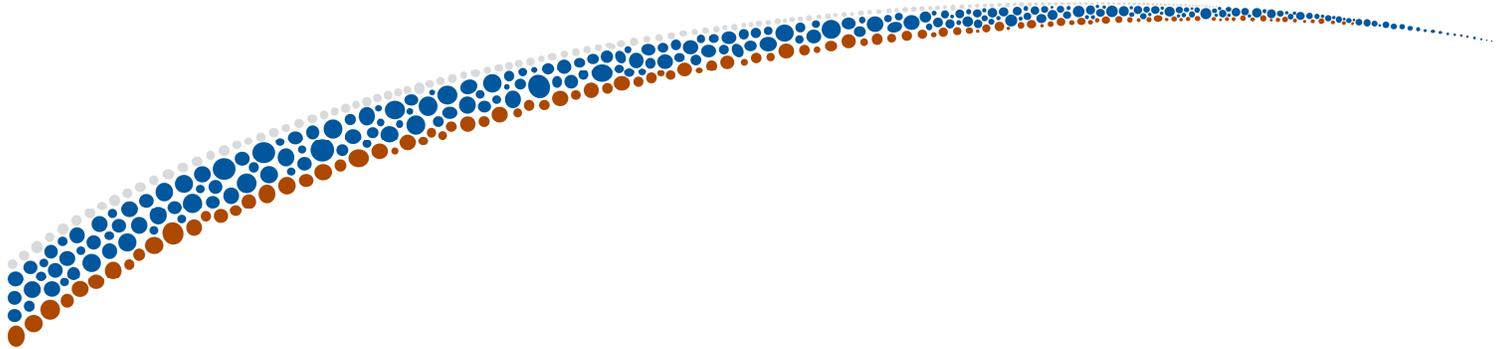




Government of **Western Australia**
Department of **Health**
Aboriginal Health

A culturally respectful and non-discriminatory health system

Understanding Institutionalised Racism



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Contents

Introduction	2
Defining Racism	2
Racism and Aboriginal health outcomes	3
Why recognising racism as a key social determinant of health is important	4
How can institutionalised racism be addressed?	5
Building cultural competency in WA Health	5
1. Governance:	5
2. Policy implementation:	6
3. Service delivery:	6
4. Recruitment and employment:	6
5. Financial accountability:	6
References	8

Introduction

Historically, racism in Australia has been expressed as an overt and straightforward rejection of, and hostility towards, a minority group underpinned by beliefs of biological difference and inferiority. Racism was publically displayed, socially accepted and, in many circumstances, upheld by Government policy and legally sanctioned (e.g. the 'White Australia Policy' and forcible removal of Aboriginal children from their parents).

Although there has been a significant shift away from blatant forms of racism, accompanied by major changes in government policy and legal frameworks around racial discrimination, more subtle forms of racism have persisted. Modern forms of racism are more difficult to identify, complex and entrenched. Understanding the nature and existence of modern forms of racism is essential in order to recognise and counter it successfully.

Defining Racism

Racism can be broadly defined as behaviours, practices, policies, beliefs and prejudices that underlie avoidable and unfair inequalities across groups in society based on race, ethnicity, culture or religion (Berman & Paradies, 2010). This definition encompasses overt forms of racism such as racial abuse and refusal of a service, as well as more subtle forms of racism such as racial stereotyping and microaggressions.

Racism can occur at different levels that are interrelated and often overlap in practice (Paradies et. al, 2008). For the purposes of understanding the impact of racial discrimination on Aboriginal health care, the focus is:

- **Interpersonal racism:** Interactions between people that maintain and reproduce avoidable and unfair inequalities across minority groups. For example, microaggressions include commonplace daily verbal, behavioural, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults (Sue et al, 2007).
- **Institutionalised, or systemic, racism:** The sometimes unconscious and unintentional embedding of practices, policies or processes within systems or institutions that maintain and reproduce avoidable and unfair inequalities. This follows from the assumption that the dominant group represents the normative and superior culture, with minority groups representing aberrations of some form or other.

Institutionalised racism often involves assimilationist goals whereby the minority group is incorporated in to the dominant group so that their valid needs do not receive recognition (Sanson, 1997).

Racism and Aboriginal health outcomes

In response to the identification of racism as a key driver of ill-health in the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (National Health Plan), Pat Anderson - Chairwoman of the Lowitja Institute, stated:

*“... there is a growing body of evidence that the health system itself does not provide the same level of care to Indigenous people as to other Australians. This systemic racism is not necessarily the result of individual ill-will by health practitioners, but a reflection of inappropriate assumptions made about the health or behaviour of people belonging to a particular group. What the research tells us, then, is that **racism is not rare and it is not harmless: it is a deeply embedded pattern of events and behaviours that significantly contribute to the ill-health** suffered by all Aboriginal and Torres Strait Islander Australians.” (Anderson, 2013).*

The Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 defines its application of the term racism as follows:

“Racism is a key social determinant of health for Aboriginal and Torres Strait Islander people, and can deter people from achieving their full capabilities, by debilitating confidence and self-worth which in turn leads to poorer health outcomes. Evidence suggests that racism experienced in the delivery of health services contributes to low levels of access to health services by Aboriginal and Torres Strait Islander people.” (Department of Health (Cth), 2015).

Racism is understood to have a negative impact on health and wellbeing outcomes for a number of reasons (Paradies et al., 2009):

- Racial discrimination restricts access to resources required for health (e.g. employment, housing and education) and increases exposure to health risks (e.g. unnecessary contact with the criminal justice system).
- Affected individuals can internalise negative evaluations and stereotypes of their own group, leading to poor self-esteem and stress which may have a negative impact on psychological and physiological wellbeing, including depression and anxiety.
- It can result in individuals disengaging from healthy activities (e.g. exercise and taking medications), disengagement with services (e.g. Discharge against Medical Advice) and can lead to behaviours with negative health impacts (e.g. smoking, problematic alcohol and other drug use).

The impact of racism upon health and wellbeing outcomes for Aboriginal people is supported by a growing evidence-base. For example:

- A study conducted in a rural town of WA (Larson et al., 2007) found the 183 Aboriginal respondents had lower health component scores, were more than twice as likely to report fair-to-poor general health and 2.6 to 5 times more likely to report negative racially based treatment (compared to non-Aboriginal respondents). Aboriginal respondents who reported negative treatment were more likely to have poor health.
- A cross-sectional study of 345 Aboriginal people aged 16–20 years concluded that self-reported racism was associated with poor social and emotional wellbeing outcomes, including poor overall mental health and suicide risk (Priest et al., 2011).

- Analysis of the Darwin Region Urban Indigenous Diabetes (DRUID) study indicated that racism explained one-third of the prevalence of depression and poor self-assessed health status among Indigenous Australians, and of the 312 Indigenous participants, 70 per cent reported experiencing interpersonal racism (Paradies & Cunningham, 2009).
- In the case of kidney transplants, Anderson et al. (2012) found that treating specialists' reliance on notions of Indigenous Australians being commonly characterised as 'non-compliers' in their decision-making for transplant referral is likely to result in continuing disadvantage for Indigenous Australian end-stage kidney disease patients.

Why recognising racism as a key social determinant of health is important

Institutional, or systemic, racism is often difficult to recognise and counter, particularly when it occurs within institutions and systems that do not perceive the impacts of their policies, practices or procedures as racially discriminatory, nor seek to address this as a contributing factor in unequitable outcomes.

It is critical to the achievement of better health outcomes for Aboriginal people that WA Health recognises racism as a key social determinant of health for Aboriginal people, and to strive for health care to be free from racism.

The Commonwealth Government has taken the important step of recognising that racism is a key social determinant of health for Aboriginal and Torres Strait Islander people. Racism is identified as such in the National Health Plan and includes the goal that "All health care, whether government, community or private, is free of racism".

The National Health Plan also acknowledges that direct discussion on racism is not easy:

"Discussion about racism is difficult and highly charged in the Australian community and action should be focused on the development of respectful relationships and sanctioning of discriminatory behaviour, policies and practices, including within the health system".

The need to address racism is further embedded in the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 through the action:

"Systemic racism and discrimination is better understood, addressed and prevented."

One of the 2018 deliverables for the above action states:

*"Indicators for measuring cultural safety, such as **discharge from hospitals without medical advice**, and elimination of the differentials in access to best practice clinical care for Aboriginal and Torres Strait Islander patients irrespective of geography and socioeconomic status will be considered in the preparation of the data development plan."*

How can institutionalised racism be addressed?

In developing a matrix for identifying, measuring and monitoring institutional racism within Public Hospitals and Health Services in Queensland (the Matrix), Marrie and Marrie (2014) highlighted five key indicators of institutionalised racism:

1. **Governance:** Aboriginal representation in governance structures, including at Executive and Board level, for direct involvement in decision-making and “legal visibility” in enabling health service laws and regulations.
2. **Policy implementation:** An integrated and coordinated approach between public health and Aboriginal Community Controlled Health Organisations, Aboriginal community engagement and readily available sources of information to Aboriginal people if community engagement is to be effective.
3. **Service delivery:** Culturally secure health care hinges upon having both a culturally competent non-Aboriginal workforce and strong participation by an appropriately trained Aboriginal workforce.
4. **Recruitment and employment:** Measuring the actual status of the Aboriginal health workforce against national and state targets, commitment to employment equity principles at a local level and strategies in place to improve Aboriginal employment.
5. **Financial accountability:** Transparency and accountability in funding arrangements, including at the local level.

The Matrix is underpinned by a set of 13 criteria and indicators which are derived from publically available information. For example, under the ‘Service Delivery’ key indicator, a number of Tier 3 Health System Performance Measures were selected from the *Aboriginal and Torres Strait Islander Health Performance Framework 2014* including:

- **Discharge Against Medical Advice**
- Selected potentially preventable hospital admissions
- Cultural competency
- Aboriginal and Torres Strait islander people in the health workforce.

The use of publically available data allows the Matrix to be applied for internal and external review and to offer quantifiable and comparative approach across health services. Whilst the Matrix was developed independently to measure the Queensland health system, it is intended to be adaptable to other jurisdictions and scaled to the local level.

Building cultural competency in WA Health

Building WA Health’s capacity, capability and responsiveness to prevent and reduce systemic racism can be progressed by improving cultural competency across the health system. The Department of Health, as System Manager, is currently developing and/or delivering on a number of initiatives that address the indicators described in the Matrix above, and which are important steps towards building cultural competency in WA Health.

1. Governance:

The Department of Health is a joint partner of the WA Aboriginal Partnership Forum alongside the Department of Health and Ageing (Cth) and the Aboriginal Health Council of WA (AHCWA). The Department of Health also participates in the Aboriginal Health Network together with Health Service Providers, AHCWA, other state agencies and statewide peak bodies.

The Aboriginal Health Policy Directorate is represented at, and provides support to, the Aboriginal Health Executive Forum (AHEG), with the primary role of providing oversight and leadership to Aboriginal health.

The newly established Health Service Boards provide an opportunity for Aboriginal people to be represented in high level WA Health governance structures.

2. Policy implementation:

WA Health system-wide frameworks include the *Strategic Intent 2015-2020* and the *WA Aboriginal Health and Wellbeing Framework 2015-2030*.

The draft *Implementation Guide for the WA Aboriginal Health and Wellbeing Framework 2015-2030*, which is currently under development, will seek to provide the scope for Health Service Providers and other health partners to operationalise the Framework within their local context through flexible, tailored and culturally secure implementation plans that are developed in partnership with local Aboriginal communities and Aboriginal leadership.

3. Service delivery:

The WA Health Aboriginal Cultural Learning Package (ACLPL) was made available to WA Health employees on 1 July 2015. ACLPL is a suite of online cultural learning tools and resources designed to assist WA Health staff on Aboriginal cultural learning. The ACLPL is aligned to the WA Health Aboriginal Cultural Learning Framework and provides all WA Health employees with access to Aboriginal Cultural eLearning (ACeL); Aboriginal Cultural Learning Plan (CLP), Aboriginal Cultural Learning sessions (CLS) and Aboriginal Health Impact Statement and Declaration (ISD).

As of the 30 June 2016, 28,178 (65%) of employees had completed the ACeL; 833 individual CLPs had been created; 384 ISDs had been created, and 3,323 employees had committed to continuous Aboriginal cultural learning.

4. Recruitment and employment:

The *WA Health Aboriginal Workforce Strategy 2014-2024* aims to develop a strong, skilled and growing Aboriginal health workforce across WA Health including clinical, non-clinical and leadership roles through the key priority areas of attraction and retention, workforce skill development, workforce design, workforce planning and evaluation. This is underpinned by the *WA Health Aboriginal Workforce Policy* which mandates six Aboriginal recruitment and workforce development initiatives until WA Health has reached the Public Sector Commission's Aboriginal employment target of 3.2%, and which will also form part of Health Service Agreements Schedule T: Better Health Outcomes for Aboriginal People.

5. Financial accountability:

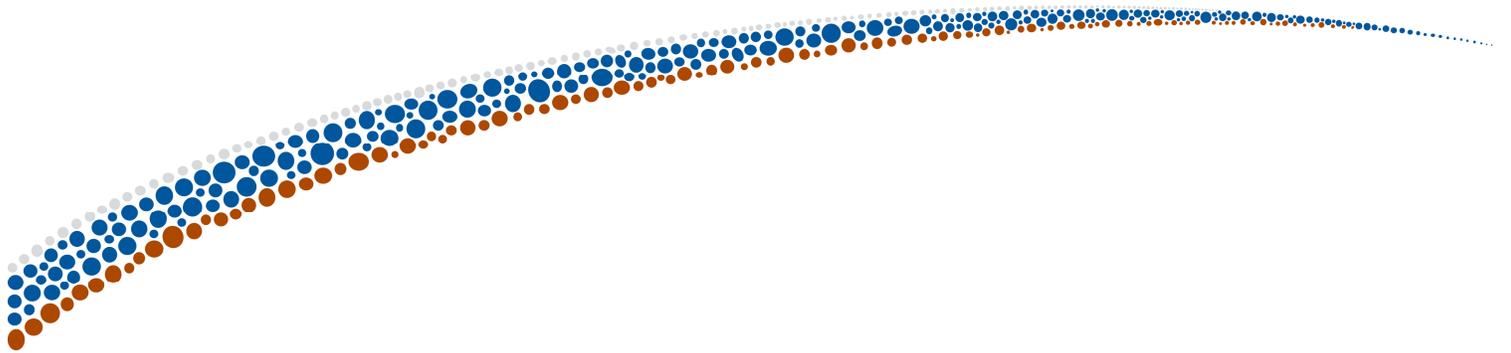
In 2014, WA Health undertook two reviews: (1) *A Promising Future: WA Aboriginal Health Programs* (the Holman Review); and (2) A review by WA Health's Chief Procurement Officer into procurement practices, processes, policies and associated requirements involved in procurement arrangements for Aboriginal health programs.

WA Health has undertaken a significant body of work to ensure that, as far as is practicable, all recommendations have been implemented. As part of these measures, WA Health worked collaboratively with service providers to transition from output reporting to an outcome based

reporting framework. WA Health is currently preparing for a further independent review of programs under the *WA Footprints to Better Health Strategy*.

References

- Anderson, K., Devitt, J., Cunningham, J., Preece, C., Jardine, M. and Cass, A. (2012). *If you can't comply with dialysis, how do you expect me to trust you with transplantation? Australian nephrologists' views on indigenous Australians' 'non-compliance' and their suitability for kidney transplantation.* International Journal for Equity in Health, 2012, 11:21.
- Anderson, P. (2013). *Racism a driver of Aboriginal ill health.* Opinion piece for The Australian. Accessed online 25/08/16: <https://nacchocommunique.com/2014/02/28/naccho-aboriginal-health-and-racism-what-are-the-impacts-of-racism-on-aboriginal-health/>
- Berman, G. & Paradies, Y. (2010). *Racism, disadvantage and multiculturalism: towards effective anti-racist praxis.* Ethnic and Racial Studies. 33(2), pp. 214-232.
- Casas, J.M. (2005). *Race and racism: the efforts of counseling psychology to understand and address the issues associated with these terms.* The Counseling Psychologist, 33, 501-512.
- Cunningham, C. (2002). *Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous.* Medical Journal of Australia 2002; 176 (2): 58-62.
- Department of Health (Cth). (2015). *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.* Australian Government, Canberra.
- Department of Health, Western Australia. (2014). *WA Health Aboriginal Workforce Strategy 2014–2024.* Perth: Aboriginal Health, Department of Health, Western Australia
- Gallaher, G., Ziersch, A., Baum, F., Bentley, M., Palmer, C., Edmonson, W. & Winslow, L. (2009). *In our own backyard: urban health inequities and Aboriginal experiences of neighbourhood life, social capital and racism.* Flinders University, Adelaide.
- Larson, A., Gilles, M., Howard, P. J. & Coffin, J. (2007). *It's Enough to Make You Sick: The impact of racism on the health of Aboriginal Australians.* Australian and New Zealand Journal of Public Health, vol. 31, no. 4, pp. 322–9.
- Marrie, A. & Marrie, H. (2014). *A Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services.* Bukal Consultancy, Gordonvale, Qld. Accessed online: <http://www.avidstudy.com/wp-content/uploads/2015/08/Matrix-Revised-2-9-14.pdf>
- Paradies, Y., Chandrakumar, L., Klocker, N., Frere, M., Webster, K., Burrell, M. & McLean, P. (2009). *Building on our strengths: a framework to reduce race-based discrimination and support diversity in Victoria.* Victorian Health Promotion Foundation, Melbourne.
- Paradies, Y. & Cunningham, J. (2009). *Experiences of racism among urban Indigenous Australians: findings from the DRUID study.* Ethnic and Racial Studies Vol. 32 No. pp. 548-573.
- Paradies, Y., Harris, R. & Anderson, I. (2008). *The Impact of Racism on Indigenous Health in Australia and Aotearoa: Towards a Research Agenda.* Discussion Paper No. 4, Cooperative Research Centre for Aboriginal Health, Darwin.
- Priest, N.C., Paradies, Y.C., Gunthorpe, W., Cairney, S.J. and Sayers, S.M. (2011). *Racism as a determinant of social and emotional wellbeing for Aboriginal Australian youth.* Medical Journal of Australia, 194 (10): 546-550.
- Sanson, A.S. et al (1997). *Racism and Prejudice: psychological perspectives.* The Australian Psychological Society. Melbourne Vic.
- Sue, D.W. et al. (2007). *Racial Microaggressions in Everyday Life: implications for clinical practice.* American Psychologist. Vol 62, No. 4, 271-286.



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