Reducing racism in Aboriginal health care in Australia: where does cultural education fit?

Angela Durey
Centre for International Health, Curtin Health Innovation Research Institute, Curtin University, Western Australia

Disparities in morbidity and mortality rates between Aboriginal and Torres Strait Islander (Aboriginal) and other Australians are well documented and continue at unacceptable rates. While this information is not new and has been subject to enquiry for many years, Aboriginal Australians are disadvantaged across a range of social, economic and health indicators. These include exposure to racism across all domains of contemporary Australian society with concomitant deleterious effects on their health and wellbeing.1-4

Despite a recent reduction in mortality rates from chronic disease, the 2008 Health and Welfare Report of Australia’s Aboriginal and Torres Strait Islander Peoples identified alarming health statistics. Aboriginal Australians represent 2.6% of the Australian population with 43% living in regional areas and 25% in remote areas. Aboriginal adults were twice as likely as other Australians to report fair/poor health (29% compared with 15%) and twice as likely to report very high levels of psychological distress. Hospitalisation for chronic disease occurred at a rate 14 times that of other Australians and Aboriginal life expectancy is 17 years less.6 The 2004-2005 National Aboriginal and Torres Strait Islander Health Survey found that, despite poorer health, many Aboriginal Australians did not seek health care because of access difficulties including cost, transport/distance, cultural barriers and lack of available services.6

The paper begins by identifying racism as a social determinant of health and explains how it is reproduced. It argues that white Anglo Australian cultural dominance that treats Aboriginal people as inferior and denies them resources is not only racist but constitutes what Bourdieu terms ‘symbolic violence’ to be explained shortly. The paper discusses how the tertiary sector, health systems and service providers can perpetuate Aboriginal health care disparities through their attitudes and practices. It supports a multi-tiered approach, institutional, organizational and individual, to identify and reduce racism.2,8 Education has been established as a common strategy to address disparities and the paper discusses the extent to which cultural education of undergraduate students and health professionals is successful in reducing racism and ensuring institutions and practitioners deliver culturally respectful health services. The paper concludes that a multi-tiered commitment to reduce racism in health and tertiary sectors is important and long-term evaluation of cultural education programs is necessary to identify whether early changes to behaviour and practice are sustained.

Racism and health

Racism is a fundamental social determinant of health where interpersonal and institutional racist attitudes and behaviours are often embedded in social, structural and political contexts.9,10 Karlsen and Nazroo’s11 study in the UK found that experiences or perceptions of racism have been associated with poorer mental and physical health. Respondents from ethnic minority groups who had experienced verbal abuse were 50% more likely to report their health being fair or poor. Those believing that most British employers were racist were 40% more likely to respond similarly. A systematic review of research from 2005-2007 linking racial disparities and health and focusing mainly

Abstract

Objective: This paper discusses whether educating health professionals and undergraduate students in culturally respectful health service delivery is effective in reducing racism, improving practice and lessening the disparities in health care between Aboriginal and non-Aboriginal Australians.

Approach: The paper supports the concept of race as a social construction that is discursively produced and reproduced. Studies on the effectiveness of cross-cultural education for undergraduate students and health professionals to reduce racism and deliver culturally respectful health care to indigenous or minority populations are examined for evidence of sustained improvements to practice.

Conclusion: Programs in culturally respectful health care delivery can lead to short-term improvements to practice. Sustained change is more elusive as few programs conducted long-term evaluations. Long-term evaluation of programs in culturally respectful health care delivery is necessary to identify whether early changes to behavior and practices are sustained. Strategies linking policies to practice to reduce health disparities between Aboriginal and non-Aboriginal Australians are also needed.

Implications: Confronting the effects of racism in health services towards Aboriginal Australians is a priority requiring a multi-tiered commitment to strategies linking policy to practice to reduce health disparities between Aboriginal and non-Aboriginal Australians. Part of this strategy includes preparing undergraduates and health professionals for culturally respectful health care with education programs that are evaluated for long-term improvements to practice.

Key words: Racism, Aboriginal health care, cultural education and training, reflective practice.

Aust NZ J Public Health. 2010; 34:S87-92
doi: 10.1111/j.1753-6405.2010.00560.x
on African Americans in the US identified studies reporting an inverse association between racial discrimination with poor mental and physical health. In Aotearoa-New Zealand, Harris et al. found that Māori experiences of racism through verbal or physical abuse or unfair treatment in the health, employment or housing sectors were significantly associated with poor to fair health, lower physical functioning, lower mental health, smoking and cardiovascular disease. Racism in Australia has its genesis in the negative effects on Aboriginal Australians of colonisation and oppression powerfully illustrated in stories of the Stolen Generation in the Bringing Them Home report. Findings indicate that racism occurred interpersonally and institutionally in all sectors with Aboriginal Australians receiving less benefit from the same policies than other Australians and being subject to disparaging comments in both health and social contexts.

This paper supports the concept of race as a social construction that is discursively produced and reproduced. Currently, ‘whiteness’ underpins the production and reproduction of dominance rather than subordination, normativity rather than marginalisation, privilege rather than disadvantage. Individuals identify themselves and others by being socialised within ideologies of race where specific social groups define boundaries of inclusion and exclude those who do not ‘fit’ their criteria. Racism and oppression14 powerfully illustrated in stories of the Stolen Generation in the Bringing Them Home report.2,11 Despite Australia’s recent ratification of the 2007 United Nations Declaration on the Rights of Indigenous Peoples reports on the negative effect of racist practices on individual health and wellbeing continue. Article 24 states that indigenous individuals have the right ‘to access, without any discrimination, [to] all social and health services’ and ‘have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively full realisation of this right’. Fostering this goal requires countering the effects of racism to reduce health disparities between Aboriginal and non-Aboriginal Australians.

To understand how racism is reproduced I draw on Bourdieu’s notion of symbolic violence, which plays an important role in his analysis of domination. In the context of race relations, symbolic violence occurs when white (Anglo-Celtic) Australian dominance is legitimated as part of the normal social order whereby Aboriginal Australians are treated as inferior and denied resources. Lack of reflection and interrogation of the existing social order reproduces discriminatory practices in structural systems such as health care, in institutions and in health professionals. Yet ‘circles of resistance’ by those who are ‘othered’ in response to such discrimination can precipitate change. This was evident in the establishment of Aboriginal Community Controlled Health Services (ACCHS).

Health services

ACCHS were initiated in the early 1970s as Aboriginal people faced increasing difficulties accessing mainstream healthcare due to health practitioners’ racist attitudes and practices and the cost of services. ACCHS are ‘culturally appropriate, autonomous primary health services, initiated, planned and governed by Aboriginal communities through their elected board of directors’. They integrate a biomedical clinical paradigm within a holistic framework of health care. The services promote health, treat illness, foster community development and support services to Aboriginal people as well as provide educational resources for health professionals. Setting up ACCHS led to the National Aboriginal Community Controlled Health Organisation (NACCHO) and ACCHS throughout Australia being successfully developed and implemented. They are not only that such actions are considered axiomatic in social relations, but that they are internalised or accepted, thereby reproducing rather than reducing symbolic violence. White Australians know that Aboriginal Australians are disadvantaged, few may be willing to turn the lens on themselves to reflect on the advantages of being white when considering health, education, training and employment. McIntosh argues that the beliefs and practices reinforcing ‘white privilege’ as ‘an invisible package of unearned assets’ are normalised and seldom interrogated by the dominant culture. Instead, the position of privilege is often denied and protected so it continues to benefit those who are white and disadvantage those who are excluded or ‘othered’: ‘White people rarely see acts of blatant or subtle racism, while minority people experience them all the time.’

The insidious nature of this type of violence exercised on an individual or social group ‘with [their] complicity’ suggests not only that such actions are considered axiomatic in social relations, but that they are internalised or accepted, thereby reproducing rather than reducing symbolic violence. White Australians know that Aboriginal Australians are disadvantaged, few may be willing to turn the lens on themselves to reflect on the advantages of being white when considering health, education, training and employment. McIntosh argues that the beliefs and practices reinforcing ‘white privilege’ as ‘an invisible package of unearned assets’ are normalised and seldom interrogated by the dominant culture. Instead, the position of privilege is often denied and protected so it continues to benefit those who are white and disadvantage those who are excluded or ‘othered’: ‘White people rarely see acts of blatant or subtle racism, while minority people experience them all the time.’

Table 1: Implications for health care practice.

- Racism has a negative impact on the health of Aboriginal and Torres Strait Islander Australians.
- Confronting the effects of racism in health services towards Aboriginal Australians is a priority requiring a multi-tiered commitment to strategies linking policy to practice to reduce health disparities between Aboriginal and non-Aboriginal Australians.
- Education programs in culturally respectful health care, as part of this strategy, need to be evaluated for long-term effectiveness in improving practice.
opportunities for change

using cultural education to reduce racism

These studies focus on antiracism, encouraging dominant cultural groups to reflect on their own values and practices when working with indigenous or minority populations. As mainstream health providers may be unaware their behaviours are racist or exclusionary, policies promoting culturally respectful care require clear guidelines for implementation into practice and ongoing evaluation for their effectiveness. This strategy provides an opportunity to identify and reduce symbolic violence and improve health by advocating models of care that are equitable, respectful and responsive to need. Yet, to what extent are cultural training programs, increased Aboriginal content in undergraduate health science curricula, and related strategies effective in leading to sustained, culturally respectful health care?

Defining culturally appropriate health care

Kleinman and Eisenberg 33 in their seminal work on culture, illness and care, advocate for consideration of the client's cultural rules and practices when delivering care in a cross-cultural setting within a western biomedical model of practice. They argue that illness is ‘culturally shaped’ (p.252) and best practice includes health professionals, in this case doctors, learning about the client’s model of illness in order to respond effectively to ‘discrepant views of clinical reality’ (p.256). Yet, the current plethora of definitions, terms and explanations for culturally acceptable health care practice is confusing. Care can be culturally appropriate, culturally sensitive, culturally responsive, culturally aware, culturally safe, culturally competent, culturally secure, culturally congruent, and culturally proficient and this list is not exhaustive.

Cultural safety was a term coined by Maori nurses denoting ethical practice when working with diverse minority groups. It advocated nurses’ awareness of how their own cultural values influence practice. 14 While the term ‘cultural safety’ may be ‘poorly understood and the subject of ongoing controversy, conflict and confusion’ 35,39 it nevertheless highlights the importance of self-reflection. Coffin 36 uses the term ‘cultural security’ to describe the synthesis of cultural awareness and cultural safety, for which she offers examples rather than definitions. She suggests that cultural security links understanding with action that is reflected through policies and practices.

Cultural competence has been broadly described as ‘the ability of systems, organizations, professions and individuals to work effectively in culturally diverse environments and situations.’ 37,39 Betancourt 38 describes cultural competence as an important building block in clinical care and, while not a panacea to reduce health care disparities, is nonetheless a necessary core competency in delivering high quality patient care. It includes ‘knowledge and information from and about individuals and groups that is integrated and transformed into clinical standards, skills, service approaches, techniques, and marketing programs that match the cultural experiences and traditions of clients and that increase both the quality and appropriateness of health care services and health outcomes.’ 39,41 Regardless of definition, the issue is whether cross-cultural care promotes health. It is often unclear how knowledge, skills, understanding, standards and proficiencies are demonstrated or measured in practice and evaluated for their effectiveness in health services and tertiary settings.

Is education in culturally respectful care effective in changing practice?

Many educational frameworks are currently available to increase knowledge, attitudes and skills of undergraduate health science students and health care providers. These include curriculum frameworks for medical students, 40,41 nursing students, 42,43 occupational therapy students, 44,45 psychology students, 46 policy frameworks for culturally appropriate health care, 6,30 communication and cultural knowledge, 11,48 and anti-racism. 2

Edwards 49 suggests that consultation and building partnerships between academia, health services and Aboriginal communities is integral to teaching health care professionals about advocating for and contributing to better health outcomes for Aboriginal clients. To do this, policy makers and health professionals are required to embrace new knowledge to successfully negotiate professional relationships in Aboriginal contexts. Effective communication is a priority and not restricted to language alone: professional competence, appreciating difference, a caring attitude and community engagement also underpin understanding and acceptance across cultural domains. 48

Much can be learned from the model of culturally appropriate care developed by the Aboriginal Community Controlled Health Services but not rolled out into mainstream health care services. Culturally appropriate, autonomous health services governed by local Aboriginal communities are embodied in NACCHO’s definition of culturally appropriate health care, implying that
mainstream models cannot achieve this because the services are not controlled by Aboriginal communities.24 However, given that mainstream health service providers have a responsibility to deliver culturally appropriate care to Aboriginal clients,23 engaging Aboriginal Australians meaningfully at all levels of health system design, governance and delivery is an important strategy to achieve this.27 This type of engagement values Aboriginal knowledge and expertise to develop and implement culturally appropriate practices across policy, health services and the higher education sectors. Mainstream health services that implement protocols, policies and procedures defining and fostering culturally appropriate practice is an important step to also improve Aboriginal Australians’ access to services.36,49

In the US, Reimann and colleagues50 found that knowledge of cultural factors per se and simple exposure to other cultural groups in practice, do not directly facilitate culturally competent care. Instead, such care was most strongly predicted when participants were more reflexive and recognised that cultural factors and awareness of personal biases were important. From their research with Mexican Americans, the authors argue that medical education focusing not solely on basic information about their client group but also exploring provider biases and preconceptions will be more effective in developing a culturally competent workforce. In the UK, Papadopoulos and Lees41 went a step further in their cultural competence training for nurses highlighting the importance of reflexivity at individual, interpersonal and systemic or institutional levels. This required four steps: i) cultural awareness, involving reflexivity and examining and challenging our own beliefs; ii) cultural knowledge, involving interactions with other cultures, identifying barriers to health care and avoiding essentialism; iii) cultural sensitivity, building trust, respect, empathy and iv) cultural competence, a synthesis of the three previous concepts as well as actively challenging racism. Lamiani52 and colleagues developed a patient centred model where health professionals from the US and Italy discussed their respective cultural interpretations of the meaning of terms in health care, opening the door to reducing ethnocentrism and developing ‘cultural humility’ by identifying their own blind spots and realizing that, ‘thanks to the ‘other’ … we ultimately learned more about ourselves’ (p. 396).

This paper supports the view that cultural education includes opportunities for participants to reflect on their own culture and how their beliefs and practices intersect with those from other cultural backgrounds. Despite good intentions that ‘I am not racist, I treat everyone the same’, the reality can be different. Prejudice and stereotypes53 where the effects of such practices can negatively impact on the health of those exposed to them.1,54 Yet, programs to improve health providers’ cultural competence have limited effectiveness in reducing healthcare disparities. Anderson and colleagues55 evaluated five approaches to improve cultural competence in health services including cultural competency training for healthcare providers. Their results were inconclusive because of lack of quantity and quality of studies. Price et al.60 also concluded that a lack of methodological rigour limits the evidence for the impact of cultural competence training on the quality of care to minority populations.

Fozdar et al.16 argued for the inclusion of broader structural and ideological aspects of racism to ensure multi-tiered effectiveness. While findings from some evaluations on the effectiveness of cultural education in changing attitudes and practice have been inconclusive, see also 61,62 the recent implementation of Aboriginal health in the medical curriculum led to early positive shifts in students’ knowledge, skills and attitudes63 and cultural psychology units were effective in students accepting cross-cultural differences.4 Beach et al.64 searched the literature up to 2003 and located 34 studies evaluating interventions to improve cultural competence in health professionals. They concluded that there is excellent evidence that cultural competence training improves the knowledge of health professionals, good evidence that cultural competence training improves their attitudes and skills, and good evidence that cultural competence training impacts on patient satisfaction, but found no studies that evaluated patient health. Bean53 conducted a study in the Australian public and community sectors on the effectiveness of cross-cultural training and found some gains in cultural awareness, knowledge and understanding. However, understanding the deeper effects of one’s own culture in this context was missing. Another study targeted public service employees and evaluated an applied prejudice reduction intervention immediately after the program and three months later. Findings showed that knowledge increased and prejudice decreased immediately after the program but there was no significant difference between baseline levels of prejudice and negative stereotyping at three months although knowledge remained significantly higher.65

Despite positive evaluations of programs immediately after cultural competence presentations, long-term evaluations are required to assess whether changes to behaviour or practice are sustained. Pedersen et al.66 found that evidence was mixed on the effectiveness of anti-racism strategies with some programs reinforcing racism rather than diminishing it. The long term effects of anti-racism strategies are often not sustained and suggest the need for a top-down approach to intersect with a bottom-up focus. They stressed the importance of considering social and historical context prior to implementation and evaluation that is multi-methodological and longitudinal. In other research, the process, or how the material on racism was delivered, as well as the content of the presentation were important.55 If people feel under attack for their views, they are less likely to change them. The mixed effect of individually orientated training on attitudes and behaviours suggest that, for
anti-racism strategies to be effective and change implemented, collective support is required at institutional, organisational and individual levels. This also requires addressing the diversity between social and geographical contexts, strategies useful in one context may not work in another.

Conclusion

Confronting the effects of racism on Aboriginal health and reducing health disparities between Aboriginal and non-Aboriginal Australians is a priority that requires a multi-tiered commitment to action. The political will to change race-based inequities in the health care system is paramount to facilitate culturally appropriate health service delivery across the board in line with Article 24 of 2007 United Nations Declaration on the Rights of Indigenous Peoples. With an emphasis on reflective health care practice, cultural education to reduce symbolic violence inherent in racism and improve the health of Aboriginal Australians is one way to achieve this. This strategy, located within a broader systemic anti-racist framework, would seek to eliminate the negative impact of structural and ideological aspects of racism on health and health care practices. It would plan and implement education and training in culturally appropriate practice in the higher education and health service delivery sectors and would identify measures to demonstrate change to this effect. Programs would be evaluated for their long-term effectiveness in increasing access to services by Aboriginal clients, improving health service delivery and attaining better health outcomes in Aboriginal Australians. Collaboration between policy makers, mainstream inter-disciplinary health services, academia and key Aboriginal stakeholders is an important step in achieving this goal.

Acknowledgements

Special thanks to Ann Larson, the reviewers and editors for their feedback on this paper. I acknowledge the support of the Australian Department of Health and Ageing for the University Department of Rural Health Program.

References


