

## Culture in Health: A Neglected Necessity in the Australian Health Care System

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*Australia is a culturally diverse society located in a culturally diverse world that is also "on the move". Our multicultural future is unquestionable, but is our health sector responding to this reality? It appears training institutions and service delivery agencies are sticking to conservative concepts about health. The radical scientific method that invented modern medicine seems unprepared to embark on new types of enquiry that will expand the concept of health and the role that culture plays in health outcomes. This must change, not just so that more equitable and appropriate services will be available, but because it is economically efficient and there will be a dividend for the entire community.*

'Health' and 'culture' are two simple words, taken for granted and used every day. Most people also believe they have a clear idea of what is meant by them. But examine each of these words closely — their layers of meaning, nuance and inference — and then combine them to extend their meaning, and a vast, complex matrix of ideas, understandings, contradictions and challenges is entered into. Every year numerous books are published, conferences are held, state and national advisory bodies established, policy frameworks prepared and projects undertaken to attempt to address some of the issues posed by the interface between health and culture. Given this, the mere attempt to interpret what they mean in so short an article creates a significant challenge, so I will only attempt to introduce the subject to those who may not have thought deeply on this theme before.

Culture is a field of considerable importance to the health sector in Australia. It relates to its equity, its efficiency and cost, to the quality of services (and quality of life of many service users), to service standards, to the skills and abilities of the workforce, to training and curriculum design, and to the contemporary paradigm of medicine as practised by much of the medical profession in Australia. But an over-riding theme for those who work, even on the fringe of the health sector, is the compelling belief that when culture is truly and fully reflected into health planning and delivery, there will be enormous benefit for the entire community — user and practitioner alike. This is sometimes called the "diversity dividend" (Downton & Eisenbruch 2000).

### Who We Are Talking About

This population group is often described as ethnic Australia, or if preferred, multicultural, immigrant, non-English speaking background, language other than English, or culturally and linguistically diverse. Such attempts to even define these communities are fraught with difficulty and highlight its complexity — the very diversity of language used to describe our population's plurality illustrates the trouble we have defining it. Furthermore, what is meant by 'ethnicity'? Is the term a restrictive, outdated or intrinsically marginalising label? Does it infer a 'deficit' model of social identity? Could the group or groups classified in this way be described better in other terms such as their first language, their culture, spiritual beliefs, social values or race?

In Australian health care planning there often appears to be an assumption that there is a 'mainstream' set of health care service users, and another set of 'other' users. This assumption is intrinsically flawed for several self-evident reasons. Firstly, because it becomes a matter of impracticality or unfairness to imply favour for certain groups over others (will there be a priority to address the needs of Indigenous users, people with a disability, youth?) Similarly, attempts to bundle groups together becomes an equally meaningless exercise. For example, saying one group of people has a unique set of needs (other than their possible difficulty understanding English) because of their different use of first languages, is both an inefficient and unworkable approach.

Language cannot be separated from culture, and once the cultural dimensions are taken into account, the differences are so significant that the attempt to lump all such variety into the "all the same because they are so vastly diverse" camp is patently absurd. The Australian statistics on suicide are a case in point. The suicide rates for people from

culturally and linguistically diverse backgrounds (CLDB) are often discussed as a whole, but upon analysis of the data, it seems highly probable that trends mirror those of home countries. Those people who come from countries with traditionally high rates of suicide have higher rates than the general Australian population, and those from countries with low rates of suicide repeat similar incidence levels. This indicates that cultural, religious, social and other value or lifestyle systems and patterns of behaviours are likely to play important roles in either protecting or increasing risk factors associated with self-harm (Dusevic et al. 2002).

Another reason why the current approach is not constructive is that it assumes the 'mainstream' community can be clearly identified, communicated with, influenced, provided with health services; that the 'mainstream' community can generally be managed within a clearly defined understanding of health and how to promote and protect it, prevent and treat illness, and to manage the recovery from adverse events. This thinking is largely geared to managing disease, rather than treating the complex, and often multiple health needs of individuals.

### **Cultural Diversity and the Health System**

Those who critique the current health system have more concerns than the broad policy settings that define diversity. There are profound questions about the assumptions made by modern clinical practice. These focus on the 'Western' concept of health and include issues such as: spiritual dimensions of health; the value of alternative medicine (such as traditional remedies); the specialist approach to diagnoses and treatment; cross-cultural communications between clients and health service providers; how health workforces are recruited and trained; the design of curricula and the delivery of continuing medical education programs; and compliance to health service standards.

This might sound like a call for a complete and radical overhaul of the health sector, from how services are designed to health practice, but this is not the case. Such an approach is both impractical and dangerous. The Australian health system, in spite of its many shortcomings, is still an essentially sophisticated, well-organised sector, providing good quality care for the majority of its citizenry. However, it can and should do better, and relatively modest changes in approach in service design, compliance and training will deliver substantial benefits for users, more rewarding professional careers, and long-term savings to the health budget. Locating culture in the health sector is one of the keys to achieving these improvements.

#### **A Case for Better Cross-Cultural Communications**

A Hmong woman suffered greatly after experiencing a caesarian section at an Australian hospital. The Hmong are a relatively new community in Australia, coming here from Laos in recent years; they are a tribal people with a unique spirituality that incorporates belief in several souls. The woman in question believed she had lost one of her souls during her operation and, as an incomplete human, experienced a deepening malaise that her Australian doctor was incapable of diagnosing and treating. Fearing ridicule or lack of understanding the woman's family only revealed what they believed would remedy the situation after the intervention of a researcher-advocate. Once the hospital agreed to have a Hmong shaman conduct a 'soul calling ceremony' in the delivery suite where the soul was lost, the woman rapidly recovered her former good health. Understanding, cooperation and respect from hospital staff resulted in a very positive result for this Hmong family (Rice 1996).

### **Culture and Medical Science**

Culture can have an important impact upon health, especially for those individuals whose culture does not so clearly differentiate between the physical, the psycho-social and the spiritual dimensions of health (see box). In many Indigenous and Eastern cultures, health is seen much more holistically than in the modern Western bio-medical health paradigm. While

this is gradually changing, the medical profession in particular, is still defined within the Western empirical scientific method.

No doubt this method has been responsible for many of the incredible improvements in both advanced scientific practice, as well as in the elementary hygienic, nutritional and environmental gains that have extended human life expectancy in the past century. While this approach has served medical science well for a long time, increasingly, there are barriers to further developments in some areas of health due to the methodology that has helped achieve so much. Introducing the concept of culture more fully into health, and actually learning from some of the alternative medical traditions of the world is not going to embed 'irrational' science into medicine. Rather, it is returning to the kind of empirical enquiry pioneered by European philosopher scientists, which has led to so many great discoveries. This can be seen in the Western pharmaceutical industry beginning to explore what it can learn from traditional eastern and Chinese medicine (Noyce 2001).

Evidence-based clinical practice (EBCP) and randomised control trials are key tools of the modern, Western medical researcher. There is an assumption that if EBCP methodology informs research it necessarily follows that the results will be scientifically valid. However, clinicians are not generally trained epistemologists. They design research to explore a gap in knowledge, to validate a thesis or test a product. While the testing method may be rigorous, I would doubt many of the cultural assumptions that inform the underlying research questions are considered; fundamental, that all humans, from a clinical perspective, are the same — their physiology, psychology and body chemistry work in fairly predictable ways.

While this is in one sense true, it is also false in others. Different peoples do have different responses to external stimuli: Indigenous Australians appear to respond more strongly to alcohol, Asians respond to psychotropic drugs differently to non-Asians, diet can more radically increase the risks of diabetes amongst Pacific Islander communities, to mention just a few examples (Lambert 2003). The science of ethnopsychopharmacology assists clinicians to understand and prescribe mental health medications in ways that complement the different ways population groups respond to pharmaceutical products. But as well as physiology, culture clearly has a capacity to affect health outcomes. It also has other well-known effects such as somaticisation or even the power of the human will to transcend circumstances in which, if the logic of inductive reason were applied, it would be impossible for them to overcome (Kopczuk & Slemrod 2001).

There is much scepticism in the minds of many traditional Western bio-medical practitioners about the extent to which culture impacts upon health. However, there is probably an equal amount of scepticism in the minds of those who believe the model of research and practice that now exists must be expanded to better take into account the ways humans function at the physical, emotional, cognitive, spiritual and cultural levels. A person is not just a single organism made up of various 'parts' that must be treated if damaged or diseased, but an entity functioning as a complex whole, and one that also functions with spatial, environmental, cultural, social and other dimensions that can impact on health in far more sophisticated ways than are presently understood.

### **What Can We Do?**

I am always aware that this could be interpreted as an unrelenting criticism of the whole concept of health and, as such, remedies to these dilemmas or contradictions are insurmountable. This is not the case. There are approaches to the location of culture in health that can be taken to make enormous improvements. One of the most obvious examples is that of reciprocal learning and health partnerships. Australia already has an example of a medical school at the University of NSW that utilises this model. Here educators work with the human capital within the university community — students from overseas or CLDB Australians. These students have a great fund of knowledge about how health is understood and practised in their home communities and cultures. The case studies used are not so much, "how do I treat a patient presenting with depression?" as "Mrs Nguyen is a 60 year old, Vietnamese woman presenting with insomnia and headaches; how do I diagnose and treat

her?" This kind of approach to teaching medicine does not compromise the standards or quality, but it does locate culture firmly in the curriculum in such a way that the next generation of general practitioners will be better placed to understand the needs of their clients (see <http://cch.med.unsw.edu.au/cch.nsf/website/education.teach-learndevelop.medEd>).

The challenge is how to inspire well-established institutions to embrace the complexity that working cross-culturally involves. The general track record suggests there is either a widespread rejection of the demand, or sufficient disinterest in the service needs of clients to motivate training institutions to restructure curricula. Similarly, many service agencies fail to respond to their users by reflecting culture as a fundamental function of program delivery or policy principle. This is in spite of the existence of a public service charter that has been agreed to by all three tiers of government in Australia (Department of Immigration and Multicultural Affairs 1998).

The most obvious way, therefore, to deliver change is to establish clearer funding guidelines for training institutions and service agencies. Standards, along the lines used at the national level for mental health services, are a good model in terms of principles (National Mental Health Working Group 1997). The problem, however, with these particular standards is that there is no adequate compliance system to remedy services that fail to meet them. Once a comprehensive system of standards is working, the whole health sector is likely to gear up to respond far better to the needs of its diverse client base. Sadly, given the complex structure of the health system with different tiers of government or agents of governments responsible for the various parts, agreement on the content and principles of such a standards system — let alone an effective monitoring and enforcement structure — continues to make this suggestion a distant dream.

The demands upon the health sector to respond to diversity, nevertheless, will continue to become ever louder. Our world is moving, developing and integrating at an almost exponential speed. Globalisation is, more than ever before, bringing communities together in new ways. This creates many opportunities for economic development and cultural exchange. It has also lead to the rise of global anxieties reflected in a deteriorating security environment, the 'clash of cultures', economic inequalities, social exploitation, environmental destruction and cultural genocide.

Along with the mass extinctions of our planet's biodiversity is the loss of our cultural diversity. People are moving in large numbers — either dislocated by localised conflict or economic immigration. This phenomenon is global; people from the third world such as asylum seekers, as well as affluent people are also on the move. The world faces the challenge of how to protect our heritage of world cultures, while allowing them to evolve, and ensuring that humans can maximise the harmony with which they interact with and learn from each other. So, rather than considering 'multiculturalism' an outdated concept — it should be considered one of the most important and contemporary public policy issues.

Internationally, there is vigorous debate about cultural diversity; much of this highlights just how far Australia has been falling into an intellectual, moral, social and policy complacency. The UNESCO *Universal Declaration on Cultural Diversity* (2001) and the United Nations Development Programme's *Human Development Report* (2004) — amongst other recent and important United Nations documents — outline the relationships between the environment and cultural heritage, the health of populations, sustainable development, human rights and cultural liberty. Taking a population health approach, how people live and relate to their physical environment, how they maintain self-respect and cultural identity and how they feel they are valued as humans will inevitably impact on the standard of their physical and mental health. These understandings, so elementary, are generally not being dealt with by a health sector that is still fixated on systems management not the needs of individuals.

To conclude, those of us who strongly advocate for a far greater location of cultural diversity values in the health sector in Australia believe this is not just a rights-based claim. It is one that is justifiable on the grounds of efficiency, economics and good science. While a culturally

competent and sensitive health sector will provide a dividend for all Australians, the fundamental issue is that we need a system that does not cater for special groups which are part of the mainstream anyway, but a system that handles diversity as the normal reality and lived experience of us all.

### **Principles to Underpin Reform of the Health System**

1. Reciprocal Learning  
This should involve willingness to learn from different cultures, alternative approaches to health care and medicines, as well as from patients. This demands an enquiring approach to dealing with diversity (which may not be restricted to cultural difference) and a genuine willingness to work collaboratively and across sectors.
2. Openness to New Ideas  
This principle follows from the reciprocity model. All those others who make up our health sector need to be freed from the rigidity of existing models whether these relate to funding, administration, research, service planning and delivery or teaching.
3. Respect  
Respect is not only critical for the professional/client relationship, it is vital if partnerships are to be realised and if learning is to occur. Where respect is genuine it is likely there will also be less hubris and gross self-interest. It is these two qualities, particularly amongst the specialist colleges, that have done so much to atrophy, restrict and exclude new ideas, skills, creativity and reform in the health sector in Australia.

### **Changes that are Possible Within the Current Health System Structure**

1. Establishment of uniform, national standards relating to cultural competence and access and equity for CLDB clients at all publicly-funded hospitals and health centres, and a compliance regime to ensure these standards are met.
2. Integration of culture into curricula at Australia's medical schools and health disciplines at the tertiary level to ensure far greater cultural competence in the next generation of medical and health workers.
3. Increase funding for health promotion activities targeting Australia's culturally and linguistically diverse communities, and into research with these communities in Australia, to determine the causes and extent of morbidity and mortality, but also protective health factors enjoyed by these communities as well as attitudes, knowledge and behaviours relating to illness and healthy lifestyle.

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