Can cultural differences affect access of families to health care?
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Abstract

Differences in culture can become apparent when families seek out or require access to health care in Australia. The importance of family health care is that it aims to strengthen and support families, prevent illness and manage risks (Barnes & Rowe 2009). Given that the health status of Indigenous Australians is reported as among the worst of any group in the so-called “first world” (ABS 2005) it would appear that there is a disparity between health outcomes of Indigenous and non-Indigenous Australians resultant of these cultural differences. This paper focuses on, with relation to Indigenous Australian families, why there is a health disparity, Aboriginal health beliefs, Western health beliefs, worldviews and cultural vitality in order to ascertain if in fact these cultural differences can and do affect family’s access to health care.

The subject matter of this paper is how cultural differences can affect access of families to health care. The paper will concentrate on identifying and examining core issues relating to the cultural differences of Indigenous Australians and attempt to correlate them with how they are affecting families’ access to health care. With the following core issues to be explored: why there is a disparity in health outcomes, Aboriginal health beliefs, Western health beliefs, worldviews and cultural vitality. The importance of family health care is that it aims to strengthen and support families, prevent illness and manage risks (Barnes & Rowe 2009) and is something that should be afforded to all Australian families. However, the reality is that this is not the case and one particular instance where this is illustrated is by the poor health status of Indigenous Australians.

The health status of Indigenous Australia is reported by the Australian Bureau of Statistics (2005) as among the worst of any group in the so-called “first world”, suffering more ill health, experiencing more disability, poorer quality of life and dying younger than non-Indigenous Australians. The disparity between Indigenous health outcomes compared to non-Indigenous health outcomes is undoubtedly influenced by cultural
Can cultural differences affect access of families to health care?

T. Lewis

differences between Indigenous and non-Indigenous Australians and as a consequence is affecting Indigenous families’ access to health care.

In order to make relevant the use of Indigenous Australians as an example in this paper an understanding of Indigenous family structures must be gained. Eckermann et al. (2010) categorise 4 different family types: Extended families, Nuclear families, Single-parent families and Compound families. They go on to further define Compound families as those in which an endless combination of relatives and non-relatives all reside under the same roof. This definition is significant in that it allows the paper to make reference to Indigenous Australians per se and discuss in the broadest possible way the impact of cultural and family structure on access to health care.

There are several factors which can be attributed to the disparity in health outcomes of Indigenous Australians to date: Colonisation, Aboriginal health beliefs and the inflexibility of Western health professionals (Matharu 2009). The colonisation of Australia has long been impacting the health outcomes of Indigenous communities (Astbury et al. 2000; Harris 2003; Paradies, Harris & Anderson 2008). The notion of ‘racial inferiority’, the dispossession of Aboriginals from their land and also, the challenging and subsequent dismissal of their social and spiritual beliefs have attributed to the ongoing poor health status of Aboriginals. This poor health status must be considered side by side with that of Aboriginal health beliefs. Aboriginal health beliefs are not just vested in the health of the individual per se, but more so the social, spiritual and cultural wellbeing of the community (family) as a whole (Barnes & Rowe 2009; Bourke et al. 2006) and when this deteriorates so does families’ access to health care. Therefore, the early notions of racial inferiority, a remnant of colonisation, and the way the Western biomedical model works, for example; differences in the understanding of causation and categorisation of illnesses, some Western medical professionals are unable to relate to and incorporate Aboriginal health beliefs and assumed realities in to health services provided and ultimately fail to offer culturally appropriate health services that results in a disparity in desired health outcomes (Gorman et al. 2006; Gorman & Best 2005; Mcgrath et al. 2006).
Aboriginal health beliefs are closely related to their connection with the land, community and spiritual beliefs (Barnes & Rowe 2009; Boulton-Lewis et al. 2002; Eckermann et al. 2010; Gorman et al. 2006) and can be grouped into three categories: Categorisation or type of illness, cause of illness and treatment of illness. Categorisation or type of illness refers to how Indigenous Australians categorise different illnesses. They identify 5 specific categories; natural causes, environmental causes, direct supernatural causes, indirect supernatural causes and Western causes (Maher 1999). With the last a direct result of colonisation and includes illness such as sexually transmitted infections, alcoholism and diabetes (Bourke et al. 2006; Rivera 2009). The 5 different categories of illness types are important when understanding how they can affect access of Indigenous families to health care. The categories allow for further division of the illness or injury into specific causes which are often connected to, and reliant on, spiritual beliefs, for example; the belief of sorcery and the connection to the land and their community. The treatment of illness and injuries are dependent on the categorisation and the cause of illness. For example; an illness that falls into the category of direct supernatural causes maybe be a result of breaching certain taboos (Maher 1999) and even though physiologic symptoms may present it would warrant the use of a traditional healer as opposed to a general practitioner who is not versed in their cultural healing traditions. On the other hand, an illness or injury relating to natural causes, such as a broken arm may easily be treated with a visit to the local general practitioner for a cast instead of traditional healer performing a ritual dance as long as there is acceptance in the community that accessing Western medicine is appropriate.

Gorman et al. (2006) state that Western medicine, with its emphasis on a scientific evidence base, has a tendency to see non-Western health practices as less credible and therefore a factor that might affect the accessing of health care by Indigenous families by way of alienating them from their beliefs. Several reasons as to why Western medicine portrays non-Western medicine in such a way might be due to; technological advances, scientific knowledge base and the biomedical model. Technology has allowed for a greater understanding of the human body and disease processes along with the recording and storing of vast amounts of information and the distribution and teaching of said knowledge.
Therefore, it stands to reason that Western medical knowledge in a Westernised worldview is far superior to that of Indigenous Australians but potentially no more effective in some instances. The use of scientific knowledge bases in understanding causes, categorising and treatment of disease is another pertinent factor in why Western medicine depicts non-Western medicine as less credible. Whereas Indigenous medical knowledge is passed on from generation to generation through word of mouth (Gorman et al. 2006) and used by the whole family (Devanesen & Maher 2000) it has the potential to be lost, forgotten, misinterpreted and/or given up on over time. With the increase in technology and the use of scientific knowledge bases the biomedical model has became more dominant (Eckermann et al. 2010) and is in conflict with the holistic approach undertaken by Indigenous Australians. Where the biomedical model focuses on recognition and treatment of disease, the traditional medicine way is to respond to the personal, family and community issues surrounding the disease and offers a ‘why’ to the ‘how’ (Devanesen & Maher 2000).

One cultural difference with a great potential to affect access of families with different cultural norms to health care is that of worldviews. Worldviews are defined by Eckermann et al. (2010) as ‘the ideas and beliefs which a group of people hold about its world and the people and things in it’. Two such health related worldviews differing between Indigenous and non-Indigenous Australians are the holistic approach versus the biomedical model and, the use of traditional or ‘bush’ medicine versus Western medicine. Devanesen and Maher (2000, p. 2) state that the Aboriginal approach to health care is a holistic one. It recognises the social, physical and spiritual dimensions of health and life. As opposed to the biomedical model which ‘teaches diagnosis and treatment in isolation from wider social, historical and politico-economic considerations (Eckermann et al. 2010, p. 164)’. From these two statements it is obvious that there are significant cultural differences, approaches and beliefs with relation to health and wellbeing, which ultimately can and will affect access of families to health care as they are on opposite ends of the spectrum. As it has already been established that Aboriginal health beliefs are grounded in a connection with the land, it makes sense that they would derive their sources of medication from it. Furthermore, it should be noted
Can cultural differences affect access of families to health care? 

T. Lewis

that many modern Western medicines’ active ingredients have a basis from flora and fauna themselves and here at least there is some common ground.

Cultural vitality encourages ‘the maintenance and continuation of cultural beliefs, practices and way of life’ (Eckermann et al. 2010, p. 99) and is affecting families’ access to health care, it encourages Western culture to maintain that the biomedical model is the best health methodology and for Aboriginal culture to maintain its holistic approach. Therefore, it is easy to see how in maintaining and continuing one’s own cultural practices, beliefs and way of life, there is a negative flow on affect on the families’ access to health care. Although it should be noted, that in some Aboriginal communities there is a move towards utilising Western health services in conjunction with traditional ways or after the traditional ways have not worked. Problems with the concept of cultural vitality arise when it is taken as the only method of ensuring that one’s own culture persists even when not effective and is evident in the poor health status of Indigenous Australians.

However, there is a move to further utilise Aboriginal Health Workers (AHW) in remote health centres, with AHWs forming a core component of the Aboriginal health service sector (Hamrosi, Taylor & Aslani 2006). AHWs are health professionals trained in Western health methodology and are of Aboriginal lineage and are utilised to offer services congruent with the needs of community and in a way that allows the community to keep their cultural vitality (Genat & Bushby 2006;).

In summary; Colonisation, Aboriginal health beliefs and the inflexibility of Western health professionals was examined and it was concluded that they have contributed to the disparity in health outcomes for Indigenous Australians. Aboriginal health beliefs were established to be based on connections to the land, the community and their spiritual beliefs and that categorisation, cause and treatment are interdependent not only of each other but also these connections. Following on
Can cultural differences affect access of families to health care?  

T. Lewis

from Aboriginal health beliefs was Western health beliefs. Western medicine has a tendency to view non-Western health beliefs as less credible and this may be attributable to technology, scientific knowledge and the biomedical model. Worldviews on health with relation to Aboriginal and Western viewpoints was discussed, it was recognized that Indigenous Australians employ a holistic methodology whereas Western views identify with, and follow, the biomedical model. Additionally, natural medicines in comparison to Western medicines was briefly focused on and the notion put forward was that since Aboriginals have a strong connection to the land it was no wonder that they should derive their medicine from it. Cultural vitality was ascertained to be the principal cause of cultural differences and that it furthers these differences between Indigenous and non-Indigenous Australians through encouraging each to preserve their own cultural beliefs, practices and way of life without regard for any another. However, from the literature there appears to be an attempt to lessen the culturally devastating ideals of cultural vitality through the use of AHWs. Overall, it appears that cultural differences regardless of their origins, occurrences and rationale have been affected and will continue to affect access of Indigenous families to health care. In order for such problems to be overcome some serious thought needs to be placed into implementing a second health care system, specifically for Indigenous Australians, or some serious thought about the incorporation of Aboriginal health beliefs into the Western health system.

References

Can cultural differences affect access of families to health care?

T. Lewis


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Can cultural differences affect access of families to health care?

T. Lewis


