4

Models of Health and Well-Being

The majority of health and human service professionals in the U.S. subscribe to a biomedical model supported by their training and an historical dominance of this approach. Yet, it has become apparent that outcomes in health and human services are not fully explained or addressed by biomedicine alone. This chapter describes various models and definitions of health and how they fit within the context of diverse and complex client care.

Chapter Objectives

After completing this chapter, you should be able to:

- discuss the various definitions of health and articulate a personal definition of health
- compare and contrast various models of health
- critically analyze the implications of competing or complementary models of health for healthcare or human services practice

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- examine the role of health and human services professionals in relation to various models of health.

Definitions of Health

If you were asked to explain what it is that makes a person healthy, you might suggest things like eating healthy food, maintaining good hygiene, getting plenty of exercise and rest, not smoking, and so on. Or would you? If you were a person who believed strongly in a biomedical definition of health, you might. However, another person might say that what makes them healthy is having family around, breathing fresh air, feeling as if they 'belong'—knowing who they are and where they come from. This would be a different way of thinking about being healthy, and there might be as many ways of thinking about health as there are people reading this book.

Activity: Personal Definition of Health
What do you do to stay healthy? There would obviously be many different ways to answer this question. Take some time before you continue reading to write down your own definition of health. You will need to revisit this as we discuss various models of health to see where you are most closely aligned.

Regardless of your views of health, as professionals, much weight will undoubtedly be placed on Western biomedical models of health care—and that's OK. That is your training and the service in which you might practice. You are not asked to take on your clients' health beliefs or their preferred way of living, but you are asked to provide care that doesn't diminish or demean another because of them. No one needs to negate their own culture and cultural values in order to practice cultural safety principles and appreciate another's culture. The precepts of cultural safety simply ask all health and human service professionals to *reflect* on their own culture and *acknowledge* the potential impact that differing ways

of knowing and power relationships might manifest. Cultural safety asks you to act with care, compassion, and courage as you attempt to meet the health and social care needs of people in your care.

Not everyone shares the same ideas about what health means or what illness means. These different understandings lead to, for example, differences in what people will do to be healthier or what they do when they are ill, and what sorts of things might be prioritized. Perhaps the most cited definition of health is the World Health Organization (WHO, 1978) definition:

> Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

This is the definition in the Preamble to the Constitution of the World Health Organization adopted by the International Health Conference, New York, 19–22 June 1946 (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on April 7, 1948. *It* came about partly in reaction to ideas of health as being *not ill*—ideas that lead to healthcare practice being focused on simply treating disease or illness.

The WHO definition might seem like a pretty good one at first glance, but what is 'complete' and who decides if someone is healthy or not? If someone has a disability, are they not healthy? What if someone has a disease or chronic condition such as asthma—are they not healthy or 'well'? What is well-being? Who defines well-being? Taken literally, the WHO definition would suggest that none of us is ever really fully 'healthy' or 'well'. Indeed, consider that nearly half of the U.S. population have at least one chronic disease (Raghupathi & Raghupathi, 2018) and about 1 in 4 adults live with a disability (CDC, n.d.).

Let us look at other ways to define health. Indigenous definitions often view health as being more than an absence of disease—health requires a physical, spiritual, mental, and emotional well-being of *whole communities* and usually contains a connection to the land or sea and the environment. For example, the United Nations (2016, p. v) provides this definition of health: 'the right to health materializes through the

well-being of an individual as well as the social, emotional, spiritual and cultural well-being of the whole community'.

Website
Explore the U.S. National Library of Medicine website *Native Voices: Native Peoples' Concepts of Health and Illness* for a wide range of sources and information relating to health and wellbeing and Native Peoples.
https://www.nlm.nih.gov/nativevoices/index.html

Reading
Koithan, M., & Farrell, C. (2010). Indigenous Native American healing traditions. *The Journal for Nurse Practitioners: JNP*, *6*(6), 477–478. https://doi.org/10.1016/j.nurpra.2010.03.016
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2913884/

One important difference in the Indigenous definition is the focus on the health of the 'whole community' as compared to the WHO definition, which focuses on 'individual' health. While this difference might seem minor, it has huge implications for healthcare funding, healthcare practice, and how 'health' is measured. If we were to look at how a whole community was faring, for example, if we saw high rates of crime and unemployment as well as high rates of various health conditions such as obesity and diabetes, we might have a very different approach to helping that *community* become healthier. These arguments warrant consideration of models of health, which influence such issues as funding allocation (structural dimensions) or health care and other human services practice.

Elements of an Indigenous definition of health can be challenging if you view health as only being located in the body. Spirituality is generally not something people can see or put a finger on—it is not something you can touch. Land, on the other hand, is something we can see and

touch; but relationship with land and its importance to health and well-being generally don't feature in Western models of health—not overtly at least. Yet, spirituality can and does play a role for many non-Indigenous people as well, even though it may not be prominent in Western health. And with that, let us now look at the different models of health.

Models of Health

As students or employees in the health and human services professions, you signal your alignment to particular models and definitions of health and practice. The model to which the majority of health professionals will subscribe in the U.S. today is a Western biomedical model. There will be a diversity of approaches within this model, with some practitioners also incorporating social models and other definitions of health along a spectrum. For example, integrative medicine is a more holistic approach to health and illness that is growing in popularity. Often, the health model that we function under is not obvious or explicit, but it does influence our professional practice. This may not present any problems or issues for us professionally until we work with clients who have a different understanding or worldview about health; it is then that it becomes important to reflect on and be aware of health models and understandings.

Western medicine has much to offer. Few could argue with the benefits and progressions made in disease treatments, trauma management, and public health for example. However, Western medicine is based upon a particular worldview that is not universally accepted. Within the biomedical model, health is viewed through physical changes to an individual's body. Western medicine sees the body as an entity of interrelated systems that requires a state of homeostasis for optimal functioning. Health is mostly about anatomy and physiology, with disease transmission based on germ theory.

The biomedical model has been criticized for being reductionist—reducing health and illness down to the smallest biological elements; mechanistic—assuming that diseases have a primary biological cause;

dualistic—neglecting social and psychological influences; and empirical—assuming that causes of all illness can be objectively and biologically identified (Lyons & Chamberlain, 2006). Additionally, the biomedical model has been criticized for being overly disease focused (at the expense of health), and overly interventionist and intrusive (Lyons & Chamberlain, 2006). We can't be too critical, however. The biomedical model has an important role to play but can be enhanced by fusion of approaches that allow for diversity both at the individual and broader population level.

In contrast to the biomedical model, a social model of health explores the causes of inequality between groups, such as racial or ethnic groups or groups with differing economic status. In a social model of health changes are made through public policy to improve health-related living and working conditions. The social model of health underlies social and economic determinants of health. Social and economic status (SES) is a statistical measure that classifies individuals, households, or families according to income, occupation, and education. This area of research shows that the wealthier you are, the higher your job status, and the higher the level of education you have achieved; the longer you will live, the less illness you will suffer and, if you do become sick, the better the quality of treatment you will receive and, therefore, the better your health outcomes will be (for example, see Marmot, 2015). Table 4.1 shows some key differences between the biomedical model and the social model of health in terms of focus, assumptions, key indicators, causes, interventions, and goals.

The 'biopsychosocial' model of health falls between the biomedical model and the social model if we were to think of these models as falling on a continuum, rather than as discrete models. Engel proposed the biopsychosocial model in 1977. In this model, biological, psychological, and social elements are considered to be influencing factors in health. Some have suggested that the biopsychosocial model is really the biomedical model in disguise (Lyons & Chamberlain, 2006). Other concerns with the biopsychosocial model include that the different elements and how they differ from one another have not been clearly defined. That is, how is 'social' different from 'psychological', or how is 'psychological' different from 'biological'?

Table 4.1 Key differences between biomedical and social approaches to health

Element	Biomedical	Social
Focus	Individuals who are sick	Social groups' living and working conditions
Assumption	Individual responsibility for health	Social responsibility for health
Key Indicator	Individual pathology	Health inequalities between social groups
Causes of Illness	Gene defects; Micro-organisms (e.g., viruses) Lifestyle: risk-taking	Political & economic factors (e.g., poverty) Cultural factors (e.g., discrimination)
Intervention	Cure individuals who are sick; Modify behavior of individuals at risk	State intervention to reduce inequalities Community participation
Goals	Cure disease Preserve life Reduce risk factors to prevent disease in individuals	Prevent illness Ensure quality of life Reduce health inequities between social groups

Source Adapted fromGermov and Poole (2007)

What is the impact of health care that is at odds with, or perceived as being at odds with, your own personal set of beliefs and values? Balance—whether it is physiological or otherwise—would seem to be a core value of most cultures' ideas of health and well-being.

Health professionals today often refer to 'evidence-based practice'. Evidence-based practice is an approach to health care and human services work that assumes that there is evidence available upon which care should be delivered and that, if we just follow the evidence, then our practice will be effective. The problem with the approach of evidence-based practice is that these assumptions limit what is accepted as evidence. For example, the 'evidence' is based on Western biomedical notions that are reflected through the use of randomized control trials (RCTs), held up as the gold-standard of medical research (Ezzy, 2002). However, RCTs often fail to take into account the social and other elements influencing health and illness or that those methods can be inadequate to identify such elements. Additionally, consider that many Indigenous Peoples and other long-standing health practices such as Traditional Chinese Medicine or Ayurvedic medicine have thousands of years of evidence-based practice on which they have developed their own

particular health strategies and wisdom. This kind of knowledge, in a Western evidence-based notion, is often undermined and determined to be lacking in evidence because these practitioners have not followed the Western research paradigm and yet, increasingly, there is a re-orientation happening toward non-Western knowledges and cultural practices to deal with environmental and other health concerns.

Despite not being fully accepted in Western medical and health systems, complementary and alternative medicines have increased in popularity. These approaches reflect the reality of multiple bodies of knowledge and evidence throughout the world and over time. However, look at the language used to describe approaches that fall outside the dominant biomedical model. Healthcare practices used by millions of people for generations are deemed to be 'complementary or alternative'. This has implications for funding, health insurance, and uptake, with most clients 'funneled' into mainstream systems and services. Pharmaceutical industries are invested in research that reinforces health behaviors that demand a prescription rather than research that supports advice to engage in relaxation techniques, eat a balanced diet, and exercise more.

Film and Website of Interest

Escape Fire: The Fight to Rescue American Healthcare is a 2012 film by Matthew Heineman and Susan Froemke that explores the problems with the American healthcare system and provides some direction for an improved healthcare system that is focused on prevention and healing.

The interactive website http://www.escapefiremovie.com/ provides a wealth of activities, information, and tools for gaining a better understanding of the issues and solutions to improved health care in the U.S.

Making It Local

- What health or related services can be found in your local area? Who are the main users of these services?
- Are there any that would fall under the category of 'complementary or alternative'?
- Who uses these services?

Social Determinants of Health

The Social Determinants of Health (SDoH) are gaining greater prominence as it has become clearer that biomedicine does not fully explain or deal with causation, behaviors, health seeking practices, or outcomes. We discuss this idea more fully in the Determinants of Health Chapter, but we introduce it here as it is an important concept in understanding different ways to think about health and illness. The Office of Disease Prevention and Health Promotion defines the social determinants of health as the:

> …conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place." In addition to the more material attributes of "place," the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins. (Office of Disease Prevention and Health Promotion, n.d.)

In the U.S. today, it seems that a lot of people have concerns with what is perceived to be *socialism*, when what is actually being put forward is a means of addressing inequities. Social models of health promote an equitable approach to health and social care, to make it affordable, accessible,

and acceptable to all. The COVID-19 pandemic meant people became acutely aware of their own vulnerabilities and potential for getting sick despite all efforts to 'protect' themselves. In this context, most people understood the value of health care being accessible to everyone.

Activity
Look up definitions of socialism; universal health care; Affordable Care Act; privatized health insurance; single-payer versus multi-payer health care. Write down what you see as the pros and cons of each.

Primary Health Care

Primary health care (PHC) was first put forward as a somewhat radical approach aimed at addressing the inequities in health among the world's populations. PHC, like cultural safety, is both a philosophy and a model of service delivery. The U.S. is a nation with major disparities in health among its populations. The Bureau of Primary Healthcare committed to adopt a PHC approach to health care in the 1970s. Again, like with cultural safety, PHC is yet to be fully implemented. 'Health for all by the Year 2000' was a catch-cry of much of the 1980s and 1990s, and yet PHC still remains a distant aspiration or a service model only for underserved or marginalized populations. What has happened is that the catch-cry simply gets updated—it was to be by 2020, now it is to be 'by 2030' and undoubtedly the goalposts will continue to shift. So, what is PHC and why should we bother with it?

Primary health care outlined a set of principles for health service delivery that was believed to have particular relevance for the world's Indigenous Peoples and others in less developed countries. The U.S. is a highly developed country, where much of Western health care focuses on high-technology, high-cost, curative and treatment interventions. However, in developing countries, where health infrastructure and health

needs are far more basic, this kind of health care generally has little relevance. In the U.S. however, some sectors of the community experience health outcomes that are similar to outcomes within poorer countries.

Websites

See the World Health Organization website for Primary Health Care including the 2019 Fact Sheet: https://www.who.int/news-room/fact-sheets/detail/primary-health-care.

This webpage hosted by the Commonwealth Fund provides an excellent and engaging overview of primary health care for women: Transforming Primary Health Care for Women Part 1: A Framework for Addressing Gaps and Barriers (Zephyrin, Suennen, Viswanathan, Augenstein, & Bachrach, 2020: https://www.commonwealthfund.org/publications/fund-reports/2020/jul/transforming-primary-health-care-women-part-1-framework.

At the World Health Organization Conference held in the Russian city of Alma-Ata in 1978, the following definition was developed and presented within the Declaration of Alma-Ata to which the U.S. became a signatory:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing healthcare process. (*Declaration of Alma-Ata*, WHO, 1978)

This is not the complete definition, but rather the core components that are often repeated when trying to succinctly describe PHC:

- essential (or first-level care)
- accessible—available to the people wherever they are, with no barriers to using the service
- acceptable to the people—there is no conflict with the manner in which services are delivered, that is, it is culturally safe to use the service as provided
- full participation—it is not top-down directed care
- affordable—it does not rely on high-cost, highly technologized treatments and interventions.

Critical Thinking

How does the PHC model fit in with the clinical or other professional practice you have experienced so far? Or how does the PHC model fit with your experience of healthcare services?

Would you say the health service provided was universally accessible, acceptable, and affordable? Why or why not? What changes would need to be made to make it accessible, acceptable, and affordable? (You may want to revisit your definitions above about various health policies.)

Reflection

You are walking by a river when you see someone in the middle, drowning. You jump in and rescue them. You commence basic life support, and they are OK. Before you go any further, there is another person. The same thing—you save them, treat them, and then can't get any further down the river, because the tide of people falling into the river continues.

It's a seemingly endless cycle—drowning, rescue, save, treat. While you are so busy saving everyone, you are fast becoming exhausted, unable to continue to meet the needs of the people in the river for much longer. With your attention so firmly focused on saving each person you come across, there is no time to move upriver to see what is causing all of these people to be in the river in the first place.

This old analogy is used to illustrate the difference between the various levels of health services—tertiary, secondary, and primary. With the focus so firmly on treatments and intervention, the problems become self-perpetuating. Nothing is being done to stop the problems before they occur (i.e., prevention). All levels of health services are important, but when one is given more resources and support than other levels or when the various services work in isolation rather than collaboration, then 'health for all' is impossible.

The Principles of Primary Health Care

PHC requires healthcare services to re-orient away from high-cost, technology-driven curative models to a focus on prevention and promotion. What follows is a brief overview of some key tenets of primary health care.

1. *A social view of health*

The social view of health recognizes that health is more than just the absence of disease and infirmity or the prevention of individual and family health problems. It is the recognition that providing a safe environment—such as clean air, adequate water, and sanitation supply, sound occupational health and safety standards, acceptable standards of housing, the lowest possible levels of poverty—is also vital. It is a fact that in the U.S. today, not all sectors of the community enjoy such basic rights as these. We can look at the alarming rates of skin infections leading eventually to an epidemic in renal failure among Indigenous Peoples, but if we fail to take a social view of health that accepts the root causes as having more to do with injustice and inequality than medical and behavioral factors, the impact of our practice will be limited. For health and human services professionals specifically, it means incorporating a wide range of interventions that recognize the person as a whole in the context of their lives, families, communities, and culture.

Holistic care is not new—it just remains something that is often given more lip service than practical application. Increasingly, there is greater attention in research and literature to the social determinants of health. Biomedical approaches that do not include the social determinants are limited in their potential to effect better health outcomes.

2. *Focus on self-reliance*

The individual, family, and community need to participate in defining the health problem. That is, they must set what the health priorities are for them, their family, and community. They need to be supported by funding and resources to determine the strategies to counter these problems. Historically, too many approaches have tended to develop dependency rather than self-reliance.

How important is the principle, 'focus on self-reliance', in light of past policies that actively promoted dependence and took away individual control?

3. *Multidisciplinary team approach*

Traditionally doctors, nurses, and other health professionals have been the dominant holders of power once a person entered the healthcare system. PHC requires the power to be located with the consumer and that all people—professionals, service providers, support staff, family, and the individual—actively participate in decisions about health issues in the community. In a PHC approach, the multidisciplinary team is meant to include more than the immediate members of a health center or unit. They need to coordinate care with professionals who may be geographically distanced from the clients. Podiatrists, occupational therapists, dental therapists, social workers, psychologists, etc., all need to be recognized as part of the multidisciplinary team in a PHC approach rather than as discrete service providers. The silo mentality that has been fostered by mainstream health service structures often stifles efforts to provide a truly comprehensive PHC approach, and clients can easily 'fall through the cracks'.

4. *Diversity of workforces and practitioners*

In an Indigenous context, PHC cannot be adequately implemented without Indigenous health personnel across all areas and levels of the health service. This principle applies more broadly as well. Women's health, Veterans' health programs, LGBTQ health, rural initiatives, all benefit by having workforces that are representative and have knowledge of their communities. If members of your own cultural group are not visible in a specific setting, how effective can that service be in truly understanding the needs of the population being served?

Activity
Look at the diversity in your own workplace or in your experience of health services. How representative are the staff for the population they serve?

5. *Focus on main needs as defined by the community*

The issue here is of utilization of resources that will benefit the greatest number of people. This means that, rather than powerful lobby groups determining where the health dollar is spent, priorities include the most common issues and areas of concern.

In order for this to happen, however, people need access to information in a way that is meaningful to them, which is discussed in Intercultural Communications. Making informed decisions about health and well-being can be limited by poor communications, misunderstandings, and low levels of health literacy.

Additionally, for health services to meet the needs of the community requires a certain level of engagement with the local community. When communities are engaged in their healthcare services there are many benefits such as improved health outcomes, improved equity, improved access to services, services are more relevant and acceptable, the quality is enhanced as well as responsiveness (Bath & Wakerman, 2015).

6. *Special attention to high-risk and vulnerable groups*

PHC must not only address the major and most common health problems in our society but must also pay special attention to those groups in our society who are high risk, vulnerable, and very often voiceless against the continuous lobbying of the more powerful groups. The demands of social justice are that these groups—women, people in remote areas, and people with disabilities—are assisted with affirmative action strategies to improve their health status. PHC is about addressing disparities, particularly disparities within already high-risk groups. One of the challenges in focusing on specific groups, if it is not done following a comprehensive PHC approach, is the risk of further marginalizing or relocating the vulnerability.

7. *Individual and community participation*

This is, arguably, one of the more important principles of PHC. It means allowing people, no matter where they are—in the Intensive Care Unit in the most technologically sophisticated hospital in the country or living in the middle of the desert—to be in control of their health care, in fact, of their life. It means genuinely encouraging individuals and communities to define their own needs and ways of meeting those needs. This is probably the hardest issue for health professionals to face because of the misconception that 'we have the knowledge, the expertise. We know best. Trust us!'.

Scenario
A client has refused a blood transfusion. You have been asked to explain to the client the consequences and your supervisor has asked you to 'Make sure you get the consent signed'.

- How do you respond in this situation?
- What principles of cultural safety could you apply here?
- What would you do if a client or community made decisions that you did not believe were in their best interests?

Does locating the control with the individual and community mean that health professionals merely have to go along with whatever is required, or do they have a role in ensuring that the choices made are truly informed by the provision of accessible information?

- By talking with the client, in the scenario above, you find out that their objection is not on religious grounds but based on a fear of needles. How might this change what you do?
- What would you see as a culturally safe outcome in both situations—fear of needles or religious objection?

PHC is most often thought of as an approach that occurs outside of hospital settings, but the principles of participation in decision-making are just as relevant in any healthcare or human services.

8. *Broad range of strategies*

PHC includes services and strategies that meet acute needs. Rehabilitation and long-term care also come under the PHC banner, as does political action to create conditions that are conducive to, and that create and maintain, healthy environments. PHC, as with cultural safety, is not about *what* you do but *how* you do it. Once again, it is about attitudes.

9. *Prevention*

As integral to PHC as the strategies above are, one strategy that is often associated most clearly with PHC is prevention. Substance misuse, motor vehicle accidents (MVAs), poor living conditions and overcrowding resulting in respiratory disease, chronic infections, and communicable diseases account for a majority of preventable impairments. Any treatment or rehabilitation service that does not address the issue of prevention is of little value.

One of the major challenges with prevention is that of readiness to change. How many people do not actually engage in preventative health care until they have had their first health scare? Prevention is a difficult

concept to embrace for anyone who feels relatively well and is unable to see the potential harm in their actions.

10. *Inter-sectoral collaboration*

This principle rests on the recognition that the conditions for health are determined beyond the healthcare system. Inter-sectoral collaboration means cooperation and coordination across government and non-government departments. When health is thought about in its social, cultural, economic, political, and environmental context, as well as in its medical context, factors such as housing, employment, town planning, education, and motor vehicle design have to be taken into consideration.

More than 40 years since the Declaration of Alma-Ata, it is not unreasonable to wonder where that commitment has gone. For a developed nation, the healthcare needs of the majority of our population are dramatically different from those in underdeveloped and developing countries. Health challenges facing those in Third World regions have largely been met here in the U.S. through stringent public health measures and infrastructures that are not yet realized in other parts of the world.

PHC was in recognition of the fact that major inequities have existed and continue to exist, even in developed countries. PHC was promoted as a means of addressing these inequities and of meeting future challenges. Since Alma-Ata, there have been several developments and redefinitions of PHC.

Activity
Find a current definition of PHC. How does this differ from 'primary care' and 'public health'? Critique services that describe themselves as PHC to see how they match the original principles. How do the principles of PHC and cultural safety relate? Are there any commonalities?

Activity

Look at these websites for their relevance to PHC:

- Bureau of Primary Health Care https://bphc.hrsa.gov/ https://bphc.hrsa.gov/about/what-is-a-health-center/index.html
- The American Academy of Family Physicians, Health Care for All: A Framework for moving to a Primary Care-Based Health Care System in the United States: https://www.aafp.org/about/policies/all/health-care-for-all.html
- Centers for Medicare and Medicaid Services Patient's Bill of Rights: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Patients-Bill-of-Rights

Readings

Birn, A. E. (2018). Back to Alma-Ata, from 1978 to 2018 and beyond. *American Journal of Public Health*, *108*(9), 1153–1155. https://doi.org/10.2105/AJPH.2018.304625 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6085028/

Rifkin, S. B. (2018). Alma Ata after 40 years: Primary health care and health for all-from consensus to complexity. *BMJ Global Health*, *3*(Suppl 3), e001188. https://doi.org/10.1136/bmjgh-2018-001188. Accessed from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6307566/

Making It Local

- Explore the websites for health services within a defined geographic region, not just your local community. Does your county have a Board of Health? Look at the website for information on health services and the approach to health care and health services.
- What, if any, PHC services exist in your city or town or region or county or state?

- What evidence is there of PHC principles being applied in non-PHC settings?

There is no doubt that excellent professional skills are essential for practice in all settings. However, no matter how good your skills, without a reorientation of health services and practices that incorporate a PHC approach, professionals will be destined to provide band-aid solutions at best. In an environment where the 'photo opportunity' can drive political activity, few politicians would be as happy to cut the ribbon on a basic water supply to a community as they would open yet another hospital. Health professionals and services need to shift their focus to genuine primary health care that reflects the commitment previously made by our politicians and that is reaffirmed by current health initiatives.

Health Beliefs and Models of Care

While mainstream health services in the U.S. are dominated by a biomedical approach to health, we have already noted that not everyone holds the same perspective. There are many other specific beliefs about health and illness causation. Germ theory, for example, may not be part of these beliefs.

Remembering that people are diverse in their cultural beliefs and practices, and are influenced by differing life experiences, we cannot provide a succinct discussion of health beliefs and how these might impact upon care. However, there are some excellent readings on the beliefs of different cultural groups that provide some insight into what could be influential for some clients. From a cultural safety perspective, it is not necessary to even know what these health beliefs could be, only that clients may not subscribe to the same explanations and practices as you might. The following scenario looks at the role of health professionals when faced with conflicting health beliefs and models of care.

Scenario
The community you are working with has high rates of smoking and chest infections. You want to conduct community education sessions, but no one attends, except for one elderly person who tells you that the community's health problems are all related to the buffalo being absent from their lands.

- How do you respond to this information?
- How might you have approached your practice differently?
- What role might you have in supporting the community to address the elder's concern, if any?
- What happens to your concerns about smoking rates and chest infections? Do you just forget about them? What would you do differently?

As we can see, health is very much culturally determined. More often than not, professionals dismiss Indigenous and other explanations because of their supposed lack of 'scientific credibility'. This is understandable. Most people will value their own culture and beliefs above others. It is the extent to which this occurs that can be problematic. If we place our own culture as 'superior to' rather than as simply 'different from' another, then we engage in ethnocentrism—a destructive attitude that has the potential to cause harm.

Scenario
A child in the hospital has not been improving and is eventually moved to the Pediatric Intensive Care Unit (ICU). The family is increasingly concerned and calls for a traditional healer to attend their child. The healer examines the child and identifies that his spirit has 'jumped out' of his body and it has to be retrieved.

How would you respond to this explanation of the child's deteriorating health?

What would you see as your role in this encounter?

Activity

Can you think of any incident in your own experience that radically altered your own long-held views and beliefs?

People throughout history have demonstrated considerable expertise and resilience in adapting to new situations. The introduction (or imposition) of Western health care has not been rejected. On the contrary, many non-Western people view Western medicine and treatments as useful adjuncts to their own healthcare practices. So, the challenge for professionals is to find a way to incorporate and accommodate multiple views and conceptualizations of health without positioning one at the expense of another.

Activity

Ideas about health and illness change over time. What do you believe about health and illness today?

- Review how you personally define health. Has anything changed for you since the earlier exercise?
- Is your definition related in any way to your culture?
- Has your way of thinking about health changed over time?
- Think about your own worldviews and cultural values. Whose cultural values and worldviews are often prioritized or reflected in healthcare services that you are familiar with?

Film

The film *Wilhemina's War: Fighting HIV and AIDS in the South*. PBS, Independent Lens: https://www.pbs.org/independentlens/films/wilheminas-war/. Depicts the variety of concerns to be considered when working in some communities. This film shows issues of stigma, barriers to accessing care, issues with health literacy and prevention, and extended family and community dynamics relevant to health and care. This film

also looks at how policy decisions impact on delivery of health care and services.

Conclusion

This chapter explored a selection of models for health care, including PHC as a model with the potential for providing culturally safe and accessible care. It is extremely important not to assume a standard set of beliefs and preferred ways of operating for any particular group. Cultural safety requires health and human service professionals to ask the individual how they might want to be cared for. This is a challenge in itself, but a necessary undertaking in achieving positive health outcomes for recipients of care, especially where there is a cultural difference between provider and recipients.

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