). But colonisation and colonial attitudes freeze cultures. Cultures once fluid, alive and open to the future are classified, systematised and fixed through colonial interpretations. Colonisers, who by definition wield power, claim the central subject position in relation to Indigenous peoples and other minority groups. They take on themselves the task of defining the otherness of marginalised people.

Although Aboriginal people in Australia have successfully claimed the right to self-determine who is Aboriginal and to determine the basis upon which their claims are legitimised, descendants of colonisers who appear to be unaware of this legal change continue the task of defining who is and isn't an Aboriginal person. In the media and in some academic discourses, Indigenous people are classified according to an 'either/or' traditional versus contemporary dichotomy. In rural towns it is frequently stated that if Aboriginal people want the same material benefits as whites, they cannot make a claim for cultural distinctiveness and different cultural needs: Aboriginal people who use modern facilities cannot be traditional and cannot claim 'traditional rights' such as subsistence hunting of native animals. Aboriginal people find themselves to be too contemporary to be traditional, and too Indigenous to be modern (Stewart 2003). Stewart sees this project of defining and excluding as unfinished colonialism. An understanding of alternative modernities can help to break down the psychologically damaging traditional/modern dichotomy.

Indigenous modernities are not the same as Western modernity (Gaonkar 2001; Muecke 2004). Western modernity developed in the context of Enlightenment assumptions about autonomous personhood based on self-interest, private property and the social contract (Chakrabarty 2000:217–8). Indigenous modernities developed within the context of

European colonial domination, which negated Indigenous people's concepts of land tenure, relational personhood and forms of reciprocity. However, Indigenous modernities, both urban and rural, maintain distinctive meanings of 'family', childrearing practices, work practices, concepts of time, processes of decision-making and forms of sociality.

Marcus and Fischer (1986:78) encourage theorists to move away from:

measuring change against some self-contained, homogeneous, and largely ahistoric framing of cultural unit toward a view of cultural situations as always in flux, in a perpetual historically sensitive state of resistance and accommodation to broader processes of influence that are as much inside as outside the local context.

Eckermann *et al.* (1992:109) believe that colonised Indigenous peoples need to develop a positive self-image to be able to function psychologically and socially. They need, above all, the power to define and organise their own cultural identities against white colonial and neo-colonial powers.

Social exclusion and inclusion

Galabuzi and Labonte (2002) describe social exclusion as the inability of certain groups to participate fully in civil society, to utilise public or social goods, and to participate in meaningful and economically viable employment. This inability relates to intersectional disempowerment. Social exclusion contributes to high health risks. Eckermann's (1977) study of a small Aboriginal population in rural southwest Queensland in the early 1970s found that about half of the adults drank to excess. She traced this to cultural exclusion and a socio-economic environment distinguished by few resources and unskilled or semi-skilled employment within an ever-growing atmosphere of chronic poverty. This was partially the result of restructuring of primary industries, which further restricted economic possibilities (Eckermann 1977, in Kunitz 1994:95). The social determinants of health approach needs to go beyond socio-economic measures to account for the health impacts of being excluded from the socio-cultural systems that facilitate access to economic and political resources.

Social exclusion of marginalised peoples has been intensified by the restructuring of global and national economies, the deregulation of markets, commoditisation of public goods, increased global migration, changes in workplaces towards flexible deployment, longer hours, work fragmentation, multiple jobs and non-standardised work, and the decline of the welfare state (Galabuzi & Labonte 2002). There are clear challenges here to health and education sectors in Australia, for example, the challenge to develop inclusive education and explore two-way (or intercultural) learning (Hooley 2002). Within the health sector, the development of Indigenous-specific health services and programs needs to continue and not be curtailed. Aboriginal community-controlled medical services today can learn from their thirty-year history. Organisations can develop more effective governance structures and community capacity-building within the broader struggle for Aboriginal self-determination (Martin 2004; Taylor R. C. 2003, 2004; CAEPR & Reconciliation Australia 2004).

Socialisation of health staff

Eckermann *et al.* (1992) attempt to make health professionals aware of their socialisation into professional roles by questioning the 'egalitarian principles' underlying the International Pledge and Hippocratic Oath; that is, the promotion of 'service irrespective of nationality, culture, creed, colour, age, sex, political or religious belief or social status'. Maori nurses in Aotearoa, New Zealand, suggest that this 'egalitarian' approach may 'harm the culturally different because they are different and they do have different needs' (Paige & Martin 1983, in Eckermann *et al.* 1992:163). When health staff members are encouraged to 'treat everyone the same', 'health' is defined by the dominant culture and it is the symptoms of the disease that are treated, rather than people. This contrasts with professionals who have developed the capacity to engage in intercultural dialogue and to switch between Western and Indigenous modes of knowledge and practice.

Winsor (2001:7) sees lack of respect as the basis of 'horizontal violence' towards Aboriginal health workers in mainstream health services. She talks of control, humiliation and denigration of dignity that routinely occur within the workplace, where other health professionals act as 'professional opponents and oppressors' (Winsor 2001:7). Winsor sees behavioural change as a requirement for equality in the workplace—the behaviours of co-workers must change to respect, and the behaviours of Aboriginal

health workers must change to self-respect. Flick (1997) asks why the development of Aboriginal health worker training within Western individualistic career structures should be viewed as 'empowerment', and argues that non-Indigenous health professionals need to be educated about Indigenous relational values and paths to self-esteem.

Racism within Aboriginal community-controlled health services

Racism directed towards Aboriginal people is not only evident in mainstream health services—it is also expressed by Western professionals who work within Indigenous organisations. Racism within Aboriginal community-controlled health services tends not to be based on external appearances but on how far people's beliefs and values deviate from the Western norm. Western culture is taken to be the norm against which other cultures and practices are measured. In community-controlled health services, it is said that Aboriginal people do not have a work ethic, cannot keep appointments, cannot distinguish between work and leisure time, have no knowledge of bodily processes, and are hopelessly non-compliant with treatment regimes (Barker 2005; Cramer 2005).

People are shocking in their compliance with treatment regimes. They are just not willing to comply for whatever reason... There is still the expectation that the clinic will fix it... We are still here to pick up the pieces (Nurse practitioner, in Cramer 2005:123).

Steffensen and Colker's (1982) study of Aboriginal women's compliance with treatment regimes shows that the absence of shared concepts between practitioners and patients may impede even willing compliance. When patients do not possess the background knowledge, or schemata, undergirding the Western practitioners' conclusions and proposed treatment, they are unable to fully understand what is communicated because they lack the conceptual framework for integrating and holding the information presented. Coulehan *et al.* (2005) state that a basic premise of successful health service delivery is effective communication between health staff and patients to achieve shared understandings about health, illness and treatment goals. This will enable patients to make informed decisions about treatment options and compliance with therapies. Devitt and McMasters (1998:165) suggest that the less patients understand what it is they must do and why, the more compliance itself becomes simply an issue of obedience.

High turnover of health staff

Borland (2000), Hegney, McCarthy and Rogers-Clark (2002), Carruthers and Warr (2004) and Cramer (2005:67–70) discuss the high turnover of staff in health services in rural and remote Indigenous communities. The current system of selection, medical education and remuneration does not encourage medical practice in rural and remote Australia (Mara 1999). Remote area practice, in particular, reveals inadequate preparation of healthcare staff, poor staff coping strategies, burn-out and rapid staff turnover, and poor continuity of health programs (Wakerman 1999). The research of Hegney (1998), Cramer (2005) and Drury (2005) indicates that healthcare staff frequently lack awareness of the debilitating effects of colonisation, do not have skills in intercultural communication, and are inadequately trained in health services management, chronic diseases management and preventative health programs. High turnover of health staff in Indigenous health services has been identified as a form of racism (Kaul 2003). Staff members are continually in a learning phase, the wheel is continually re-invented, and health programs are continually disrupted (Bookallil, Chalmers & Bell 2005; Mak & Marshall 2003; Smith 1997).

Reducing high staff turnover is a challenging task, given the working and living conditions of community life (Bell, Daly & Chang 1997; Alcorn & Hegney 2000; Bradley & McLean 2000; van Haaren & Williams 2000; Hegney, McCarthy & Rogers-Clark 2002). Borland (2000) described the challenges that rural nurses face in the delivery of services—dispersed populations, diverse cultures, geographic isolation, harsh extremes of climate, poor infrastructure, problematic transport, small economic base and limited political clout. Five themes emerged from Drury's 2005 study of the experiences of rural mental health nurses: provision of community healthcare; isolation, autonomy and advanced practice; professional development and status recognition; educational support; and caseload numbers and composition. Studies by Borland (2000) and Drury (2005) validate the perception that rural and remote nursing offers few incentives and few rewards in spite of increased responsibility and accountability.

AMSANT (2001) believes that the high levels of disease and disability in Aboriginal populations need to be addressed through the provision of well-resourced primary healthcare services based in communities. However, Deeble (2003) found that most of the 1999 federal government funding for Aboriginal health was directed to secondary and tertiary programs, highly technological solutions and high-level aged care. Deeble calculated that funding provided to

Aboriginal health services should increase by \$245 million. The Australian Medical Association (2004) estimates that an extra \$400 million per year is necessary to improve primary healthcare for Aboriginal people. The extra funds are needed to employ and educate additional health staff to meet the critical shortage of health professionals working in Aboriginal health. Kunitz (1994) believes that the basic inefficiency at the heart of health service delivery to Aboriginal people is grounded in politics, and that conflicts between Commonwealth and state governments are primarily responsible for ineffective implementation of programs.

Cramer's (2005:226–7) research reveals that nurses represent the largest proportion of health professionals and provide the largest proportion of health services in rural and remote areas. On the Ngaanyatjarra Lands in 1999 nurses and Aboriginal health workers provided between 89 per cent and 98 per cent of all health services rendered. But nurses' perceptions of healthcare delivery are largely unrecorded and are overshadowed by medical views of 'Aboriginal health'. Nurses also do not feature as an expenditure on Aboriginal and Torres Strait Islander health services. Ignoring the services nurses provide independently of doctors, the report merely noted that 'without information on the full set of services available in every region it was difficult to draw conclusions' about their accessibility. Cramer asserts that this missing information needs to be collected in order to expose the failings of health services records.

Hanna (2001) reports that difficulties facing rural and remote nurses first emerged decades ago, and recent federal government rural health strategies promised improvements in health outcomes. However, close scrutiny of funding allocations reveals that although nurses provide the majority of healthcare in rural and remote regions, they receive only a small fraction of funding support. For Cramer (2005:227), elision of nurse practice in remote and rural health records is nowhere more apparent than in the disproportionate 'mismatch' between federal budget allocations for doctors in comparison with nurses. In the 2000–01 rural health budget, over 76 per cent of workforce funds was allocated to doctors for education and other incentive programs. Nurses were subsumed under 'Allied Health Services' and no funding 'specifically targets' nurse practice issues.

Recommendation: More research should be conducted into strategic approaches to recruitment and retention of rural and remote area health staff. Research should be conducted into recording procedures of health services and into funding allocations.

Anti-racist strategies

Decolonisation is not just for the colonised; the process must also include the coloniser (Kortright 2003). Health research can include analysis of politico-economic policies and practices that create excluded groups and conditions (Galabuzi & Labonte 2002). National and regional health offices can establish official policies on racism within health services and develop strategic plans to combat racism. Anti-racist strategies can be taught in cultural education programs for new health staff and focus on the dominant culture, on whiteness, institutional racism, intersectionality and social exclusion (Hollinsworth 1992; Razack 2002). Health policies need to be developed within a social inclusion framework and should focus on empowering marginalised people. CRANA's commitment to collaborate with AMSANT to support Aboriginal models of health in remote area nursing practice is an example of what can be achieved (AMSANT 2001).

Socio-cultural factors that inhibit the development of healthy behaviours and successful participation in healthcare delivery

Many health researchers locate the solutions to Aboriginal ill health in well-funded healthcare services. However, others such as Kunitz (1994), Robinson (1996), Sutton (2001, 2005) and Thomson (2003) argue that Aboriginal health issues are too complex to be tackled solely by the available range of healthcare services. Historical, socio-cultural and environmental factors, which are outside the scope of medicine, contribute to the development of Aboriginal ill health (Thomson 2003:493).

Much contemporary literature on the social determinants of health omits culture as a factor that may work synergistically with other social determinants to perpetuate ill health. In his discussions on the social determinants of health, Marmot (2001, 2004) focuses on socio-economic factors, particularly social position and household income. People

with low control over their life circumstances at work and in daily life have a higher incidence of metabolic diseases such as diabetes and cardiovascular illness. Marmot sees Indigenous peoples primarily as a socio-economically disadvantaged group. Policy makers, likewise, tend to treat Australian Aboriginal people as blank slates and do not take into account cultural difference or cultural dissonance with Western institutions.

Kunitz (1994:187) argues that Aboriginal people are not just an oppressed people who are victims of poverty and prejudice: they are a people with distinctive cultural practices that were developed in hunter-gatherer environments, but which in different environments can contribute to ill health. Sutton (2001, 2005) believes that the serious health problems faced by Aboriginal people arise from a complex conjunction of pre-colonial socio-cultural factors, including a kin-based economy, gender relationships and childrearing practices, with colonial and neo-colonial factors such as population density and the easy availability of alcohol, tobacco and other drugs. 'Culturally embedded behaviours' that directly impact on Aboriginal people's health include domestic sanitation and personal hygiene, housing density, diet, care of children and old people, conflict resolution, social acceptability of violence, cultural expression of emotions, the value placed on physical wellbeing, attitudes to new knowledge, and attitudes to behavioural change (Sutton 2005:2). The *Report of Uwankara Palyanyku Kanyintjaku* identified nine healthy living practices that need to be implemented to improve Aboriginal health in desert regions: washing people, washing clothes/bedding, removing waste, improving nutrition, reducing crowding, separating dogs and children, controlling dust, temperature control and reducing trauma (Nganampa Health Council, South Australian Health Commission & Aboriginal Health Organisation of South Australia 1987; Pholeros, Rainow & Torzillo 1993).

Marmot (2001, 2004) and other health researchers state that the social conditions associated with the best health are those of white, middle-class people. Sutton (2001:137) appears to believe that Western practices and values are better (or more healthful) than Indigenous ones, and that Indigenous people need to make 'deep cultural changes' in order to catch up. Sutton (2005:9) endorses Pearson's (2004) suggestion of sending children away from their home communities to urban regions, in this case to learn a different 'health culture'. What these statements ignore, and even conceal, is that the health problems endured by Aboriginal people are the direct outcome of agricultural, industrial and post-industrial practices. A nutrient-dense hunter-gatherer

diet fits all the requirements for the prevention of diet-related chronic diseases (O'Dea 1994). Hunter-gatherer diets are advocated today as therapeutic diets for people at risk of diabetes and vascular disease (Eaton, Shostak & Konner 1988; Washington 1994; Cordain *et al.* 2002).

The health of Aboriginal people has been undermined by the nutrient deficiencies and infectious diseases of land-clearing agricultural societies and by the diet-related chronic diseases of industrial and post-industrial societies. Agricultural development is everywhere linked to decreasing average height, increasing obesity and a decline in overall health. The agricultural industry, developed to increase food production for increasing human populations, has had an adverse effect on human health and vitality (Cassidy 1980; Boustany 1999; Wadley & Martin 2000). The *raison d'être* of the global food industry is no longer feeding the masses, but making large profits for the few (Paul & Steinbrecher 2003). Harris and Seid (2004:248) found that neoliberal politics, trade liberalisation and deregulated markets have led to unemployment, environmental degradation and health decline in economically deprived regions. Research by Hawkes (2002) and Morelli (2003) shows that healthy eating programs are undermined by the global food industry, which directs marketing particularly to children and teenagers. The global marketing of unhealthy food, tobacco and alcohol penetrates Third and Fourth World communities, and there is pressure on young Aboriginal people today to conform to a global fast-food culture (Kouris-Blazos & Wahlqvist 2000; McMurray & Smith 2001).

White middle-class people with high educational levels and high incomes are able to take advantage of health promotion messages about immunisation, quitting smoking, taking daily exercise and eating healthy diets. People who hold liberal atomistic models of human agency (that is, the perception that moral agents can act in isolation from others and are limited only by their own values and capacities) are able to prioritise individual bodily health over social wellbeing (Donchin 1995; Heil 2003). They avoid the diseases created by agricultural, industrial and post-industrial technologies by practising excessive personal hygiene, personal diet and exercise regimes, by not smoking and by drinking in moderation. Middle-class people keep their minds and bodies healthy by adopting the city-state virtues of reason, efficiency and moderation (Prior 1991:195).

Biomedical treatments are also tailored to the requirements of atomistic, self-motivating individuals. Chronic disease self-management programs are articulated in terms of

future-oriented, goal-directed individuals who adhere to an ethic of delayed gratification (McDonald 2006b). However, rather than trying to turn Aborigines into white people, Western health professionals can learn to value and work with relational cultures. This valuing has already begun in some theoretical disciplines. Recent feminist work has moved away from a focus on individual autonomy towards a view of human action made meaningful through social engagement. An understanding of relational autonomy requires a focus on the importance of supportive social conditions for fostering human action (Sherwin 1998). Aboriginal families can follow the *Report of Uwankara Palyanyku Kanyintjaku* recommendations through community-based rather than individualised healthy living practices. Rather than expecting household heads to buy and maintain technologically complex equipment, Aboriginal cooperatives can run not-for-profit community facilities such as laundromats that include disinfecting facilities. Aboriginal cooperatives can also run not-for-profit cafes to sell healthy stews and soups at lower prices than commercial take-away food outlets.

Recommendation: Research should be conducted into the feasibility of developing or extending not-for-profit community facilities in order to implement the healthy living practices recommended by the *Report of Uwankara Palyanyku Kanyintjaku*.

In New South Wales the Aboriginal Employment Strategy, which began in Moree and has spread to other regional and urban centres, has the explicit goal of creating an Aboriginal middle class in regional and urban Australia (Dusevic 2005). The ability to generate a good income and standard of living, along with a sense of pride in one's talents and creative energies, does not have to equate with atomistic individualism. Collectivist cultures manage hygienic regimes and nutritional practices as well as individualistic cultures. Kim and Park's 2005 research shows that relational efficacy and social support received from significant others have a strong influence on human motivation, wellbeing and personal accomplishment in relational cultures. Whiteness studies can help people to make a critical distinction between middle-class attainment and whiteness (Moreton-Robinson 2001).

Time and sociality

In many parts of Australia Aboriginal people's cultural imperatives relate to particular concepts of time and forms of sociality. A Northern Territory man told Jordan (2005:99), 'We're not like you Balanda [white people]. You drink a little bit everyday, but we Aboriginal people don't do that. We drink it all at once and get full drunk. We're different.' Phillips (2003:20) stated that in a north Queensland community, Aboriginal people who drink alcohol tend to be binge-drinkers. They join grog parties and frequently drink for up to four to seven days at a time (Phillips 2003:45). Turner and Graham's (2005) survey of Aboriginal people living in Kakadu National Park found that food and drink coming into households was consumed relatively quickly, and a large proportion of the population went without food for a twenty-four hour period in the preceding week. Aboriginal people's use of food, alcohol, tobacco and other drugs reflects a temporal system in which the rewards of immediate consumption outweigh future adverse health outcomes.

At Murrin Bridge in central New South Wales, binge-drinking has been incorporated into notions of sociality and conviviality. 'Being on the grog' is 'good fun' and 'enjoyment'. People who decide to stop drinking, and move to another town to facilitate this, are considered to be 'not one of us' (Heil 2003:166, 206). As a result of shared identity and feelings of empathy between kin, family members often provide excessive drinkers with protection and support, and do not show disapproval towards their behaviour (Brady 2004). Parents supply teenage children with money for marijuana, saying, 'They are my blood. I have to help them out.' Help is seen in terms of short-term relief of stress, rather than in terms of the long-term adverse effects on health. O'Connor (1984), writing about alcohol use in Central Australia, argued that the priority of relationship is evident in decisions to keep drinking even when it causes ill health. If a choice between biological death and social death must be made, many people will choose biological death.

In some communities Aboriginal people do stop drinking by joining an honorary kin group such as the 'Church mob'. The decision to stop drinking may relate to a doctor's advice (Brady 2002) or it may relate to the person's family circumstances, for example, the desire to nurture young grandchildren. The person's individual decision to stop drinking needs to be nurtured and legitimised by a wider group. Kinspeople say of non-drinkers, 'The Church can't let them drink'. This is an acceptable explanation because it does not violate notions of kinship and social obligations.

The kinsperson is not saying, 'I won't drink with you'. Rather, the Church is saying, 'You can't drink with them'. Solutions to harmful drinking practices may be found in creating other kinds of honorary kin groups to support people who choose to stop drinking (McDonald & Wombo 2006).

Recommendation: Research projects should be developed to look for ways to 'work with' Aboriginal cultural practices and values, for example, working with kinship networks to discourage alcohol and substance use.

Childrearing practices

Aboriginal people in many parts of Australia adhere to permissive childrearing practices that worked well in hunter-gatherer times and that are humane in comparison with Western disciplinary practices. Traditionally, there were 'no recriminations for disobedience; in fact, there is no idea that a child should obey, for in the normal course of life, the child will do what he wants' (Hamilton 1981:78). Parents trusted the country (and the ancestors) to look after children and trusted their children to learn from their experiences. The land itself nurtured children by providing food and shelter. Aboriginal children were taught to be self-reliant and physically autonomous from a young age. Children learned by observation and imitation, and by trial and error. They learned many things about the world from peers rather than from their parents (Hamilton 1981; Tonkinson 1991:82-6; McDonald & Wombo 2006).

Boustany (2000:5), writing of Koori childhood in the Northern Rivers region of New South Wales, says that a 'sense of independence is strongly encouraged from childhood and Koori women will not molly-coddle their children as in western culture'. Urban Aboriginal and non-Aboriginal people stereotype each other's childrearing practices rather than trying to understand cultural differences. Urban Aboriginal people say that white children are babied by their parents and carers. Westernised people say that Aboriginal parents do not discipline their children. Western childrearing practices, which can be traced back to militarised city-state and nation-state cultures, would not prepare children for a self-reliant hunter-gatherer life. Likewise, permissive childrearing practices do not work well in a Western environment with institutions that are highly regulated and disciplinary, which promote an industrial work ethic, adhere strictly to the notion of working days and working hours, and run on clock time (McDonald & Wombo 2006).

Today in many parts of Australia, Aboriginal parents still trust the environment to provide for their children and trust their children to learn from their experiences, but the environment is no longer benign. Many parents are unable to provide parental guidance to their children because they have been unable to achieve a good life for themselves. Some parents are unavailable to their children because of their dependence on alcohol and other drugs (McDonald & Wombo 2006). The Kimberley Aboriginal Medical Services Council Health Promotion Unit and Social and Emotional Wellbeing Unit have made parental guidance and encouragement of children a high priority. The central theme, 'Children—Praise Them Up to Raise Them Up', is being promoted to Kimberley communities, parents and children (KAMSC 2005).

Recommendation: Collaborative research with Aboriginal psychiatrists, psychologists, doctors, nurses and health workers should be carried out to develop Indigenous parenting and family wellbeing programs that 'work with' Aboriginal childrearing practices to foster a strong sense of Aboriginal identity in young people and develop their ability to thrive (and to avoid the pitfalls of substance misuse, violence and legal-system entanglement) in the contemporary world. Mentoring programs for young people should be developed to help broaden young people's horizons and empower them to make life choices that will benefit themselves, their families and communities.

Colonial legacy

Phillips (2003), an Indigenous health researcher, has found that poor healthcare delivery in a north Queensland community reflects the legacy of colonisation—the community's relationship with the Church; factionalism between different landowning groups living in the community; factionalism between Community Council and health staff, which inhibits the development of creative solutions to community problems; and the failure to decolonise Western theoretical frameworks (Phillips 2003:115-17; 126-9). Other factors mentioned by Phillips include the role of kinship in taking up and continuing alcohol, tobacco and other substance use (64-6), and children's normalising of dysfunctional behaviours, for example, children imitating adult card playing and fighting (55, 77) and children playing with ropes around their necks following a community suicide (160).

Recommendation: Community-based collaborative research should be carried out to explore solutions to the problems identified by Phillips.

Pentecostal churches and provider–client relationships

Some Pentecostal churches in northern Australia inhibit successful Indigenous participation in health service delivery and contribute to Indigenous people's high mortality rates because pastors insist that God does not want people travelling to large metropolitan hospitals to undergo major operations such as kidney transplants. God wants to heal them in their own environment and without human intervention to demonstrate to Aboriginal people his supernatural power. Pastors make extravagant claims during healing sessions that the sick person will never again need a wheelchair, dialysis tubes or insulin. They claim that, 'God is at this very moment fashioning new kidneys for [the sick person] with his own hands' (McDonald 2001:143).

In many parts of Australia, Aboriginal people's cultural values are strongly egalitarian. Aboriginal people do not accept a hierarchical, authoritarian relationship between health practitioner and patient. Doctors are considered to be authoritative but fallible, and sometimes not to have the interests of their patients at heart. Many people do not feel any compulsion to give the doctor an accurate account of their diet and lifestyle and do not feel they must pay attention to the doctor's advice. In the provider–patient relationship, Aboriginal people see themselves as having a choice (McDonald 2006b). For Humphery *et al.* (2001), medical debates about patient compliance are inappropriate in a post-colonial era. The *Sharing the True Stories* project emphasises the need for health professionals and Indigenous clients to develop shared understandings of health and illness, thereby enabling Aboriginal people to exercise more control in their healthcare (Coulehan *et al.* 2005).

In northern Australian Indigenous communities, Aboriginal assimilation of Pentecostal messages about healing, resistance to hierarchical provider–patient relationships and a one-way flow of health information and health professionals' cultural knowledge deficits have contributed to many unnecessary deaths.

Ways to work with 'culture' to contribute to improved Indigenous health outcomes

Health promotion

Much mainstream health research has viewed cultural difference as an impediment to good health (Bond 2003). However, the Geneva declaration of the health and survival of Indigenous peoples affirms that cultural identity and expression is essential to a people's wellbeing (Committee on Indigenous Health 2002). In health promotion programs, a one-way flow of information from Western health professional to Indigenous patient is a form of institutional racism. If we do not explicitly take into account Indigenous beliefs and values, we are in fact excluding them and diminishing their value (Garcia 2001:15). Using Indigenous concepts and practices in health promotion programs can contribute to the decolonisation of Western medicine in Indigenous communities (Garcia 2002).

For Aboriginal people in many parts of Australia, sickness is perceived as coming from malignant outside forces or antisocial actions. In health programs it is helpful to view chronic diseases as coming from outside forces, for example, the effects of colonisation, and to speak in terms of tools to overcome these effects (Heffernan 1995:284). Cultural understandings, such as Aboriginal concepts of strength and weakness, heat and coolness, and flow and blockage, and cultural images of good lives and strong bodies can be developed to promote a sense of control over the disease. Aboriginal notions of strength (versus weakness), movement (versus stasis), coolness (versus heat) and flow (versus blockage) can be used to humanise Western physiology and produce health programs that are meaningful to Aboriginal people (McDonald 2006b).

HEATworks (Health Education and Theatre Works) is a Kimberley Aboriginal-controlled health promotion performance group. It uses writers, actors, musicians, singers and Aboriginal advisers who work within an Indigenous culture of oral transmission of knowledge. The group writes dramatic stories to help people identify with the characters and their problems. Health information is presented within 'real life' contexts. HEATworks has worked on Aboriginal youth anti-smoking campaigns, condom promotions, HIV/AIDS workshops, pap smear awareness programs, environmental health projects, NAIDOC Week programs, self-esteem

workshops and health music concerts. The group has performed *No Prejudice, A Change of Heart, It's a Crab's Life, The Good Feeling* and *Moving Stories* (KAMSC 2004).

Health practitioners frequently find that Aboriginal people can repeat information about good nutrition and appropriate diets without feeling any compulsion to change their food choices (Harrison 1991:163; Cramer 2005:120–21; Saethre 2005). Health educators can engage with Aboriginal concepts of desirable food in order to counteract the aggressive marketing of the global food industry. Aboriginal people's love of sweet plants and fat grubs and animals is well known (Green 2003). When these food preferences coincided with energy-dense but nutrient-poor rations on pastoral and mission stations, metabolic disturbances occurred, leading to the current epidemic of diabetes and vascular disease. Health promotion messages can 'work with' Aboriginal people's food preferences by making a distinction between naturally sweet foods and artificially sweetened foods, or between sweet plants from the ground and sweet food made in factories.

If health education is taken out of a narrow biomedical framework, which focuses on micro-level bodily functions, it will become more accessible to Aboriginal people. Chronic diseases can be discussed within a larger socio-political framework, for example, their origins in agricultural practices and their intensification in industrial and post-industrial practices. Health programs can be developed within a framework of community empowerment to explore the relationship between globalisation and the increasing incidence of chronic diseases in economically deprived regions (Braithwaite & Lythcott 1989; McDonald 2006a). Community empowerment programs can explore ways to offset the negative impacts of globalisation on community life (McDonald & Henderson 2005).

Provider–client relationships

In Western countries over the last three decades the doctor–patient relationship has become an important focus of research attention. This relationship has evolved from a paternalistic model, where patients' preferences were generally ignored, to a current model of relative patient autonomy. The medical interview, the means by which the doctor elicits a patient's medical history, has been subject to scrutiny by social scientists (Haidet & Paterniti 2003; Roter 2000). In medical schools doctors are taught to create good interpersonal relationships, and learn to develop empathy, respect, unconditional acceptance and mutual trust (Ong *et al.* 1995:904).

Research papers have been written on patient-centred interviews (Nagy 2001), narrative-based interviews (Haidet & Paterniti 2003), participatory communication (Khadka 2000), 'truth telling', 'enhanced autonomy' models, 'relationship-centred' models (Quill & Brody 1996) and shared decision-making (Dominick, Frosch & Kaplan 1999). Doctor–patient communication influences the patient's satisfaction with care, adherence to treatment, understanding of medical information, coping with disease processes and quality of life (Ong *et al.* 1995).

Provider–client relationships in Indigenous communities

A number of studies have shown that Aboriginal patients in northern Australia frequently express dissatisfaction with their medical treatment and with the behaviour of doctors and nurses. They complain that health practitioners ask too many questions during the medical consultation. Health experts should know the patient's condition (Watson, Hodson & Johnson 2002; Phillips 2003; Cramer 2005:60–5, 120). The fact that Western doctors must question their patients to diagnose an illness, while traditional healers can see what is wrong, reveals the superiority of traditional healers (Peile 1997:167). Aboriginal people are often dissatisfied with the explanations provided by health professionals, and do not believe they are being told the 'full story' or 'true story' (Reid 1983; Watson *et al.* 2002; Weeramanthri 1996). People complain that doctors send some patients but not others to large metropolitan hospitals for treatment. Family members fear that disclosure of a relative's poor prognosis will contribute to that person's premature death (Trudgeon 2000).

A study by Cass *et al.* (2002) of communication between health professionals and Aboriginal patients with end-stage renal disease in Darwin revealed serious miscommunication, often unrecognised by participants, regarding fundamental issues in diagnosis, treatment and prevention. Factors impeding communication included dominance of the biomedical model, marginalisation of Indigenous knowledge, lack of control by the patient, lack of shared knowledge and understanding, differing modes of discourse, cultural and linguistic distance, lack of staff training in intercultural communication, and failure to call on trained interpreters. There was an absence of educational resources and opportunities to construct a body of shared understanding, not only of body organ physiology and disease, but of the cultural, social and economic dimensions of the illness experience of Aboriginal patients.

Fenwick and Stevens's (2004) report on Aboriginal women's experiences of post-operative pain in a Central Australian hospital reveals that Western-trained nurses have a profound knowledge deficit regarding Aboriginal interpretations and management of pain. Central Australian Aboriginal women believe that nurses should know when patients experience post-operative pain. Nurses know when to give patients medication, when to give patients food after an operation and when to get patients up to walk. They should also know when patients are in pain. Because Aboriginal women did not communicate their experiences of pain to nurses, nurses fell back on the old misconception that Aboriginal people have a high pain tolerance requiring less pain relief.

Eades's (1985, 1991, 1994) research into information-seeking reveals that in Western contexts information is frequently elicited by asking one-sided questions. People who are seeking information do not need to provide information about themselves or their motivations. However, in Aboriginal communities, information-seeking is a two-way process, with the questioned and the questioner both contributing information. In many situations in Australia, white people in positions of power ask direct questions of Indigenous people in ways that are highly inappropriate to Indigenous ways of interacting (Eades 1994). During medical interviews, doctors frequently ask narrowly constructed closed-ended questions that require yes/no answers. Haidet and Paterniti (2003) suggest that doctors should use conversational devices such as orientation statements, paraphrasing statements, reflections and empathic statements to de-emphasise the interrogational nature of the medical interview.

Boustany (2000) advises general practitioners in the Northern Rivers region of New South Wales to encourage patients to tell their own stories, to allow time for responses and to allow time for silent contemplation. She has found that Aboriginal people prefer to deliberate rather than make immediate decisions. The process of information-seeking can be helped by explaining why health practitioners need the information. If health practitioners are unable to obtain the information they need, the patient may be happy for them to ask family members or involve Aboriginal health workers. There is a conception that illness takes over a person,

and that sick people are not responsible for their utterances while ill, so some Aboriginal people would prefer a close relative to speak for them.

Health services directed at the level of family and significant others are more likely to be successful than initiatives focused solely at the individual level. Sansom's (1982) study of life-threatening illness in a town camp focuses on the community of suffering (those who mobilise around the sick person). Sick people are believed to be temporarily deprived of volitional control, that is, they are rendered passive and unable to speak for themselves. The healing process is seen as the community's responsibility, and caring and supportive relationships are crucial to recovery (Sansom 1982). Observation and feeling are important forms of communication, and empathy and sociality are valued aspects of the therapeutic relationship (Mitchell 1996:269–70). In contrast, people who suffer from minor illnesses, which are not life-threatening, are required to exhibit personal stoicism.

The *Sharing the True Stories* project, conducted with Aboriginal client groups and health staff in renal and hospital services in the Northern Territory, identified three key strategies for improving communication between health professionals and Aboriginal patients: increasing Indigenous involvement in overall management processes and in provider–patient encounters; constructing shared understandings of key processes and concepts in healthcare through a sustainable collaborative process involving health practitioners, researchers and clients; and improving communication practices through institutional support and strengthening individual expertise (Smith 2003:5; Coulehan *et al.* 2005).

Ariotti (1999) discusses the reconstruction and re-empowerment of Anangu people's understanding of disability through the work of the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council. Service providers work within a framework that sees 'disability' in relational terms and does not confine itself to the limitations and sense of loss experienced by individuals separated from community. Service providers accept the directions of, and priorities established by, the community, as it is the perceptions of individuals within community that determine how the services are provided.

Cultural education programs

Cultural education programs for Western health staff are carried out by a number of organisations Australia-wide (see the appendix for a list of programs). However, despite the number of cultural awareness programs that are available, many health services in rural and remote areas, including Aboriginal community-controlled health services, do not provide cultural education programs for new health staff. Puntukumu AMS in the Western Desert provides no cultural education programs for health staff working with the 2000–2500 Mardu people who live at Jigalong, Parnngurr, Punmu, Kiwirrkurra and Kunawarritji communities (personal communication, Camplin, Puntukumu AMS). Many small health services do not have the funding to send health staff to cultural education programs. Many health administrators see cultural awareness programs as an unnecessary indulgence. Many Indigenous communities are so desperate for health staff that new staff are put to work immediately without any kind of orientation (personal communication, McKay, CRANA).

Recommendation: The Office for Aboriginal and Torres Strait Islander Health should fund cultural education programs Australia-wide for new health staff working in Indigenous communities and in health centres that have a majority of Indigenous patients/clients.

Cultural competence

In Western countries, cultural competence training is promoted as a key tool in reducing health disparities between whites and minority groups. Training in cultural competency has been incorporated into undergraduate medical education in America and Britain. Culturally competent doctors learn to adjust their attitudes and behaviours to the needs of patients from different cultural backgrounds. However, a criticism of cultural competence education is that it tends to become a decontextualised list of traits about 'exotic others'. This can promote stereotyping and essentialising. In many cultural competence models what is missing is an analysis of the power relations between health providers and clients, particularly clients who come from different cultural backgrounds (Fuller 2002:198–200; Hunt 2001:2). March's (2005) study did not show any direct link between cultural competency training and improvements in the health of cultural minorities. Despite widespread popularity amongst Western health professionals, cultural competency remains a vaguely defined goal, with no explicit criteria established for its accomplishment or assessment (Hunt 2001). Far more

rigorous testing is needed to show that the training does more than just facilitate better interactions between caregivers and patients (March 2005).

Cultural awareness

Cultural awareness programs should not just be about other people's cultures. Cultural competence ideally includes self-reflection and self-evaluation. Western health professionals who work in Aboriginal communities can be given the intellectual tools to develop a critical understanding of their own cultural practices and values. Western concepts of the self, concepts of time and the work ethic are not natural, but are social constructs that have their own particular histories. Historical research reveals that in Western countries before the Industrial Revolution, agricultural workers controlled their own production, and set their own working hours according to seasonal requirements (Bader 2002). The industrial work ethic was developed to support unnaturally long working hours for small rewards. Key elements of the work ethic were diligence, frugality and deferment of gratification. Factory schooling emphasised punctuality, obedience and order (Mokyr 2003; Rose 1985). In the transitional period, women and children were chosen as docile and malleable labour because adult males were often unruly and intoxicated (Mokyr 2003).

Benjamin (1988) sees time, in Western modernity, as continuous, empty and homogeneous. Any number of people, places and events can be slotted into this infinitely stretched-out flow of time. However, in non-industrial societies, time is embedded in human labour practices and seasonal events (Chakrabarty 2000). With industrialisation, working time was separated from the time of everyday life. Industrial time could be quantified, regulated and managed (Gasparini 1993). The introduction of industrial time-discipline was not spontaneously accepted by the new industrial workers (Bader 2002). Transgressions were frequent in the transitional period and were harshly penalised by industrial managers (Hobsbawm 1999; Thompson 1967).

Intercultural health services

The Mexican National Campaign to enhance the quality of health services has in the last decade been developing intercultural health services. Interculturality is based on dialogue, where both sides listen to each other, where both sides exchange cultural information or simply respect each other's peculiarities. An intercultural approach develops

same-level (horizontal) relationships and promotes empathy, equal opportunity, empowerment, win-win relationships and synergy (attaining results that could not be achieved independently). Acknowledging and incorporating cultural beliefs about health and illness into the assessment, diagnosis, treatment plan and prevention strategies contributes to successful healthcare (Garcia 2002).

After twenty-eight years of linguistic, ethnobotanical and health-related research with the Kukatja people of the Great Sandy Desert, Peile (1997) found that abstract biomedical knowledge and contextualised Indigenous knowledges need not be incommensurable, and called for an integration of Indigenous and biomedical practices in health services. Sheldon, a psychiatrist working in Central Australia, found Western models of clinical examination and assessment to be deficient in relation to Aboriginal patients. In his practice he consciously blended Indigenous and Western therapeutic practices. He worked with traditional healers and adopted Aboriginal language concepts for mood and behaviour disorders. His work is being continued by the Sheldon Foundation (Sheldon 1997).

In the 1980s Devanesen and Soong encouraged the practice of 'two-way medicine' in Central Australian health services by combining the best of Western and traditional medicine. In practice, this included recognising the skills of traditional healers and traditional midwives. Traditional paintings and stories were used in health education, and bush medicines were documented (Devanesen & Briscoe 1980). The

Northern Territory Department of Health supported a 'bicultural approach' to primary healthcare by employing a number of traditional healers who worked alongside Aboriginal health workers, nurses and doctors in Central Australian health services. Healers worked with traditional understandings of bodily processes and worked to redress moral imbalances, relieve stress and balance-up sick people (Soong 1983).

Intercultural health service is not just about facilitating the parallel use of two discrete medical systems, or about adopting best practices from two medical paradigms. It is about facilitating a creative dialogue between the proponents of two medical systems, which in most Aboriginal communities are no longer discrete. It is about engaging Aboriginal and non-Aboriginal health professionals,

researchers and community members to work together to develop common conceptual frameworks around health and illness within which health practitioners and patients can negotiate comprehensible treatment regimes, chronic disease management programs and prevention strategies. Notions of social, relational and family efficacies can be developed to facilitate behavioural change. Family-based programs, which mobilise family support and encourage family-generated health strategies, are likely to be more successful than individualistic treatment regimes, chronic disease management programs and preventive health programs (McDonald 2006b).

Western health professionals who work in intercultural health services can be educated about the colonial history of Indigenous people in Australia. They can develop respect for Indigenous cultural values, different meanings of 'family', different childrearing practices, and different ways of expressing social and emotional needs. They can learn to work with Indigenous kinship networks, forms of sociality, concepts of time and decision-making processes (Hooley 2000, 2002; Maddocks & Rayner 2003). The provider-patient relationship can become a process of information sharing and negotiation. Western and Aboriginal health practitioners and researchers can develop collaborative approaches to treating and preventing illness that satisfy both Western and Aboriginal understandings of good health.

And when we get together, for this story called Sharing the True Stories—we talk together, and present mobs of our own ideas, we bounce them backwards and forwards, backwards and forwards, those Balanda [non-Aboriginal people] and we Yolngu. What they are thinking, and what we are thinking, then we reach agreement for that point. Then we are joined together. Our story becomes one (Yolngu health researcher, in Coulehan et al. 2005:2).

Appendix

Cultural education programs

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