



**Aboriginal Holistic Health:
A Critical Review**

Mark Lock

Cooperative Research Centre for
Aboriginal Health

Discussion Paper Series: No. 2

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The Cooperative Research Centre for Aboriginal Health (CRAH) has instituted this Discussion Paper Series as a forum for its researchers, students and associates. The purpose of the DPS is:

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Thank you to the four anonymous reviewers who provided invaluable critical suggestions that improved the paper.

Abbreviations

ACCHS	Aboriginal Community Controlled Health Services
AMA	Australian Medical Association
ATSIC	Aboriginal and Torres Strait Islander Commission
COAG	Council of Australian Governments
CPHC	Comprehensive Primary Health Care
GP	General Practitioner
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NAIHO	National Aboriginal and Islander Health Organisation
WHO	World Health Organization

Executive Summary

The concept of Aboriginal holistic health occupies a central position in Aboriginal health policy discourse. But what is the concept of Aboriginal holistic health and how does it affect policies, programs and strategies? To answer this question I conducted a literature review, which, although providing limited information, is an important tool for policy makers to gain foundational understandings of an issue.

In my review, I could not find a single or definitive written source to guide my understanding of, and engagement with, Aboriginal holistic health (referred to as 'the concept') or to enable me to transfer it to the myriad of people in the health system. Instead, I found 153 publications of the health professional literature that made explicit reference to the concept, and conducted a content and thematic analysis in an attempt to gain a clear understanding. I discuss the findings through twelve engagement points and by drawing on ten themes from the literature.

This is the first time that such a critical analysis has been conducted of Aboriginal holistic health by drawing on such a diverse range of publications (point 1). From these publications come ten themes that 'frame' the concept of Aboriginal holistic health (point 2). In thinking about these themes, it should be kept in mind that the cultural authenticity and content of the publications is difficult to establish (point 3). Furthermore, an insufficient citation practice made it difficult to locate the concept's intellectual sources (point 4). Additionally, this literature did not critically locate many Aboriginal concepts of health (point 5) and authors show an unreflexive interpretation and are uncritical of the concept (point 6).

The most significant finding lies in the unfounded perception of holism as immutably Aboriginal (point 7). Also, there are confounding discourses attached to the concept that prevent a trusting engagement by policy makers (point 8). Added to this is the lack of an operating framework and shifting constituent elements (point 9). As such, there is an inability to judge health system performance using the concept (point 10). This is in part due to many barriers to effective textual and oral transfer into the policy context of Aboriginal concepts (point 11). Finally, the concept is accepted as 'excised'—without critical thought—from the meanings attached to it through its historical developmental context (point 12).

As a whole, these findings mean that I could not achieve a clear understanding of the concept. Additionally, its boundaries appear so diffuse and ethereal that any argument about the health system could be constructed as holistic. I suspect that this is, in part, due to the limitations of deriving meaning from a synthesis of written material. Nevertheless, this literature review demonstrates how the validity of such concepts can be undermined by poor definition, operationalisation, and conflicting and confounding discourse.

Therefore, I suggest that advocates of Aboriginal concepts of health have not yet effectively articulated them in writing. However, this leaves open the question about how these ideas might be operationalised in oral discourse. Further work is needed to investigate the social context in which Aboriginal health concepts are utilised. In addition, the information obtained should be crafted into operational frameworks to facilitate engagement by all policy makers in the Australian health system. Such efforts could transform their rhetorical significance into practical effect.



Introduction

What is the concept of Aboriginal holistic health and how does it affect policies, programs and strategies? I began this study after being asked this question many times. Since 1995 I have worked in Aboriginal health at a medical service, for Commonwealth and State governments, and in the university sector. I am of Wangaaypuwan descent and have often felt that I should automatically know about holistic health.¹ However, neither my work nor my identity has brought me any clarity about the concept of Aboriginal holistic health (hereafter referred to as the concept).² Also, I could not find a single definitive written source to guide my understanding and engagement with the concept or to enable me to then transfer it to the myriad of people in the health system. Policy documents failed to expand upon the common form for acknowledging the concept, which is the Aboriginal definition of health (hereafter referred to as the NAHS definition) contained in the National Aboriginal Health Strategy:

Health is not just the physical well-being of the individual, but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life–death–life (NAHS Working Party 1989:x).

The extent of the concept's acceptance is evident in its extensive use in policies, strategies and programs. Yet, I was surprised that after thirty years of existence, little operational detail exists beyond the NAHS definition. This review of health literature is my attempt to achieve greater clarity and understanding of the concept and its implications for the Australian health system.

Method

Literature detection

For this study, the health literature is defined as Australian publications that have Aboriginal health as either the sole focus or as a section within the document, and that explicitly state the key term 'holistic' and its synonyms. These requirements were captured using the following search string: (Aborig* OR Indigenous) AND (holistic OR wholistic) AND health. The search string was applied to databases of Informat³—APAIS (health, public affairs), ATSIhealth, CINAHL, Health and Society, Australian Medical Index, Rural—as well as the databases of PubMed.⁴ I focused on easily accessible publications—such as from organisations' websites and electronic databases. However, I did conduct some hand-searching for publications in The University of Melbourne library. The results from each database were cross-referenced and duplicate items were removed, with periodic repeat searches to capture new publications. Additionally, searching references in bibliographies enabled me to capture older publications and those not listed in the databases. Finally, Aboriginal affairs reports were found through relevant government and organisational Internet sites and were searched for the key terms. The publication details were entered into a spreadsheet to produce the publication characteristics shown in Table 1.

¹ The Wangaaypuwan people traditionally occupy the area around the town of Cobar in central west NSW (Indigenous Studies Program 2004). My grandmother, Marjorie Woodrow, has published her story about tracking her origins (Woodrow & Decker 2001).

² Throughout the document, 'the concept' is used for grammatical clarity and ease of style; however, there is no single and definitive source.

³ Informat is the name for an online source of Australasian information provided by RMIT publishing (<<http://www.informat.com.au/>>).

⁴ PubMed is available at <<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>>.



Content and thematic analysis

The various statements and phrases explicitly associated with the key terms were entered into the cells of a spreadsheet, and those with similar meanings were grouped together into themes. At times more than one theme was evident within a statement or phrase. The number of statements in each theme was counted as an indication of the number of instances a theme occurred (Table 1—n). This approach is called content analysis, and it is not concerned with the subject categories' production, reception or with any effects (Chapman 1988), and the count number should not be taken as the sole indicator of the importance or otherwise of a theme—known as 'quantification bias' (Chapman 1998:489). The themes emerged from the overt and implied meanings of statements and evolved with multiple readings of the literature until a clear list emerged (Table 2).

Discussion

In this discussion I do not attempt to define the concept of Aboriginal holistic health or to provide a definitive discourse. Indeed, no such thing exists and the challenge for policy makers is to navigate and interpret the diverse health literature and assemble similarly diverse messages into saleable policy options.⁵ Below, I discuss the findings of the review through the twelve engagement points listed in the executive summary.

The limited nature of this study subdues the validity of the ideas contained within the discussion. I focused on easily accessible documents but there is obviously a need to include unpublished literature, especially that from the Aboriginal community-controlled sector and publications not available in electronic format. A fuller account would consider literature from a range of domains in addition to health, combined with oral knowledge from interviews and focus groups. Nevertheless, literature synthesis is an important starting point for building evidence-based platforms and offers a beginning for policy makers to construct and understand an issue.

⁵ I use the term policy maker to include a diversity of people within different organisations that synthesise information to develop and support policy arguments.

1. Multiple themes within a diversity of publications

The diversity of publications is an indication that they contain multiple themes. The explicit use of the concept appears in a range of publication types (books, inquiry submissions, policies), with journal articles and reports constituting 63 per cent of the 153 publications (Table 1). The publications come from a range of organisations, with 39 per cent from governments and 16 per cent from Aboriginal organisations (the 'other' origin category refers to publications that had no organisational affiliation mentioned, or councils, committees and commissions). Each organisation has its own process of vetting to comply with organisational values and standards, which affects what they say in relation to holism, but I did not attempt to dissect the themes by organisation type.

Looking at the year of publication, the concept was cited in an increasing number of publications—from one in the period 1988–90 to a peak of seventy-four during 2000–02. One of the main reasons for this is because I focused on easily accessible, mostly electronic, documents, and fewer documents were electronically available in the earlier years. It is easy to perform keyword searches on documents hundreds of pages in length when they are electronically searchable, compared to physically reading pages from non-electronic documents. There are obviously many documents in the numerous libraries (whether university, government or various organisations) across Australia: I simply could not access all of these.

I noted if authors provided, or cited, the reference for their sources of understanding the concept.⁶ Twenty-four per cent of the publications explicitly cited the NAHS as their source of understanding the concept (NAHS Working Party 1989). In 12 per cent of publications, authors referenced other sources, mostly *Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Mental Health* (Swan & Raphael 1995a; 1995b), which referred to the NAHS.

I draw on the characteristics of the publications throughout the discussion. The main point is to expect a multitude of themes to come from such a diverse collection of publications. By implication, it is possible to select a bundle of publications with messages consistent with one theme, while missing others. In terms of constructing a policy using the concept, I recommend that a range of publications be searched and the results provided, such as in Table 1, to improve transparency of the reviewers' publications selection.

⁶ Citation refers to a quotation from, or reference to, a book, paper or author from which information is obtained and which authors use to expand on or substantiate their statements. Any source used needs to be acknowledged in order to secure the authors' credibility, to inform readers, as a matter of courtesy and for reasons of copyright (Snooks & Co. 2002).

Table 1: Characteristics of the health professional literature

Structure	n*	%**	Origin	n	%
Other	3	2	Professional association	5	3
Book	6	4	Research centre	10	7
Policy	9	6	Multi-institutional	15	10
Monograph	10	7	University	16	10
Inquiry submission	10	7	Other	23	15
Health strategy	18	12	Aboriginal organisation	24	16
Journal article	43	28	State government	25	16
Report	54	35	Commonwealth government	35	23
Total	153	100	Total	153	100

Year	n	%	Citation source***	n	%
1988–90	1	1	NAHS	36	24
1991–93	6	4	Other	19	12
1994–96	19	12	None	98	64
1997–99	36	24	Total	153	100
2000–02	74	48	NAHS in bibliography	81	53
2003–04	14	9	NAHS definition	18	12
Unknown	3	2			
Total	153	100			

*n — number

**% — per cent of total

*** — citation source refers to the referenced source of holistic.


2. Ten themes frame the concept of Aboriginal holistic health

Within the health literature, ten themes emerged that circumscribed a discourse around the concept. At this stage I reiterate that the number of instances a theme was counted (Table 2—n) should not be taken as the sole indication of the importance of the theme. The significance of each theme is rendered within the discussion and by drawing on the discourse from the health literature.

Table 2: Thematic boundaries constructing Aboriginal holistic health

Theme	n*
<i>Problems with Aboriginal holism</i> Examples: difficult to define; holistic health care compounds unrealistic expectations; holistic concept is used to distract health services from their core business; and data definitions and standards not adequately developed to encompass holistic view.	9
<i>Concept confusion</i> Examples: ecological model, World Health Organization (WHO) definition of health, primary health care, ethnomedicine and social medicine.	17
<i>Consistent with comprehensive primary health care (CPHC)</i> Examples: holistic CPHC; CPHC is holistic; supports provision of CPHC; and holistic CPHC services.	26
<i>Essential to improved health status</i> Examples: it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist; improvement of Aboriginal health depends upon more holistic systems; and a holistic approach to the delivery of services is essential to the improvement of Aboriginal health.	27
<i>Opposite of the Western, biomedical approach</i> Examples: holistic lifestyle opposite of European lifestyle; not built around specialities or body parts; in contrast to mind/body dichotomy of biomedicine; and body parts programs conflict with principle of holistic health.	29
<i>Exemplified in Aboriginal Community Controlled Health Services (ACCHS)</i> Examples: Indigenous services insist on a holistic understanding; Aboriginal medical services incorporate a holistic approach; ACCHS take account of the holistic context of service delivery; and they deliver holistic primary health care.	38
<i>Mainstream health system failure</i> Examples: fragmentation of roles; lack of coordination; areas that affect health outside the health portfolio; and vertical and inflexible programs.	39
<i>Broad view of health</i> Examples: broader context of health; whole-of-life cycle; multifaceted view of health; and encompass all aspects of life.	42
<i>Embodied by Aboriginal people</i> Examples: the holistic view of health traditionally held by Indigenous people; Aboriginal concepts of health are holistic; acceptance of Aboriginal peoples' holistic view of health; and a holistic Aboriginal concept of health.	59
<i>Underpinning philosophy of health</i> Examples: Aboriginal holism should be an underlying principle and philosophy of policy, program development, service delivery, strategies, and practice.	75

*n — number of instances a theme was evident in statements or phrases



I stated earlier that there is no single answer to the question, 'what is the Aboriginal holistic concept of health?' This should be evident from the themes in Table 2, where it is possible to select a bundle of publications consistent with one theme. It is significant that no document that I found examined the themes attached to the concept, as done in this study, indicating an uncritical acceptance and use of the concept by a range of authors (see point 6). I recommend that policy makers who wish to be more critical and transparent about their use of conceptual issues in policy, such as 'culturally appropriate', 'culture', and so on, need to access a range of documents from different disciplines and organisations to get a more complete picture of an issue. Furthermore, this would allow a critical analysis of the range of meanings attached to an issue, and a better understanding of what acceptance of a concept in policy would imply (see point 12).


3. Cultural authenticity and content of publications is difficult to establish

It is accepted that different cultures, ways of socialisation, education and other factors ultimately affect our worldview. By implication, then, I may want to use only publications written by Aboriginal authors, but it is not a requirement that authors identify their cultural backgrounds. Even so, given the cultural diversity of Aboriginal Australia,⁷ it raised the question as to who might be considered an authority on holism? Furthermore, should the cultural background of every author be traced, and what about mixed cultures? Finally, in publications with multiple authors, which culture of which author has the primary influence through the document?

When undertaking a literature review task such as this, it is not feasible to authenticate the cultural background of every author of every publication. This presents a challenge to policy makers wishing to comply with the 'culturally appropriate' criteria embedded in Aboriginal health policy. However, culture has both conscious and subconscious aspects, as Peter Sutton (2001:135) states: 'the trouble with culture is that it is neither fully conscious and subject to voluntary control nor wholly unconscious and beyond being brought to mind'. As such, the perspectives of different authors can reveal an understanding about an issue that is not seen if you are inculcated into that culture. Therefore, it is a valid strategy to collate the health literature together from different authors. However, at no stage does any author examined in this study critically reflect on the effect of their cultural lens on the understanding and use of the concept in their writing (see point 6).

In terms of documents from Aboriginal organisations, one theme implies that holism is exemplified by Aboriginal Community Controlled Health Services (Table 2). Therefore, I could have restricted the study to publications from this sector (16 per cent; see Table 1), but they were hard to access for a number of reasons. First, documents may be published that are not necessarily included in electronic databases. For example, several of the documents came from one peak Aboriginal organisation, whose publications I had collected over several years, but they were not indexed in the electronic databases. Second, publications may be out of print. Third, in terms of electronic access (such as in the form of the 'portable document format' or pdf file), older documents simply are not available. Finally, the Internet sites of Aboriginal organisations often do not contain downloadable electronic documents. Policy makers have limited time and resources to search for hard copy documents and to troll through hundreds of Internet sites for elusive electronic documents. Therefore, the influence of text from Aboriginal organisations can be overwhelmed with the density of text from other sources—one barrier for effective textual transfer of Aboriginal concepts of health (see point 11).

⁷ See, for example, Norman B. Tindale's catalogue of Australian Aboriginal Tribes at <http://www.samuseum.sa.gov.au/page/default.asp?site=1&page=Archives_Collections>. Also see 'Australian Aborigines—Tribal Boundaries' at <<http://www.whoseland.com/view.html>>.



Complicating the issue of cultural filtering is the fact that non-Aboriginal authors write and publish through ACCHS, and Aboriginal authors do so through research and government bodies. Furthermore, there is a suggestion that using the English language may be entirely invalid: Kathy Bell *et al.* (2000:90) state that 'while Aboriginal languages do accommodate the complex inter-related constructs involved, Western languages cannot and nor can the relevant Aboriginal constructs be translated'. This kind of evaluative judgment suggests that the authors have knowledge of *all* Aboriginal languages and their constructs (see point 5), as well as *all* Western languages and their constructs. Paradoxically, if 'Aboriginal' and 'Western' constructs are mutually exclusive, then it should not be possible to compare and contrast one with the other, but the authors apparently possess the interpretive and evaluative skills for cross-cultural analysis. Finally, no evidence is supplied in order for policy makers to examine the source of their understanding (see point 4), and there is no provision of an evaluative framework and criteria (see point 9).

Policy makers face an uncomfortable question: is an understanding of Aboriginal concepts dependent upon the Aboriginality of a person, or the organisation in which a person works or on Aboriginal languages? I do not know the answer, but in terms of a literature review a reasonable strategy is to consider publications from all sources. At best it is only possible to be aware of the potential effects of cultural lenses, as there are no 'tools' that enable policy makers to extract and attribute aspects of a text to different cultures. In terms of recommendations, I suggest improved electronic access to ACCHS publications (policies, annual reports, program evaluations) and improved indexing and cataloguing of these publications in electronic databases.

4. Insufficient citation practice fails to critically locate ‘holism’

Within publications it is important to reference or cite information from other sources (see point 1). From where did the authors gain their understanding, what documents did they read and how has their interpretation affected their use of the concept? Table 1 shows that in 64 per cent of the publications, authors did not provide a reference for their source of the concept. In 24 per cent of publications, authors referred to the NAHS document (as a whole, with no page numbers) as their source, but the NAHS Working Party did not provide any reference to its source. In 12 per cent of publications, authors explicitly stated the NAHS definition as their source of understanding (Table 1). The six ‘reviews’ dealing with Aboriginal understandings of health did not investigate the root of the word ‘holistic’, and did not go any further than the NAHS (Burden 1994; Brady 1995; Brady *et al.* 1997; Dillon 1999; Maher 1999; Morgan *et al.* 1997; Houston 2003). It seems that the concept just ‘materialised’.

Furthermore, there is a large mainstream discourse about holistic health, and no publication in this study provided a reference to this literature.⁸ Also, two mainstream reviews of holistic health neither discussed Aboriginal perspectives nor referenced the NAHS (McKee 1998; Eastwood 2000). The term ‘holistic’ also appears in mainstream health strategies (Parsons *et al.* 2000; DHAC & AIHW 1999; DHS 1999; 2001). For example, the *Partnerships for Better Health* publication from the Victorian Department of Human Services (1999:15) states that ‘Future health strategies may need to move away from a disease-specific orientation to one that is more holistic and determinant-based’. As an additional point, which is significant in terms of the theme in which Aboriginal holism is a broad view of health (Table 2), no publication referred to literature from ‘non-health’ sectors to substantiate the all-encompassing philosophy of holism. Authors fail to ‘think outside the sector’. Holism appears as a keyword in relation to Indigenous education (Exley & Bliss 2004), history (Wilson-Miller 2003), housing (Murphy 2003), native title (Atkinson 2004), welfare (Henry & Daly 2001) and law (Sweeney 1995). Thus, when reading the health literature, it is as though the concept only exists in the Aboriginal health world, which is clearly not the case (see point 7).

Policy makers need a certain level of confidence that what they are reading is a credible interpretation—in this case, the insufficient citation practice is a factor that undermines the credibility of authors’ uptake and use of the concept. However, citation of source material stems from an academic tradition unfamiliar to many authors. Additionally, it is a practice out of line with oral traditions of communication. Where possible, then, I recommend that authors need to reference explicitly their sources of understanding the concept of Aboriginal holistic health.

⁸ Mainstream: the health and health-related services that are available to, and accessed by, the general community (NATSIHC 2003:37).



5. Abject lack of knowledge about Aboriginal concepts of health

Health policy and strategy documents readily embrace the principle of culturally appropriate health care; however, there is little knowledge available for policy makers to engage with the diversity of Aboriginal concepts of health. There is only one detailed study that is based on the concept and which demonstrates the kind of exploration I think is needed for policy makers (see point 9). Significantly, it is the sole study of its type over thirty years of acknowledgment of Aboriginal holistic health. The study author, Edward Shane Houston (2003:94), states that: 'The conceptualisation of health, Aboriginal health, as holistic, is gradually being recognised even if not fully outside of Aboriginal culture'.

The NAHS definition serves as the basis of Houston's doctoral thesis, entitled *The Past, the Present, the Future of Aboriginal Health Policy* (2003), part of which also served as the basis for the Western Australian Office for Aboriginal Health's (WAOAH) 2001 consultation project for the Commonwealth Grants Commission's 'Indigenous funding inquiry'. Houston's development of the NAHS definition into components is 'at the heart of the approach developed in this report' (WAOAH 2001:259), and underlies his statement that 'this leads to a revolutionary way of conceiving of resource allocation issues in health' (Houston 2003:iii). However, Houston's review of literature did not interrogate this concept in detail (Houston 2003; WAOAH 2001).

Aboriginal concepts of health include, for example, *mwarre*, *punyu* and *wankaru* (Brady *et al.* 1997; Devanesen 2000; Anderson 1999).⁹ However, they are generally talked about in broad, sweeping, philosophical terms, such as when Judy Atkinson *et al.* (2002) and Ian Anderson (1999) write about *punyu* (following the work of Mobbs 1991), and by Devanesen (2000:10), who writes about *wankaru*. I suggest that further research is needed to develop the philosophical strength of such concepts into operational frameworks suitable for engagement by policy makers (see points 9 and 10). This is one point where Houston's work is important.

Houston's study is also important because it indicates that the skills and intellect are available to translate Aboriginal preferences into English language terms, in contrast to the suggestion that this is not possible (see point 3). Further work of the kind done by Houston is required if the advocacy of Indigenous knowledge systems (INHKD 2002; Anderson 2003) is to have anything other than rhetorical effect. Additionally, as Indigenous researchers become armed with culturally appropriate ways of research (Smith 1999), there is the potential for culturally sensitive research and subsequent articulation into policy formats.

My main point is that a lack of adequate knowledge about Aboriginal concepts of health prevents greater engagement by policy makers. The implication—in regards that 'any health care system is first and foremost a social institution built on the cultural stance of the nation it serves' (Mooney 2003:267)—is that it may not be possible to affect a reoriented mainstream health system to improve Aboriginal health outcomes. I recommend increasing knowledge about Aboriginal constructs of health.

⁹ *Punyu* is from the Ngarinman people, *wankaru* is from the Warlpiri people, *mwarre* is from the Aranda people—all in the Northern Territory. They are samples showing that Aboriginal definitions and associations of health vary with the diversity of tribal groups.

6. Unreflexive interpretation and uncritical acceptance of the concept

In the health literature the authors fail to be reflexive—they do not indicate that they considered how their backgrounds (culture, education, gender, organisation, training, experience, ideologies) affect their perceptual lenses and therefore their interpretations and application of the concept. Reflexivity in research is ‘a process of critical reflection both on the kind of knowledge produced from research and how that knowledge is generated’ (Guillemin & Gillam 2004:274). The publications come from authors writing from the perspective of a wide range of disciplines, such as epidemiologists, medical doctors, Aboriginal health workers, economists, anthropologists and nurses. They write on an equally diverse range of topics including health financing, medical education, health policy, mental health, nutrition and so on. It appears that everyone has a common and accepted understanding of the concept, which is not substantiated (see points 4 and 7).

‘Holistic’ is a popular keyword in the *Australian Journal of Holistic Nursing*¹⁰; it is a philosophy extending into the realm of medical doctors as ‘alternative’ or ‘complementary’ medicine (Eastwood 2000; Zollman & Vickers 1999; Baer *et al.* 1998; Barrett *et al.* 2003), and it is advocated as underlying a ‘new kind of GP [general practitioner]’ (Kamien 2002). For example, ‘holistic treatments’ such as acupuncture, relaxation, massage and hypnotism are increasingly used in doctors’ routines (Eastwood 2000; Kamien 2002; Wearing 1999). This is in contrast to the meaning implied in the theme that only Aboriginal people embody holism (Table 2), and is the subsequent operating method of Aboriginal health workers (see point 10).

In terms of processes of knowledge transfer (see point 11), it may be the case that a policy maker in a meeting with a doctor, health worker and nurse may get agreement on a holistic approach, but each party has different meanings and intentions attached to his or her position. Do policy makers realise that acceptance of the concept in policy implies handing ‘control’ of the health system to Aboriginal people (see point 12)? Does the doctor realise that agreement with the concept implies being removed as the focus of the health system (see point 8)? The Aboriginal community-controlled sector deliberately places the non-Aboriginal health professional in a subordinate position in its organisational structure; in contrast, the mainstream health system places medical doctors at the core. Although the Australian Medical Association (AMA) supports holism (AMA 2001a), it staunchly defends the placement of doctors at the centre of primary health care (‘The AMA strongly recommends that all PHC [primary health care] should be delivered through general practice’) and emphasises the ‘unique clinical skills of GPs in providing holistic/social care’ (AMA 2001b).


There is also a strong tendency for authors to uncritically accept the concept. The work of Brady (1995) and Brady, Kunitz and Nash (1997) is the only research that I can find which critically investigates the use of Aboriginal holism. This question needs to be asked: should it be automatically accepted that Aboriginal cultural concepts of health would be successful in improving Aboriginal health? Stephen Kunitz stated that:

failure to at least acknowledge the possibility that it is not simply poverty and oppression—real as these may be—but one’s own culture that may contribute to some of the problems that confront so many communities may limit the likelihood of growth and positive change (1994:187).

Noel Pearson (2000) has talked about how ‘culturally appropriate’ behaviours are appropriated in alcoholism and substance abuse. Peter Sutton talks about how interventions by non-Aboriginal people can be ‘culturally appropriate’, and he also raises an important point:

that a number of serious problems Indigenous people face in Australia today arise from a complex joining together of recent, that is post-conquest, historical factors of external impact, with a substantial number of ancient, pre-existent social and cultural factors (2001:127).

¹⁰ *Australian Journal of Holistic Nursing* at: <<http://www.scu.edu.au/schools/nhpc/ajohn/>>.



In summary, authors' worldviews can affect the interpretation and application of the concept, and there is an uncritical acceptance of the concept. However, tools for being reflexive in Indigenous health are difficult to find, with only one innovative workshop recently available for people working in Indigenous health (Kowal & Paradies 2003; 2005). Nevertheless, I recommend that authors explicitly think about, conduct and mention reflexivity in their interpretations and applications of Aboriginal concepts of health.

7. Unsubstantiated perception of holism as immutably Aboriginal

Given the historical context of exclusion of Aboriginal people and perspectives from health policy processes, it can be viewed as a victory by advocates that the concept is widely taken up and accepted as an underpinning philosophy of health (Table 2). The explicit use of 'Aboriginal holistic health' in publications increased from six references in the period 1991–93 to peak at seventy-four references during 2000–02 (Table 1). This is coupled with a strong impression that the concept is essential to improving health (Table 2), as stated by Anthony Dillon:

What is needed when addressing the health needs of individuals, families and communities, is a holistic approach. Understanding this truth is paramount in promoting the health and well-being of our people (1999:3).

And from the National Aboriginal Community Controlled Health Organisation:

Australia needs a mainstream health system that supports and nurtures a holistic approach to Aboriginal health if many of the most pressing issues facing Aboriginal society—such as alcohol abuse, violence and discrimination—were to be addressed (2003a).

This essentiality is underwritten by a perception that only Aboriginal people embody holism (Table 2) as Ngaire Brown states:

Most important, and central to understanding indigenous peoples, their current situation and their roles in modern society, is to have an insight into our history and an understanding of our holistic view of health, life and community... (1999:221).

Or, as more strongly put by Rosemary Wanganeen: 'We lived a holistic life, they didn't' (1994:11). Given the strength of these assertions, could it be that an English language word has come to be accepted as definitive of a collective Aboriginal body and experience?

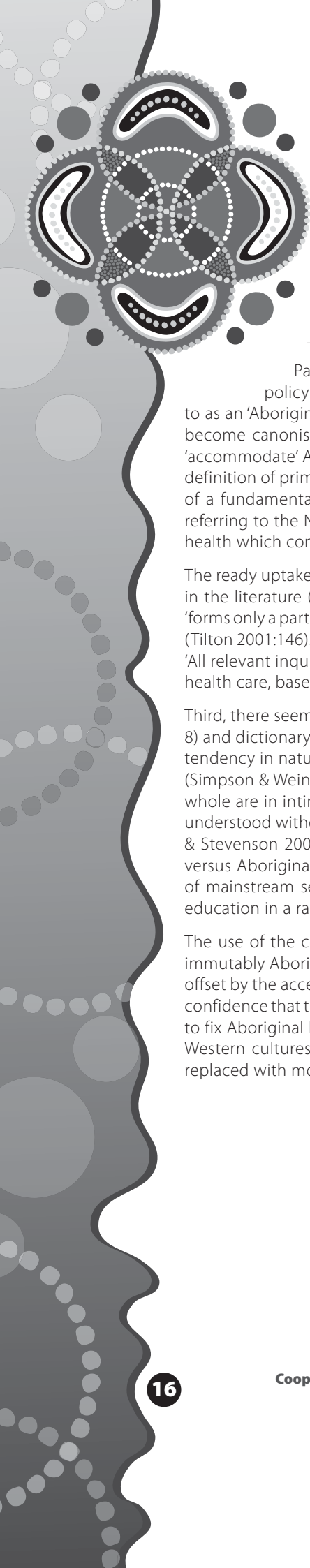
I began by following the citation trail to track the concept's origin. As stated in point 4, authors have an insufficient citation practice for referencing their sources of holism, but it is often linked with the NAHS definition—apparently written in 1974 by the National Aboriginal and Islander Health Organisation (NAIHO) (Beaton 1994). However, I could not obtain the NAIHO reference to track the source of the definition. The NAHS appeared likely to be the best source, given that 53 per cent of publications had the NAHS in their bibliographies and that the NAHS was explicitly cited in 24 per cent of publications as the source of the concept (Table 1). In the NAHS, the first use of 'wholistic'¹¹ occurs on page 60 in relation to the 'co-ordinated integration of health system components':

While these components are more often than not once removed from the personal interface they are nevertheless essential components of a wholistic system and approach to health based on the provision of primary health care (NAHS Working Party 1989:60).

The second and final use occurs deep in the 'monitoring and evaluation' section:

The Working Party has endorsed the need for a wholistic approach to improving Aboriginal health. This approach will encompass social, cultural, political, economic, environmental and physical factors, not all of which are easy to quantify (NAHS Working Party 1989:219).

¹¹ There is some discussion about the significance of the spelling of holistic or wholistic (Aronson 2003:392; Barnhart 1988:486; Simpson & Weiner 1989:307).



Significantly, the NAHS Working Party did not explicitly link the NAHS definition (which occurs on page x) and the term 'wholistic', nor did it reference its source of holism. So, from where did it originate? I looked in the *Oxford English Dictionary* (1989) and the *Barnhart Dictionary of Etymology*, and they attributed the coinage of the terms holism and holistic to a South African soldier, biologist and former prime minister, Jan Christiaan Smuts, in 1926 (Barnhart 1988; Simpson & Weiner 1989). If culturally based concepts allude to a range of meanings, and if 'such meanings delineate the conceptual field within which action develops' (Anderson 1999:65), then whose cultural base is it?

The NAHS states that 'Aboriginal culture is the very antithesis of Western ideology' (NAHS Working Party 1989:ix). A number of contradictions to this become apparent upon further examination of policy documents. First, although exclusively written in the English language, the NAHS is referred to as an 'Aboriginal document' (Murray *et al.* 2003), and it seems that 'the exegesis provided by this report has become canonised' (Brady 1995:188). This is also in spite of the apparent inability of Western languages to 'accommodate' Aboriginal constructs (see point 3). Second, the NAHS Working Party quoted in full the WHO definition of primary health care (NAHS Working Party 1989:x) without questioning its cultural basis. On writing of a fundamental 'split' in perspectives between Aboriginal and non-Aboriginal concepts, Michael Dodson, referring to the NAHS definition, states, 'The National Aboriginal Health Strategy offers a definition of 'holistic' health which conforms with that of the World Health Organization' (1995:61).

The ready uptake of primary health care as the vehicle for delivering holistic health also appears unproblematic in the literature (Table 2). Furthermore, Edward Tilton wrote in relation to vertical primary health care that it 'forms only a part of comprehensive primary health care, which is a broader, holistic approach to health problems' (Tilton 2001:146). Finally, without any reference to relevant evidence (see point 3), Bell *et al.* (2000:79) claim that, 'All relevant inquiries and studies have shown conclusively that culturally appropriate, comprehensive primary health care, based on maximum community participation, is the best way of addressing Aboriginal health'.

Third, there seems to be some similarity between the NAHS definition, the WHO definition of health (see point 8) and dictionary definitions of holism. The *Oxford English Dictionary* (1989) defines holism as, 'to designate the tendency in nature to produce wholes (i.e. bodies or organisms) from the ordered grouping of unit structures' (Simpson & Weiner 1989:307). The *Oxford Dictionary of English* (2003) defines holism as a theory that 'parts of a whole are in intimate interconnection, such that they cannot exist independently of the whole, or cannot be understood without reference to the whole, which is thus regarded as greater than the sum of its parts' (Soanes & Stevenson 2003:828). Advocates of holism readily present arguments in terms of a dichotomy of Western versus Aboriginal cultures. If they are mutually exclusive, then why do Aboriginal people also access a range of mainstream services (Anderson *et al.* 2000), work in non-Aboriginal organisations and undergo 'Western' education in a range of health professions?

The use of the concept in policy is underwritten by its Aboriginal cultural validity; however, it is clearly not immutably Aboriginal. Additionally, the anti-Western sentiment evident in Aboriginal health discourse appears offset by the acceptance and use of some Western concepts, practices and education. These factors undermine confidence that the concept is a 'new way of thinking about Aboriginal health' (Hunter 1999), and that it is 'needed to fix Aboriginal health' (NACCHO 2003a). The position that holism is immutably Aboriginal and antithetical to Western cultures appears unsubstantiated. I recommend that such discourse should be abandoned and be replaced with more nuanced positions in line with the cultural diversity of Australian society.

8. Confounding discourses prevent trusting engagement

Policy makers need to be confident of, and have trust in, the information that supports their policy arguments. This literature review reveals that a number of arguments about the concept could be constructed within the diversity of literature (point 1), insufficient citation practice (point 4), and unreflexive interpretation and uncritical acceptance (point 6). I show in this section how positions of opposition, intersection and alignment could confound clarity about appropriate policy directions. The existence of confounding discourses in the health literature prevents trusting engagement and thus undermines policy legitimacy.

Opposition

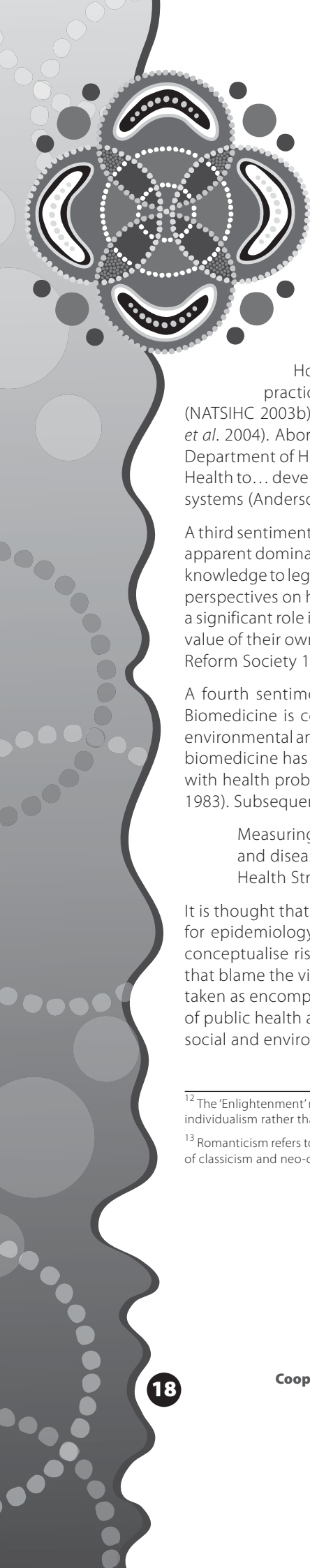
Both the Aboriginal health and mainstream health literature position holism as opposite, counter or antithetical to the West and its biomedical model of health (Brown 1999; McKee 1998; Eastwood 2000; Anderson 1999; Davis & George 1988; Wearing 1999; Dodson 1995; McDermott & Beaver 1996). This sentiment is expressed strongly in the literature, such as with the NAHS antithesis statement between Aboriginal and Western cultures (point 7), and in the themes embodied by Aboriginal people and exemplified by ACCHS (Table 2). Jenny Burden suggested that 'Aboriginal conceptions are radically different from [the] biomedical perspective' (1994:169). And Pam Nathan and Dick Japanangka that:

[t]he approach of one is mainly particularistic, bio-physical and mechanistic, and in it the disease orientation is paramount. The other is holistic, emphasising the life of a person in a way which links ill-health with health... (1983:91).

By implication policy makers could take this to mean a separatism of Aboriginal and non-Aboriginal domains, from a philosophical level to that of health service professionals and health service provision. I have already demonstrated contradictions in philosophical positions of antithesis (point 7), but here my aim is to examine four senses underlying this oppositional discourse: a first linking non-Aboriginal people with a past colonialism ethos, a second about the 'objective' principle of science, a third involving a tension between different knowledge systems, and a fourth revolving around the emphasis of biomedicine and holism. However, Aboriginal and non-Aboriginal people appear to have some value consonance that mitigates these sentiments, because we work and live together, both in traditional and acculturated contexts.

A first sentiment of opposition stems from the past colonialism policies of discrimination effected by the non-Aboriginal towards Aboriginal people, which is well documented and acknowledged in policy. As far as the medical profession is concerned, this is captured in the statement that 'the domination of Aboriginal health care by the medical model approach fitted well with other assimilation policies of the period' (NAHS Working Party 1989:59). For example, the often detrimental impact of medical doctors and health researchers in Aboriginal health is acknowledged (Anderson 21001; AIATSIS 1999). In practice, then, an Aboriginal community-controlled health organisation is 'governed by an Aboriginal body which is elected by the local Aboriginal community' (NATSIHC 2003b:12). This means that, at least in the sense of official organisational hierarchy, the influence of non-Aboriginal people—especially health professionals—is marginalised in Aboriginal organisations.

A second sentiment of opposition appears linked to the rejection of the notion of 'objectivity' embedded within Western scientific paradigms such as biomedicine. The objectivity embedded in science was not wholly extended to the *application* of knowledge in health service design and delivery, which was largely influenced by ethnocentric and racist values (see point 12). It is in this sense that biomedicine has 'a cultural history through which regimes of science annexe social values' (Anderson 1999:57). Both sets of sentiments—about the past colonial ethos and the notion of objectivity—are also relevant to other health professions.



These senses of opposition are grounded in philosophical roots. Biomedicine sits within a rationalist, Enlightenment¹² tradition, while holism sits within a tradition of Romanticism.¹³

It is interesting to note that a German philosopher developed Romanticism partly in response to certain claims of the Enlightenment, and partly as a rejection of powerful imperialist nations of the Enlightenment, such as England (Solomon 1988). In line with such a theoretical opposition would be a strict separatism in the professional health workforce, and in service delivery. The literature contains supporting statements, such as 'the Health Worker role is driven by a holistic approach' (Curtin Indigenous Research Centre 2001:xiii), and this is followed through in health service delivery in that ACCHS exemplify holism (Table 2).

However, a number of points of information show that theoretical separatism can differ from practice. It is a strong policy principle to increase Aboriginal representation in the health professions (NATSIHC 2003b), and Aboriginal people are increasingly represented as medical doctors and nurses (Dwyer *et al.* 2004). Aboriginal people work in a range of non-Aboriginal organisations, for example, the Queensland Department of Health (1999:3) 'understands that recruiting Indigenous peoples will better position Queensland Health to... develop a holistic approach to health'. Aboriginal clients access and use a range of mainstream health systems (Anderson *et al.* 2000), while Aboriginal health services readily have 'medical' in their titles.

A third sentiment of opposition revolves around the tension about the legitimacy of knowledge systems and the apparent dominance of biomedical knowledge. It is claimed that orthodox medical practitioners use biomedical knowledge to legitimise their health practices, exclude alternative practitioners, and discount lay and non-Western perspectives on health and illness (Eastwood 2000; Lewis 1997). However, non-Aboriginal medical doctors have a significant role in the advocacy for Aboriginal rights and in restructuring health systems. They also question the value of their own scientific training (Eastwood 2000), advocate for improvements in Aboriginal health (Doctors Reform Society 1997; AMA 2002) and work with Aboriginal groups (NACCHO 2004a; 2004b).

A fourth sentiment of opposition lies in the contrast between the emphasis of biomedicine and holism. Biomedicine is contrasted with holism as devaluing or disregarding personal and external social, economic, environmental and cultural factors (Lewis 1997; Knight 1998). This also has some theoretical underpinning, where biomedicine has a rationalist tradition based on a separation of mind and body; seeing the body as a machine with health problems reduced to biochemical and physiological components (Knight 1998; Hahn & Kleinman 1983). Subsequently, health is equated with an absence of disease and infirmity, as Couzos and Murray state:

Measuring 'health' is difficult, however, and, in practice, what is measured is 'ill-health'—that is, death and disease. This contrasts with more holistic definitions of health... quoted in the National Aboriginal Health Strategy 1989... (1999:11)

It is thought that this view has led to a victim-blaming mentality in public health. Neil Pearce noted a tendency for epidemiology, where some figures in the field 'espoused a holistic view of disease' (Pearce 1996:680), to conceptualise risk factors in individual terms rather than in population terms, with subsequent interventions that blame the victim. However, some shift in emphasis has occurred in the health system, where health is now taken as encompassing a broad range of factors (see 'Alignment'). The AMA currently works broadly 'on a range of public health and medical issues' (AMA 1995), and general practitioners draw 'on biomedical, psychological, social and environmental understandings of health' (RACGP 2002).

¹² The 'Enlightenment' refers to a European intellectual movement of the late seventeenth and early eighteenth centuries that emphasised reason and individualism rather than tradition (Soanes & Stevenson 2003:576).

¹³ Romanticism refers to a movement in the arts and literature that originated in the late eighteenth century as a reaction against the order and restraint of classicism and neo-classicism, and a rejection of rationalism, which characterised the Enlightenment (Soanes & Stevenson 200:1528).

Intersection

Rather than a mutually exclusive opposition, some points suggest an intersection between Aboriginal and Western constructions of health. The phrase ‘not just the physical well-being of the individual’ in the NAHS definition seems to allow an intersection with biomedical constructions. Measurements of physical well-being are generated using the tools of statistics, a reliance on which, for non-Aboriginal people, is said to be indicative of a ‘culturally established trust in numbers’ (Lea 2001:67). Also, a reliance on statistics as indicators of Aboriginal ill-health, and as a key factor in resource allocation to address needs, is criticised for being inappropriate according to Aboriginal constructions of health (Mooney et al. 1998; NACCHO 2000). However, both the NAHS and its successor—the *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for Action by Governments* (hereafter the National Framework)—heavily depend on physical well-being statistics for the construction of health need.

Although it may not be possible to measure every variable affecting health, it is interesting to note that advocates who continue to use Western scientific statistical tools as evidence of Aboriginal health need and justification for increased resources fail to offer alternative methods and indices either based on the concept or any notion of Aboriginal health (see point 9). Therefore, policy makers are expected to take it on faith that ‘Aboriginal well-being cannot simply be constructed as the inverse of an individualist and reductionist biomedical model of disease’ (Anderson 1999: 65).

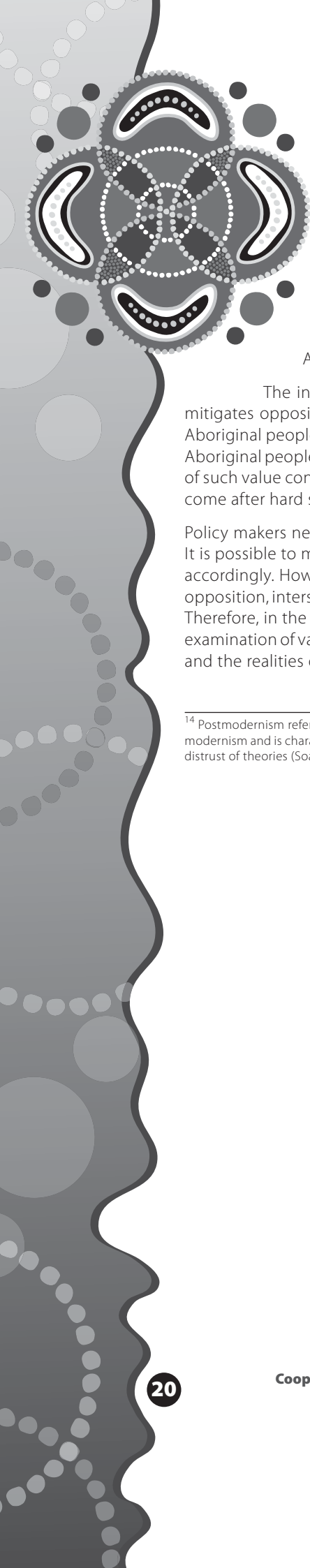
Also, such evaluative judgments rely on generalisations of culture. There are hundreds of Aboriginal groups and languages within Australia (McConvell & Thieberger 2001). Australia is also a culturally diverse nation—in 2001 more than 160 ancestries were identified (ABS 2003:12). Brady *et al.* note a diversity of notions of health in Western societies, and state that:

the apparent dichotomous opposition between the [NAHS] Definition and biomedical constructions is false ‘in the portrayal of the “west” as the bearer of a hegemonic, egocentric and solely biomedical model of health as opposed to other, more “holistic”, sociocentric and harmonious societies’ (1997:282).

Alignment

While the sentiments of opposition are based on a particular developmental context of the NAHS definition (see point 12), society, and therefore policy context, has changed substantially since the 1970s. The mainstream health system has evolved with the evidence of how broader structural factors impact on health, some of which are associated with the concept (see point 9). The WHO defines health as a ‘state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity’ (1998:1), a definition that embodies the consideration of social forces affecting health (Brady 1995; Brady *et al.* 1997). There are clear similarities between this and the NAHS definition.

Significantly, the WHO definition was agreed to in 1948 and accepted in 1978 in the Declaration of Alma-Ata, from which Australia endorsed the subsequent ‘Health for All’ slogan in 1979 as national policy (Brady 1995). These movements precede the publication of the NAHS in 1989 and the earliest date of the NAHS definition of 1974. Additionally, the WHO definition was developed by experts (professors and medical doctors) with a background in social medicine, one of whom became the first director general of WHO (Brady *et al.* 1997). The strength of association with the WHO concept of primary health care by the Aboriginal community-controlled sector is significant in this regard (see ‘Oppositional’ sentiment, and point 7).



Also, cultures and societies constantly evolve. Movements such as postmodernism¹⁴ provide the theoretical tools to critique the superiority of the positivist, modern worldview and appreciate other worldviews (Eastwood 2000). Furthermore, public health policy and strategy in Australia has an 'increasing awareness of the importance of accommodating the diverse needs of people, taking account of gender, age, ethnicity, religion, culture and socioeconomic class' (KAMSC *et al.* 2002:25). This is seen where health professionals have ready access to a range of materials in their attempts to improve understanding of Aboriginal health and culture (VACCHO & VKHRCDU 2001; Flinders University 2004; Queensland Health 2004). This combines with efforts to make systemic changes in education curricula to incorporate Aboriginal health (Yaxley 2001; Phillips & CDAMS 2004; VKHRCDU 2004).

The intersection and alignment suggest that perhaps there is a degree of value consonance that mitigates oppositional sentiments. This may be seen through the political alignment of Aboriginal and non-Aboriginal people to the principles of equity, participation and sustainability, which are most 'actively linked by Aboriginal people to their right to self-determination and community control' (Brady *et al.* 1997:277). Recognition of such value consonance does help to achieve some clarity through these confusing discourses, but it has only come after hard scrutiny of this range of literature.

Policy makers need to examine a diversity of literature in a review in order to uncover a full range of themes. It is possible to miss important themes and their meanings, and it is possible to construct different arguments accordingly. However, a full range of themes also raises some challenging findings—in this case, messages of opposition, intersection and alignment—which confound policy makers' attempts to find a clear path to support. Therefore, in the formulation of policy options based on Aboriginal concepts of health, I recommend a critical examination of various messages to help to understand the differences between theoretically expressed rhetoric and the realities of service delivery.

¹⁴ Postmodernism refers to a late twentieth century style and concept used in the arts, architecture and criticism, which represents a departure from modernism and is characterised by the self-conscious use of earlier styles and conventions, a mixing of different artistic styles and media, and a general distrust of theories (Soanes & Stevenson:1376).

9. Non-existent operational framework and shifting constituent elements

To understand and engage meaningfully with the implications of Aboriginal concepts of health, policy makers require coherent and thoroughly articulated arguments to justify policy positions. Evaluative claims about the efficacy of the concept are mitigated by a non-existent operational framework, as well as by shifting constituent elements. It seems remarkable, after more than thirty years of existence, that this remains the case.

The NAHS definition is often inserted into documents in cut-down, re-worded and re-phrased versions. For example, in the National Framework, the partners agree with a

holistic approach: recognising that the improvement of Aboriginal and Torres Strait Islander health status must include attention to physical, spiritual, cultural, emotional and social well-being, community capacity and governance (NATSIHC 2003b:2).

The National Framework is careful to build an evidence base to justify the nine key result areas—or framework for action—with extensive recourse to formal research, but the changes to the NAHS definition occur without reference to research or any discussion. Significantly, the National Framework's credibility rests on ownership by Aboriginal people due to extensive consultations, and the National Framework is agreed to by all governments to guide efforts in Aboriginal health. Both these factors serve to place a holistic approach in a critical position to influence Aboriginal health policy, but which parts of the 'underlying philosophy of health' should policy makers accept?

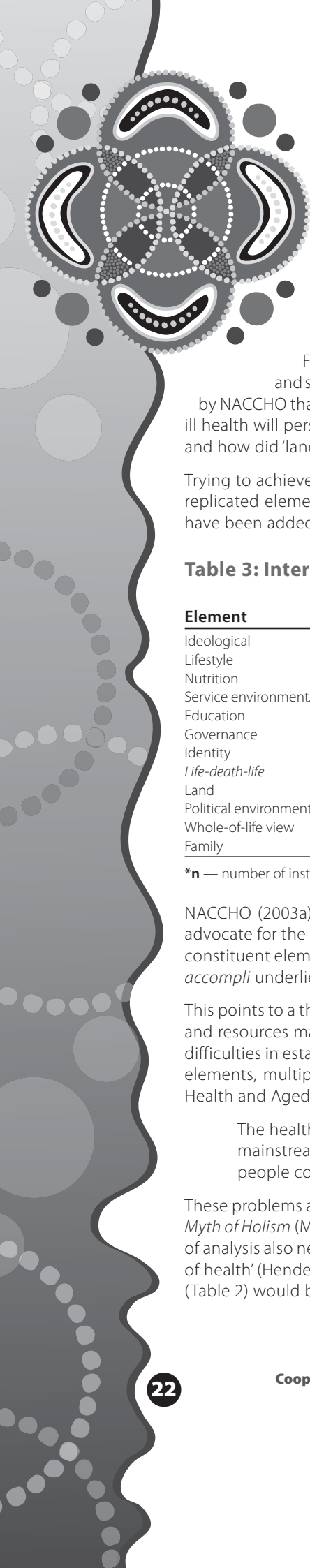
Some authors attempt to engage further with the concept by confusing it with other concepts of health (Table 2). These include the WHO definition of health, an ecological or ecosystems approach, a new public health approach and a systems model of thinking (Knight 1998; Hetzel 1990; 2000; Bartlett 1995; Khoury 1998; Devitt *et al.* 2001a; 2001b; Mathews *et al.* 2001). Further confusion occurs through its strong association with comprehensive primary health care, which can also be confused with primary care (Kelleher 2001). I suggest that the development of a clearly defined framework is necessary as an evaluative base from which to make justifiable comparisons and claims. Anderson notes this gap in relation to social epidemiology:

There has not been, to date, any work on the development of explanatory models in social epidemiology that are particular to the social and historical context of Aboriginal health in Australia (2001b:248).

There is some support in the literature for the development of explanatory models in Aboriginal health. Anderson suggests that the value of models used in mainstream health policy would be enhanced with some further theoretical and methodological development, and he suggests that

to be an effective tool in policy, these models need to draw-out the relationship between governmental interventions, social determinants of health and health outcomes... and to consider the way in which these models frame the relationship between social phenomena and individuals in whom disease is expressed... (2001b:248)

Additionally, Couzos and Murray state that 'a common equity model needs to be adopted in any consideration of planning and resource allocation in Aboriginal health' (1999:11). Such an agreed model could serve as a platform to make evaluative judgments, but what 'criteria' or 'elements' would be used?



One step further from the NAHS definition is the provision of elements that constitute it (Table 3), which could allow a policy maker to move from theoretical acceptance into operational delivery. However, these elements vary from the NAHS definition to the one used in the National Framework, to the one used by NACCHO:

Aboriginal health is holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to well being. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist (NACCHO 2003b:5).

Furthermore, the definition of the constituent elements is also contentious, such as the meaning and sub-components of 'culture', 'social', 'capacity' and 'governance' for example. However, the assertion by NACCHO that 'it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist' (2003b:5) is confusing because, compared to the NAHS definition, where did 'social' go to and how did 'land' become central? What are the required mechanisms to stimulate harmony?

Trying to achieve clarification from the literature is also troublesome because, while most of the time authors replicated elements stated in the NAHS definition or related to the 'wholistic' phrases in the NAHS, elements have been added, subtracted or modified at will (Table 3).

Table 3: Inter-related elements of Aboriginal holistic health

Element	n*	Element	n
Ideological	2	Economic	9
Lifestyle	2	Mental	9
Nutrition	2	Physical environment/infrastructure	11
Service environment/access	2	<i>Individual</i>	25
Education	3	Spiritual	29
Governance	3	<i>Well-being</i>	29
Identity	3	<i>Community</i> (development, capacity, leadership)	32
<i>Life-death-life</i>	5	<i>Emotional</i>	33
Land	6	<i>Physical</i>	33
Political environment	6	<i>Cultural</i>	35
Whole-of-life view	6	<i>Social</i>	38
Family	7		

*n — number of instances an element was stated; italics refer to the elements used in the NAHS definition.

NACCHO (2003a) with its commitment to the 'holistic approach needed to fix Aboriginal health', is a strong advocate for the NAHS definition and has agreed to the National Framework. Given the varying definitions and constituent elements, the NACCHO statement could be taken to imply 'Aboriginal ill-health will persist'. This *fait accompli* underlies the theme that the concept is essential to improve health (Table 2).

This points to a theme that there are problems with holism (Table 2), such as that by relying on holism, attention and resources may be diverted away from the core business of health services (Wilson 2001) and may lead to difficulties in establishing effective measures and indicators (ABS 2001). Without any agreed framework, shifting elements, multiple themes and confusing messages, it is quite easy for the Commonwealth Department of Health and Aged Care to state:

The health needs of Indigenous Australians are largely met through the funding and delivery of mainstream health services, with services specially targeting Aboriginal and Torres Strait Islander people complementing these mainstream services... (2000:v)

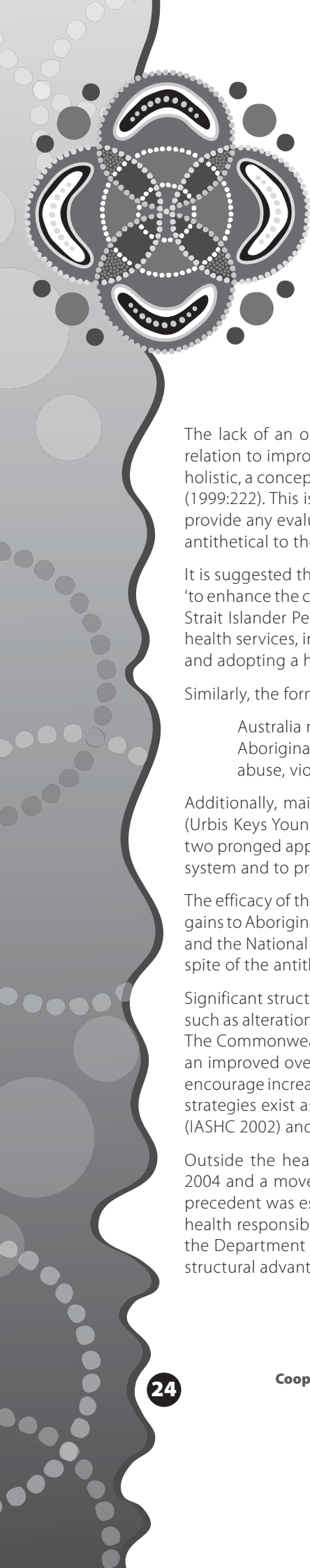
These problems and claims may be valid, but, much like the author of a recent mainstream editorial entitled *The Myth of Holism* (Morse 2003), they fail to elucidate specific criteria and indicators for their assertions. Such a level of analysis also needs to occur to justify statements such as, 'this framework reflects the Indigenous holistic view of health' (Henderson *et al.* 2002:484). As such, it appears that to underpin the health system with the concept (Table 2) would be an underpinning without substance.

I suggest that an agreed model would assist in several areas. A number of models of health exist, including Ian Anderson's (1988) 'social model' in *Koorie Health in Koorie Hands*, a 'social structure' model (Germov 1998), Turrell and Mathers' (2000) 'framework of socioeconomic determinants of health', the 'interactions of social and physiological determinants of health' model in vogue in the National Framework (NATSIHC 2003a:10), the model cited by John Mathews *et al.* (1995) and, most recently, that of Houston (2003) and the Western Australian Office of Aboriginal Health (2001).

A health economist can use such a model for costing health service provision, as attempted by Houston (2003). In terms of training health professionals, curricula in medicine, nursing, dietetics and for health workers could reflect relevant elements from a common framework. Furthermore, health education courses could coordinate education materials to provide a uniform and consistent view of Aboriginal health. Statistical database designers could use such a framework to guide the design and output of data systems. Policy makers could use a framework as the basis for thinking about broader health service issues, such as system integration, coordination and collaboration.

However, there remains a significant challenge for Aboriginal leaders to forego rivalries in order to harmonise sectoral approaches (see point 12). This is harder still given the various Aboriginal concepts of health (point 6). However, such efforts need to be undertaken so that work such as the *Guidelines for the Development, Implementation and Evaluation of National Public Health Strategies in Relation to Aboriginal and Torres Strait Islander Peoples* (KAMSC *et al.* 2002) can have stronger cultural validity and provide a common framework for all health strategies. Finally, these comments are also valid to whole-of-government efforts (see points 11 and 12), given the broad nature of health.

I reiterate that the efficacy of the concept is mitigated by the lack of an adequately conceptualised explanatory model, in conjunction with incoherent theoretical assumptions underlying it. This literature review has revealed a number of points that I take to propose that any claim about the health system could be justified as holistic. I recommend that research on Aboriginal concepts of health should be careful and detailed in the development of explanatory models. Such models could then be effective engagement tools for reorienting the Australian health system.



10. Inability to judge health system performance using Aboriginal holistic health

The lack of an operational framework partly undermines the theme of mainstream health system failure in relation to improving Aboriginal health (Table 2). This is apparently because, as Ngaire Brown states, health 'is holistic, a concept that many Western models of healthcare delivery fail to identify and therefore accommodate' (1999:222). This is in complete disregard of the mainstream literature on holistic health (see point 4), does not provide any evaluative framework or criteria (see point 9), and is specious because if Aboriginal constructs are antithetical to the West (see point 7) then Western models could not possibly accommodate the concept.

It is suggested that mainstream services can be holistic, such as by the Social Health Reference Group, in order 'to enhance the capacity of mainstream mental health services to better meet the needs of Aboriginal and Torres Strait Islander Peoples'. It states: 'This requires significant reform and responsiveness from mainstream mental health services, including building strong partnerships with Aboriginal Community Controlled Health Services, and adopting a holistic approach' (Social Health Reference Group 2003:49).

Similarly, the former Chair of NACCHO, Henry Councillor, stated that

Australia needs a mainstream health system that supports and nurtures a holistic approach to Aboriginal health if many of the most pressing issues facing Aboriginal society—such as alcohol abuse, violence and discrimination—were to be addressed (NACCHO 2003a).

Additionally, mainstream services can apparently become more holistic in delivering mental health services (Urbis Keys Young 2001:62). Therefore, it makes sense that the Commonwealth Health portfolio 'is pursuing a two pronged approach, which aims to both improve accessibility and responsiveness of the mainstream health system and to provide complementary action through Indigenous specific health programs' (DHAC 2001:161).

The efficacy of this action seems justifiable. An improved mainstream health system offers large potential health gains to Aboriginal people through reorienting Australia's \$66.6 billion health system (AIHW 2004). Both the NAHS and the National Framework contain recommendations to improve mainstream health system performance, in spite of the antithesis towards it (see points 7).

Significant structural barriers have been removed in the mainstream system generally and in the health system, such as alterations to the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme (DHA 2003:198). The Commonwealth has funded a range of health-specific and general Aboriginal affairs programs, leading to an improved overall allocation (DIMIA 2002). Additionally, there are a number of mechanisms now in place to encourage increased numbers of Aboriginal health professionals (SCATSIH 2002). A range of cooperative national strategies exist as a basis for health system improvement, such as in nutrition (NATSINWP 2001), sexual health (IASHC 2002) and mental health (Australian Health Ministers 2003).

Outside the health sector, the removal of the Aboriginal and Torres Strait Islander Commission (ATSIC) in 2004 and a move towards mainstreaming Aboriginal services is negatively represented by critics. However, a precedent was established in the mid-1990s when the Aboriginal community-controlled sector advocated for health responsibilities to be moved from ATSIC to the Office for Aboriginal and Torres Strait Islander Health in the Department of Health and Ageing (Anderson 2002). In this position, Aboriginal health has achieved more structural advantage by being in an integral institutional position within the government.

Additionally, the Commonwealth Government established the *Aboriginal Councils and Associations Act (1976)* to allow direct Federal funding to more than 3000 Aboriginal organisations (Corrs Chambers Westgarth Lawyers *et al.* 2002). Since 1971, when the Redfern Aboriginal Medical Service began, more than 120 Aboriginal community-controlled health and substance misuse services have been established (Dwyer *et al.* 2004). This can be rightly claimed as policy support for principles such as community control and self-determination, which are said to be embodied in these structures (Bell *et al.* 2000; NACCHO 1999). These positive improvements are often outweighed by continuing poor outcomes, as the Chairman of the Productivity Commission, Gary Banks, notes:

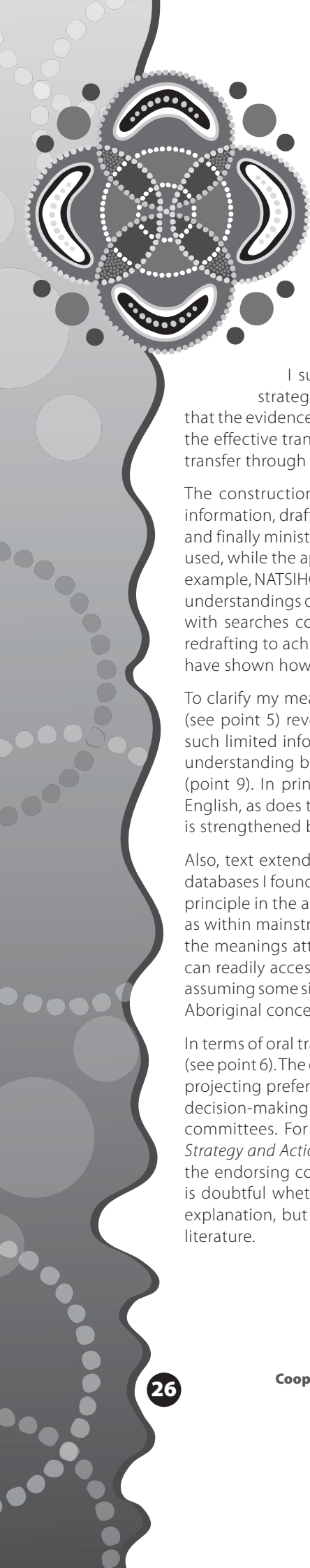
While there have been heartening improvements in some indicators since the first Report was released in late 2003, in many areas there have not, and in most the gulf between Indigenous and other Australians remains wide (Steering Committee for the Review of Government Service Provision 2005:iii).

But can all the blame for failing to improve Aboriginal health rest solely on the mainstream health system? Given that the phrase 'mainstream health system' encompasses a vast array of services and levels of government, specifically which aspects have failed? A well-articulated operational framework would be valuable here (see point 9). A policy maker wishing to make the mainstream health system 'more holistic' may heed the theme in the health literature that suggests that Aboriginal community-controlled health services exemplify holism (Table 2), as stated by Bell *et al.*: 'The ACCHS model of participatory holistic primary health care integrates illness care with disease prevention, intersectoral collaboration and advocacy for social justice' (2000:80).

While this may be the case, there is a lack of published research and evaluation of these services currently available (see point 3). In these settings, addressing the immediate needs of clients is a more pressing concern than academic style evaluations. Nevertheless, mechanisms need to be established to project such knowledge into the public domain to redress a paucity of easily accessible literature from this sector (OATSIH 2001). This would also help to overcome perceptions about there being no evaluation of their relative effectiveness (NCEPH 2000). Additionally, some significant tensions need to be addressed in relation to the evaluation of ACCHS (Anderson & Brady 1999). The available literature often uncritically proclaims success or that community-controlled service delivery is 'an uncontested good' (NCEPH 2000:4).

Furthermore, it would be of interest to understand how the array of different types of Aboriginal service delivery models delivers services holistically. The models range from dedicated Aboriginal medical services, such as in Redfern, Fitzroy and the Kimberleys, to multi-purpose cooperatives with health as part of their overall function, and to separate substance misuse services (Bell *et al.* 2000; Shannon & Longbottom 2004). They employ a range of professionals to deliver varied services (OATSIH 2003), including non-Aboriginal people such as medical doctors and policy officers. If policy makers are to engage with and learn from models of Aboriginal health service delivery, then substantially more information needs to be made accessible.

In summary, claims about mainstream health system failure and Aboriginal health system success are undermined by the range of issues in this discussion. As such, it is difficult in policy terms to sustain claims for the efficacy of one versus the other, especially as any claim about the health system could be justified as holistic. I recommend increased research into, and improved access to, current information from Aboriginal health services.



11. Barriers to effective textual and oral transfer of Aboriginal concepts

I suggest that the effective uptake of Aboriginal concepts of health in policy, programs and strategies requires not only more information and research, but improved transfer mechanisms. Given that the evidence-to-policy transfer process is complex (Hanney *et al.* 2003), there are a number of ways in which the effective transfer of conceptual meanings into the policy context can be compromised. I focus broadly on transfer through text and through oral processes.

The construction of national Aboriginal health strategies generally follows the same pattern of gathering information, drafting and redrafting documents, argumentation and revision through various committee layers, and finally ministerial endorsement. In national health strategies the bibliographies list sources of text that were used, while the appendices list the organisations and people consulted, as well as the process followed (see, for example, NATSIHC 2003). The initial literature review is an important tool for the policy maker to gain foundational understandings of an issue. It is often one of the first substantive tasks undertaken prior to a consultation process, with searches conducted as I have done, using keywords and locating documents, synthesis, drafting and redrafting to achieve clear points upon which to base, or to act as a stimulus for, discussion and consultation. I have shown how complex and confusing this can be in terms of Aboriginal holistic health.

To clarify my meaning further, a text search of the Aboriginal language words of *mwarre*, *punyu* and *wankaru* (see point 5) reveals that they only exist in Aboriginal language—there is a strict textual boundary. There is such limited information on these concepts, and they have no cognate in English, that I cannot gain further understanding by aligning them with Western concepts, as is done with holism and other concepts of health (point 9). In printed matter they have far greater visual power because they stand out in stark contrast to English, as does the Maori concept *Whare Tapa Wha* (McPherson *et al.* 2003). Additionally, their cultural validity is strengthened because of their clear delineation from the English language.

Also, text extends beyond human life, generations and geographical boundaries. Therefore, when I searched databases I found that the term ‘holism’ appears as a political ideology (Heywood 2003:272) and as fundamental principle in the anthropological school of British structural-functionalism (Barnard & Spencer 2002:214), as well as within mainstream health discourse, and all without attachment to Aboriginal meanings (see point 4). Thus, the meanings attached to Aboriginal holism are easily diffused within this depth. Furthermore, policy makers can readily access the various texts mentioning holism and bring their understandings into Aboriginal health, assuming some similarity. My point is that the attempted co-opting of the term ‘holistic’ to demarcate a definitively Aboriginal concept of health has failed in text.

In terms of oral transfer, people can come together with assumed meanings and perpetuate misunderstandings (see point 6). The development of policies and strategies in Aboriginal health always involves a multitude of voices projecting preferences through ideological, institutional, professional and cultural perspectives. Executive and decision-making committees receive information after filtration through a hierarchy of advisory and consultative committees. For example, in the development of the *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan*, the majority Aboriginal working party was in effect a sub-sub-sub-committee below the endorsing committee of the Australian Health Ministers Advisory Council (NATSIN Working Party 2001). It is doubtful whether in this process Aboriginal concepts and knowledge receive full oral argumentation and explanation, but it is feasible that the committee members will have some knowledge of holism from other literature.

Additionally, Aboriginal people comprised 2.4 per cent of the population in 2001 (ABS 2002), but in 2001 only 0.9 per cent of health care providers were Aboriginal (AIHW 2003). There are also low numbers of Aboriginal people in the Commonwealth Government structures that require proactive recruitment and retention policies (DEWR 2002; DFCS 2003). Furthermore, given the diversity of Aboriginal groups and in-group rivalries, as well as between urban, rural and remote communities (Weaver 1983; Peters-Little 1999), it seems unlikely that oral transmission of a single, agreed concept would occur. Therefore, I suggest that it is not possible for Aboriginal people to occupy a sufficient number of positions, either generally or strategically, to 'pass the oral baton' of understanding vertically and horizontally through all the processes of the health system.

In terms of a broad view of health associated with Aboriginal holism (Table 2), the implications of this study carry into 'non-health' policy areas. It is perhaps because of problems in textual and oral transfer of Aboriginal concepts, as well as the issues that I have outlined above, that neither the concept nor any Aboriginal concept of health receives mention in the first release of *Overcoming Indigenous Disadvantage: Key Indicators* (Steering Committee for the Review of Government Service Provision 2003a; 2003b) and receives only one minor instance in the second report (Steering Committee for the Review of Government Service Provision 2005:11.41). The purpose of this performance monitoring framework was stated by Prime Minister John Howard in his capacity as the Chairman of the Council of Australian Governments (COAG): 'The key task will be to identify indicators that are of relevance to all governments and indigenous stakeholders and that can demonstrate the impact of programme and policy interventions' (Steering Committee for the Review of Government Service Provision 2003a:xvi).

The influence of the framework extends into all policy areas. In health, a framework for monitoring progress in Aboriginal health, called 'The Aboriginal and Torres Strait Islander Health Performance Framework (ATSIHPF) project', will be consistent with the COAG report, and 'will be the chief vehicle for assessing the effectiveness of implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Health' (Dwyer *et al.* 2004:xviii). An obvious tension exists here because the National Framework partners accept a holistic approach (see point 9), whereas the COAG report reflects no Aboriginal concept but takes precedence over the National Framework. I see this as a failure on the part of advocates of Aboriginal concepts of health to provide a coherent and well-articulated framework amenable to policy makers' effective engagement.

Recognising that policy 'is the outcome of the competition between ideas, interests, and ideologies' (Bridgman & Davis 2000), an important opportunity has disappeared for Aboriginal cultural constructs to influence the Australian social system. As such, the approach of the Howard Coalition Government in dealing directly with individual Indigenous communities through the 'new arrangements for Indigenous affairs' (Office of Indigenous Policy Coordination 2005) seems justified in regards to oral transfer of Aboriginal concepts. From another perspective, the 'new arrangements' could improve the influence of the diversity of Aboriginal concepts of health on whole-of-government policy, especially given the willingness of the Australian Public Service 'to engage in holistic thinking and think beyond the boundaries, conceptualise broad outcomes, and understand areas of commonality' (Management Advisory Committee 2004:53).

In this section, I have discussed the implications of the previous points in terms of transfer of Aboriginal concepts of health to policy makers in all sectors of Australian society. In such a competitive policy environment, poorly defined and articulated concepts have many textual and oral barriers to overcome. Considering all the points above, I recommend that the use of holism in relation to Aboriginal health be abandoned. The challenge is for advocates of Aboriginal concepts of health to more effectively articulate coherent frameworks in forms amenable to the many policy makers in Australian society.



12. An excised policy context

This section touches on some important historical and contemporary contextual issues that need to be considered when thinking about agreeing with the concept. It became evident during the analysis that the acceptance and uptake of the concept into government policies as an underpinning philosophy of health (Table 2) is not as unproblematic as it appears. The concept was developed in a particular historical period and appears 'excised' from this context when inserted into policy documents. In the development of health policy documents, policy makers draw on a range of research to justify the uptake of interventions, yet no health policy document addressed some critical meanings and their intent attached to the concept.

The concept and the NAHS definition are explicit policy principles in Victoria, Northern Territory, New South Wales, Queensland and Western Australia Governments, and are also advocated for as policy principles by professional associations and a range of non-government organisations (AMA 2001; DHS 1997; 2004; WAOAH 2000; Queensland Health 1994; NTG 1996; RACGP 2000; ATSI 2001). The acceptance of both seems to imply an acceptance of a range of meanings associated with the concept as attached to it through its historical developmental context. We can get a sense of opposing ideological and theoretical stances in the introduction to the NAHS *Aboriginal Australia—The Reality and not the Myth*, in which, behind a quote referring to the 1988 bicentennial celebrations, lies a powerful and emotive overture of injustice:

Dressed in the hand-me-downs that are the legacy of dispossession and dispersal, Aboriginal Australia could hardly have felt at home at White Australia's extravagantly self-congratulatory, glitzy bash last year (NAHS Working Party 1989:1).

The intent behind subsequent policy change comes through when the NAHS Working Party stated:

Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity (1989:ix).

This sentiment of control lies behind some of the themes in Table 2, but it seems most strongly implied through many statements suggesting that holism should be an underpinning philosophy of health (Table 2). This is understandable, given that the effects of actions legitimised by past Australian policies on Aboriginal people are well documented (Tsey & Every 2000; Siggers & Gray 1991; Ring & Firman 1998; Ring & Elston 1999; Anderson 2001–02). Has the context changed now?

Positive changes include active anti-discrimination laws and overturning discriminatory policies, among many other legislative changes prior to the 1967 referendum (Gardiner-Garden 1996); victories such as the Mabo judgment and the Wik decision (Gardiner-Garden 1999); more than 3000 Aboriginal organisations acting as sites for community development, private enterprise, participation and advocacy, and service delivery (Office of the Registrar of Aboriginal Corporations 2003); substantially improved Commonwealth Aboriginal specific-program funding (DIMIA 2002; Gardiner-Garden 2003); and the powerful admission of wrongdoing and requisite 'sorry' from former Labor Prime Minister Paul Keating (Keating 1992).

Negative buffers include the 'Black Armband' debates and the refusal of the Howard Coalition Government to say 'sorry' for the stolen generations (ATSI 1997; McKenna 1997); Aboriginal leaders, politicians and academics who monotonously reiterate Aboriginal health as shocking, appalling, disastrous, disgraceful and damning (Anon 1972; Ruddock 1980; Ward & Bingham 1994; Deane 1997; Morgan & Allen 1998; Baum 1999); and continuing calls to increase Aboriginal health funding (AMA 2002; ABS 1995; Public Health Association of Australia 2003; Ring & Brown 2002; AMSANT 2000), which enhance bitterness about the ineffective implementation of the National Aboriginal Health Strategy (NAHS Evaluation Committee 1994).

There are continuing tense and often vehement arguments about history (Macintyre & Clark 2004). Difficult questions need to be asked. A critical question is, in accepting the concept, does this mean an acceptance of past context? Do the governments and organisations think that Aboriginal people 'determine all aspects of their lives'? What does 'control' mean? Does this mean absolute control of all aspects of social structures, or does it mean partnership with a majority vote? These are ultimately difficult value judgments, even more so when seeking to accrue evidence to see if the contemporary context is so different. Furthermore, concerning the complexity of separating past and present (see point 6), can the concept be excised from past context and reframed in a new context?

It could be said that I am placing too much emphasis on, and giving too much effect to, the wording of policy documents. However, the 'words' can serve as markers of values, and the values of policy makers are said to infuse policy and reflect the values of society (Hanney *et al.* 2003). Some important value preferences underlie seemingly bland policy wording, such as in the Australian Constitution of 1901, where section 51 stated:

The Parliament shall subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:

The people of any race, other than the Aboriginal race in any State, for whom it is deemed necessary to make special laws (Gardiner-Garden 1996).

This legitimised actions to exclude Aboriginal people from rightful access to a range of benefits conferred to Australian citizens, such as from social welfare and franchise (Anderson 2001a; Gardiner-Garden 1996; Eckermann *et al.* 1992). These values can also survive through time and with different generations. At a meeting of Commonwealth and State ministers concerned with Aboriginal affairs in 1965, the ministers declared:

The policy of assimilation seeks that all persons of Aboriginal descent will choose to attain a similar manner and standard of living to that of other Australians and live as members of a single Australian community—enjoying the same rights and privileges, accepting the same responsibilities and influenced by the same hopes and loyalties as other Australians (Coombs 1976:3).

In 2000, thirty-five years after that meeting, Peter Howson a Federal Liberal member from 1955–72 and former Commonwealth Minister of Aboriginal Affairs, used similar words:

Australian civilisation has far, far more to offer Australia's Aborigines than the hunter-gatherer life which their forebears endured. The key to participation in this civilisation is becoming absorbed in the mores of that civilisation; in manners, in carrying-out the responsibilities of a job, in soberness and in the enjoyment of the unrivalled pleasures of domestic life. This is the only possible future for Aborigines that makes any sense, at least for the Aborigines themselves (Howson 2000:24).

However, I do not believe in policy determinism, as evidenced by the knowledge that many non-Aboriginal people throughout the history of Australia have actively campaigned for better treatment of Aboriginal people (for example, see Kidd 1997; Attwood & Markus 1999). However, the deceptively plain words of policy can be powerful, defining the context and framework in which legitimised action occurs.

This brief treatment of context serves to illustrate that policy can be a powerful frame of reference for action, and that 'it is crucial for policy makers to understand yesterday's historical context of today's political realities in order to craft tomorrow's potential policy reforms' (DeVoe 2003:79). Policy makers fail to critically examine the implications of accepting the concept, which requires a close consideration of its historical developmental context. I recommend a more concrete analysis of this context rather than a superficial acknowledgment in policy statements.




Conclusion

A literature review is a tool that policy makers use to gain a foundational understanding of an issue. In this case I reviewed Australian health literature in an attempt to answer a key question: what is the concept of Aboriginal holistic health and how does it impact on health policies, strategies and programs? I could not find a single definitive, coherently argued and cogently articulated source to improve my understanding of the concept. Furthermore, its boundaries appear so diffuse and ethereal that any argument about the health system could be constructed as holistic.

This literature review demonstrates how the validity of such concepts can be undermined by poor definition, operationalisation, and conflicting and confounding discourse. This reflects the fact that advocates of Aboriginal concepts of health have yet to articulate these ideas effectively in the written text. The limited nature and scope of this literature synthesis could be addressed through further work that investigates the social context in which Aboriginal health concepts are utilised. In addition, the information obtained should be crafted into operational frameworks to facilitate engagement by all policy makers in the Australian health system. Such efforts could transform their rhetorical significance into practical effect.

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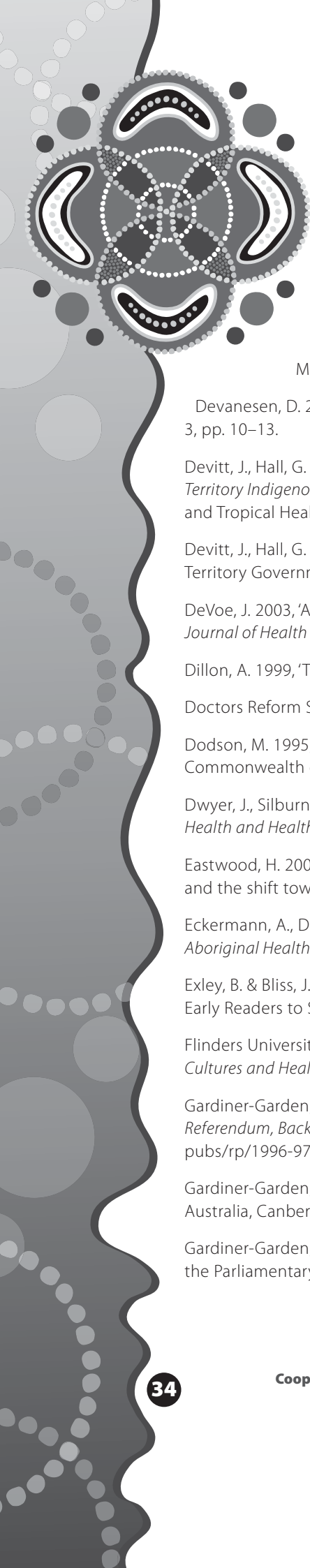
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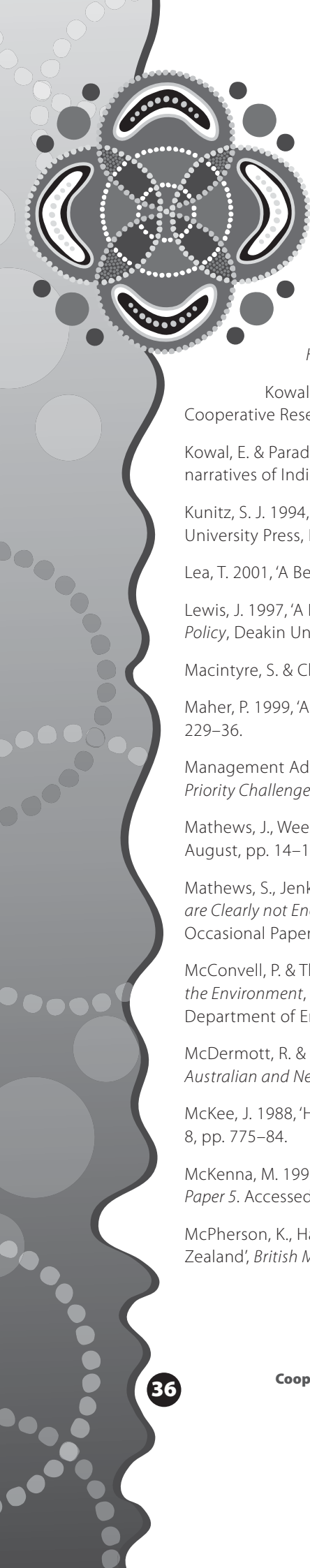
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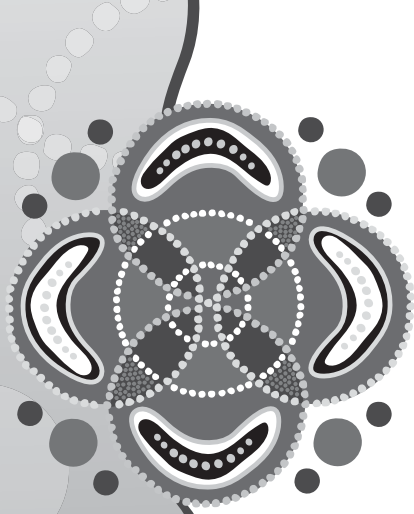
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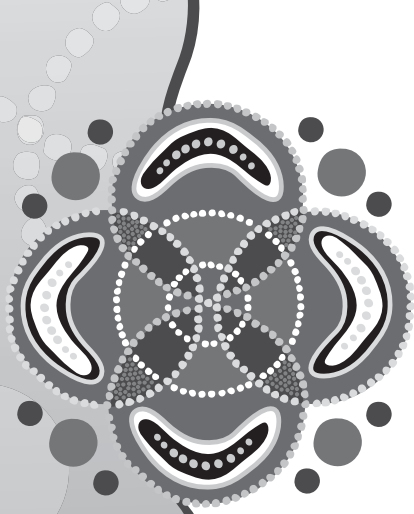
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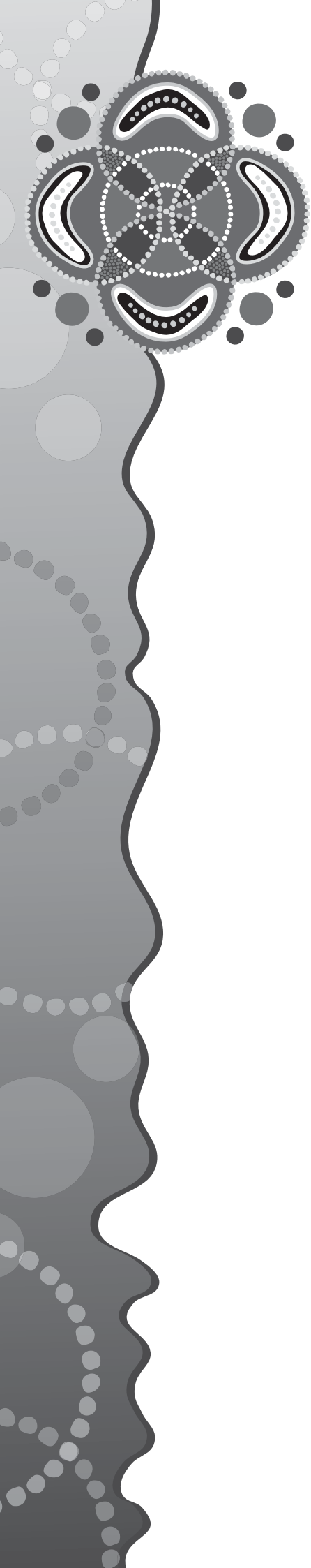
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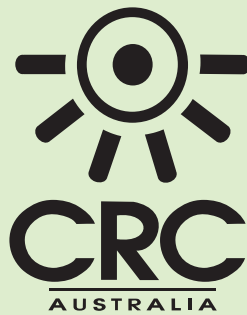
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