Towards Safety and Quality: Confronting racism in the provision of public health services to Aboriginal and Torres Strait Islander people

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Defining racism

Oppression encompasses behaviors or practices that result in avoidable and unfair inequalities in power, resources or opportunities across groups in society. Such oppression can be based on various characteristics, including gender, sexual preference, ethnicity, race, culture, religion, age, social class and relationship status. Individuals may simultaneously experience oppression on the basis of multiple characteristics.

Oppressive behaviors and practices which relate to ethnicity, race, culture and religion along with the beliefs and prejudices that underlie them can be collectively referred to as racism (Paradies, Chandrakumar et al. 2009). Racism can be broadly defined as a phenomenon that results in avoidable and unfair inequalities in power, resources, or opportunities across racial, ethnic, cultural, or religious groups in society. Racism can be expressed through beliefs (e.g., negative and inaccurate stereotypes), emotions (e.g., fear or hatred), or discriminatory behaviors/practices (e.g., unfair treatment).

Oppression and racism are intrinsically linked to privilege such that in addition to disadvantaging minority groups in society, racism also results in privilege and unfair opportunities for certain groups such as Anglo Australians (Berman and Paradies 2010). Racism can occur at three conceptual levels that are interrelated and frequently overlap in practice. Internalised racism is the acceptance of attitudes, beliefs or ideologies by members of stigmatised ethnic/racial groups about the inferiority of one’s own ethnic/racial group (e.g. an Aboriginal person believing that Aboriginal people are naturally less intelligent than non-Aboriginal people).

Interpersonal racism is characterised by interactions between people that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups (e.g. experiencing racial abuse). Interpersonal racism can be intra or inter-racial in nature. That is, racism can occur between people of the same racial group (i.e. intra-racial racism between two Aboriginal people) or between people of difference racial groups (i.e. inter-racial racism between an Aboriginal and non-Aboriginal person). In

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1 Also abbreviated to Aboriginal people in this report.
Aboriginal communities, intra-racial racism is more commonly referred to as ‘lateral violence’ (Dudgeon, Garvey et al. 2000).

Systemic racism encompasses requirements, conditions, practices, policies or processes that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups (e.g. Aboriginal people experiencing inequitable outcomes in the healthcare system). This type of racism is also referred to as institutional racism (Berman and Paradies 2010). It is important to note that although minority groups in society bear the brunt of racist experiences, under the definition above anyone can either experience or perpetrate racism, regardless of their ethnic/racial identity.

Interpersonal racism affecting Aboriginal and Torres Strait Islander people

Although relatively little research has focused on attitudes towards, and beliefs about, Aboriginal Australians, there is evidence of continued misconceptions that portray Aboriginal peoples as being welfare dependent, more likely to drink alcohol and as recipients of ‘government handouts’ (Pedersen, Dudgeon et al. 2006; Balvin and Kachima 2011). Moreover, about 13% of non-Aboriginal respondents agree that ‘non-Aboriginal Australians are superior to Aboriginal Australians’ (Stolper and Hammond 2010). Among 5000 respondents in a 2001 NSW/Qld survey, 28% expressed concern about a close relative marrying an Aboriginal person. This figure was 25% in a similar survey of 4000 Victorians in 2006. However, in the 2008 and 2010 Reconciliation Barometers, only 11% and 13% of non-Aboriginal Australians had concerns with their child marrying an Aboriginal person (Stolper and Hammond 2010). Although there have been 37 studies on this topic internationally (Paradies, Priest et al. under review), there have been none in Australia examining racist attitudes and beliefs towards Aboriginal and Torres Strait Islander people by health care providers.

Systemic racism affecting Aboriginal and Torres Strait Islander people

A range of studies highlight the widespread nature of such racism in domains such as national politics (Augoustinos, Tuffin & Rapley 1999), media (Cunneen 2001), education (Bodkin-Andrews, O’Rourke, Grant, Denson, & Craven, 2011), employment (Booth, Leigh et al. 2009), the welfare system (Sanders 1999), the provision of public housing (Equal Opportunity Commission of 2004), in the legal/criminal justice systems (Blagg, Morgan et al. 2005). For example, evidence from Victoria indicates that when apprehended by police, Aboriginal youth are 2-3 times more likely to be arrested and charged with an offence than non-Aboriginal youth (The Department of Justice and Law 2005; Indigenous Issues 2006). (Booth, Leigh et al. 2009) sent over 4000 fictional resumes to employers in response to job advertisements. Despite these resumes detailing equally qualified and experienced applications, resumes with Aboriginal names attracted 35% less interviews than resumes with Anglo names.

There is also evidence of detrimental effects specifically in healthcare settings. Compared to non-Aboriginal patients with similar characteristics, Aboriginal patients are about one-third less likely to receive appropriate medical care across all conditions (Cunningham 2002), as well as for particular diseases such as cancer (Hall,
Bulsara et al. 2004; Vallery, Coory et al. 2006) and coronary procedures (Coory and Walsh 2005). Aboriginal Australians are also three times less likely to receive kidney transplants than other Australians with the same level of need (Cass, Devitt et al. 2004).

**Racism against Aboriginal people in public health services**

In the 2004-5 National Aboriginal and Torres Strait Islander Health Survey, 4.3% of 5,757 adults reported that they received worse treatment when seeking health care in last 12 months compared to non-Aboriginal people while 4.2% of 7,342 Aboriginal adults aged 15-64 years in the 2008 National Aboriginal and Torres Strait Islander Social Survey reported experiencing discrimination by doctors, nurses or other staff at hospitals / surgeries in the last 12 months. Assuming this figure remained constant from 2008 and to 2012 as it did from 2004 to 2008, we can conclude that, across Australia, almost 15,000 Aboriginal people over 15 years of age experience racism in the healthcare sector every year (based on 2011 Census figures).

Similarly, 5% (4.0-5.9%) of 9,968 Maori adults with a regular health care provider and at least one visit in last 12 months reported racial discrimination in the 2006/07 New Zealand Health Survey (Harris et.al., 2012) while 7.1% of 889 American Indians/Alaskan natives reported experiencing discrimination in health care in the 2001 California Health Interview survey (Johansson, Jacobsen, & Buchwald, 2006).

Implicit (or unconscious) bias among healthcare professionals is widespread and has been found to lead to poorer clinical decisions about African Americans in the United States (Green et al., 2007; Moskowitz, Stone, & Childs, 2012; Sabin & Greenwald, 2012). Racial discrimination by a health professional was associated with lower odds of breast and cervical cancer screening among Maori women in New Zealand as well as negative patient experiences more generally (Harris et.al., 2012).

Among 31 key informants from a range of organisations and General Practice Networks related to Aboriginal and Torres Strait Islander health and identification interviewed in June and July 2009, 28% noted that a barrier to Aboriginal people identifying in General Practice contexts was ‘fear of racism’ (Kelaher et al., 2010).

The following quotes from rural/remote Aboriginal patients as they navigate the Adelaide public hospital system illustrate the range of racism experienced in health care settings:

*Sometimes, yeah, I got insulted a couple of times. One said to me when I went to…I had spots coming out on my arms and back and the doctor turned around and said, “Debra it’s just like a black dog with white spots, you can’t change it.” (Debra, 44, CDEP, Onkaparinga) (Gallaher et al., 2009).*

*I felt that I was treated—because I was an Aboriginal person that they could treat me anyway they want… it’s not across the board, there’s just certain people—their attitudes…you can feel the feeling of another person’s attitude towards you just by the way they look at you (P1) (Kelly, Dwyer et al. 2011).*

*A lot of them still think that we all—Aboriginals are the same… that’s the worst part,*
that’s the annoying part, they treat you all the same and, oh, come on, we’re our own now, we’ve got our own minds (C6) (Kelly, Dwyer et al. 2011).

I said if this means a delay, please, I don’t need the Aboriginal health worker, I just need the nurse. No joy… I just wanted some help. The protocols for Aboriginal people meant that I didn’t get it. These things need to be on an individual basis. It is a form of racial discrimination to assume we all need help, to be all lumped in together. It is offensive… It is not just overt racism, it is the underlying, underhanded racism. The reverse discrimination, we should not be categorized [as] ‘Aboriginal people are all like this’… it is negative and derogatory (PC23) (Kelly, Dwyer et al. 2011).

Healthcare staff also detailed their experiences of witnessing racist behavior towards Aboriginal patients:

She said, ‘why is it just because you’re black everyone thinks you’re deaf and a baby as well?… they talk to you loudly… and then talk in baby talk—oh, have we had our din dins and all that’, and this is someone that had a mind like a steel trap… (RA1) (Dwyer et al. 2011a)

Healthcare staff also discussed one of the common effects of poor cultural competence (Fredericks 2008) in an environment that includes interpersonal and institutional racism:

I think you can get stuck on blame to the point where it becomes quite destructive and people don’t want to—they’re too scared to ask questions any more for fear of it being racist, too scared to ask any questions, too scared to do anything really because it’s deemed as racist (MS1) (Dwyer et al. 2011a).

The need to address racism in public health services

Evidence from overseas indicates that racism perpetrated by healthcare providers has a range of negative outcomes for patients, including poorer self-reported health status, lower perceived quality of care, underutilization of health services, delays in seeking care, failure to adhere to recommendations, societal distrust, unmet needs for health care utilization, interruptions in care, mistrust of providers, and avoidance of health care systems (Shavers, Fagan et al. 2012).

Racism is commonplace in workplaces and has been linked to negative outcomes for staff, such as poor mental and physical health and wellbeing, psychological distress, reduced productivity and innovation; lower organizational commitment, and employee perceptions of procedural injustice, mistrust and job dissatisfaction as well as increased cynicism, absenteeism and staff turnover (Trenerry and Paradies 2012). However, in the absence of workplace racism, cultural diversity can lead to creativity and innovative thinking, greater employee commitment and team performance as well as better customer and client satisfaction (Trenerry, Franklin et al. 2012).

At a personal level, race-based discrimination has negative outcomes for both targets and those practicing it. For those who are targeted, it can ‘traumatise, hurt, humiliate, enrage, confuse, and ultimately prevent optimal growth and functioning of
individuals and communities’ (Harrell 2000, p. 42). Race-based discrimination may also have negative effects on individuals who perpetuate it, distorting their personalities and their perceptions of the world. Survey data indicate a significant association between reported levels of unhappiness and prejudiced attitudes against people from different cultural and racial backgrounds (Borooah and Mangan 2007).

Freedom from racial discrimination is a recognised international human right and is unlawful under the Commonwealth Racial Discrimination Act 1975. Addressing racism is a key aspect of the South Australian Cultural Inclusion Framework (Government of South Australia 2006). In addition, a national anti-racism strategy is currently being implemented by the Australian Human Rights Commission with the aim of reducing racism across a range of sectors in society. As noted by Johnstone & Kanistaki (2009), healthcare is one sector where care without prejudice is expected and where treatment should be non-discriminatory in nature. However, the evidence presented above belies “a genuine belief among health professionals that ‘racism no longer exists’ in health care and that if racialised practices do exist, they cause little or no harm” (Johnstone and Kanitsaki 2009). Clearly, such denial is a key barrier to addressing racism in the health system.

**Approaches to addressing racism**

In considering approaches to anti-racism, the overarching goal is “the kind of society in which people can live together in harmony and mutual respect” (Anthias and Lloyd 2002). Anti-racism can be defined as action that reduce power differentials or equalise power relations (Berman and Paradies 2010). This entails a positive sense of group difference and autonomy and an elimination of hierarchical relationships between racial groups (Young 1990). Anti-racism activity seeks to address the causes as well as manifestations/effects of racism. This differs from cultural awareness in focusing on dominant, taken-for-granted values, assumptions and practices rather than on ‘understanding’ Aboriginal people. Anti-racism is also distinct from addressing disadvantage in that it focuses on advantage/privilege and the structures and processes that maintain them. Although overlapping and interacting in practice, there are three main conceptual approaches to anti-racism: reducing racist beliefs, emotions and behaviours (e.g. (Paluck and Green 2009), conflict resolution (e.g. (Dessel and Rogge 2008) and collective action/social change (e.g. (Ellemers and Barreto 2009; Louis 2009). This paper will focus on reducing racist beliefs, emotions and behaviours in the context of power differentials between Aboriginal and non-Aboriginal people.

**Confronting racism and cultural competence**

Figure 1 illustrates continuum on which racism and cultural orientations exist.

**Figure 1: The continuum of cross-cultural client safety**
As a behavioural manifestation, discrimination is the most damaging form of racism followed by the attitudes and beliefs (i.e. prejudices) that underlie it then ‘indifference’ and a range of increasing better orientations to culture. Figure 1 also indicates at what point healthcare providers think of minority groups as ‘them’, start to also them about how they are implicated in racism and client safety (i.e. ‘us’) and then, finally, understand the need to focus on system change itself. The boxed area of the continuum denotes the point at which cross-cultural safety is achieved.

Figure 1 developed in a Canadian context can be mapped onto Figure 2 developed in an Australian context. Cultural destructiveness can be considered a form of overt racism, cultural incapacity a form of subtle racism and cultural blindness a form of indifference to culture. Cultural pre-competence in Figure 2 encompasses both culture awareness and sensitivity in Figure 1. Cultural competence is synonymous in both diagrams and congruence/integration is equivalent to cultural proficiency.

Figure 2: Cultural competence continuum

These figures demonstrate the need to address racism as a first step towards cultural
Confronting racism against Aboriginal and Torres Strait Islander people in public health services

There are seven general key principles to reducing racism (Paradies, Chandrakumar et al. 2009):

- Raising awareness
- Providing accurate information
- Recognising incompatible beliefs and promoting egalitarian values
- Increasing empathy and perspective-taking
- Increasing comfort with other groups and reducing anxiety
- Promoting positive social norms
- Increasing personal and organisational accountability

In relation to organisations there are five key areas for addressing systemic racism:

- Organisational accountability
- Human resources
- Partnership with community
- Research and evaluation
- Cultural competency/anti-racism training

Organisational accountability means incorporating non-discrimination as a standard across aims, objectives, goals in strategic policies, plans and key performance indicators; developing non-discriminatory forms, guidelines resources and protocols as well as auditing plans, policies, processes and practices; and establishing minimum standards of practice that hold individuals accountable to staff, clients and suppliers through key performance indicators. Such accountability requires visible and strong organisational leadership to combat racism and foster non-discriminatory social norms; efforts to foster positive intergroup contact in workplaces; and symbolic activities such as welcome to country protocols and flying the Aboriginal and/or Torres Strait Islander flags (Paradies, Chandrakumar et al. 2009; Trenerry, Franklin et al. 2010).

In order to create a culture of non-discrimination, employees must understand appropriate, inclusive behaviour in the workplace through clear communication that any form of racism, no matter how ‘minor’ is unacceptable. There should be an expectation that employees contribute to an inclusive, non-discriminatory workplace culture in a organisational culture where action is privileged over inaction (Paradies, Chandrakumar et al. 2009; Trenerry, Franklin et al. 2010).

The organisation should conduct employee/client satisfaction surveys, interviews and ongoing feedback system to respond to racist incidents and disparities (including resolution and grievance procedures) and monitor complaint/feedback received, policies and procedures, hiring, promotion, performance reviews, salary levels, training, mentoring, turnover, absenteeism, mentoring and staff seniority by
Aboriginal status (Paradies, Chandrakumar et al. 2009; Trenerry, Franklin et al. 2010).

Sufficient resources should be allocated to planning and implementation of collaborative activities; creating a shared organisational vision and clear communication strategy; and ensuring transparent, accountable and responsive orientations to community needs. Local knowledge and expertise should be drawn upon when forming community partnerships while remaining cognisant that there is no single ‘Aboriginal community’ but rather many Aboriginal people with a range of views, needs and ideas (Paradies, Chandrakumar et al. 2009; Trenerry, Franklin et al. 2010).

As many Aboriginal employees experience isolation, feelings of hopelessness and lack of support in their appointed positions, recruitment does not ensure retention (Durey, Wynaden et al. 2011). Retention requires support for Aboriginal staff in mainstream health system in the form of mentoring networks and affirmative action policies which emphasise merit and the benefits of diversity for the organisation.

In attracting, retaining, mentoring and supporting Aboriginal employees, it is particularly important to avoid tokenism as a danger identified in the cultural pre-competence stage of Figure 2 above. Examples of tokenism include employing an Aboriginal person even if they lack the skills, knowledge or experience for the job, asking Aboriginal staff to speak on behalf of their people or deal with Aboriginal clients even if this isn’t part of their job or within their realm of expertise and treating the need for Aboriginal cultural competence as a ‘tick-box’ activity.

Tokenism can take the form of apparently positive and well-intentioned behavior that nonetheless results in inequalities in opportunity, resources or benefits. Tokenism is closely related to benevolent racism, defined as feelings of pity, sympathy towards members of an ethnic/racial group that are considered passive, inferior and/or incompetent (Ramasubramanian and Oliver 2007). In a workplace this may include unrealistically positive feedback, overzealous helping or assigning overly easy tasks. Such behavior results in reduced opportunity for Aboriginal people to acquire further competence, knowledge, skills and abilities (Dipboye and Colella 2005).

Evidence from ten successful case studies of workplace anti-racism interventions distill the following key approaches to addressing racism against Aboriginal people at the organisation level (Trenerry, Franklin et al. 2012):

- a ‘top-down’ central team/committee with broad responsibilities and senior membership to lead, monitor and coordinate a whole-of-organisation approach
- an existing department, work unit or individual with a central rather than peripheral organisational location to provide administrative, logistic and managerial support to the team/committee
- distributed taskforces, change teams and/or workplans for sections of the organisation as appropriate (e.g. within individual departments)
- ‘bottom-up’ strategies that promote transparency, trust and information exchange between staff and organisational managers/leaders (e.g. staff surveys or forums)
- structural support for Aboriginal staff (e.g. measures to accommodate
diversity such as cultural leave);

- ongoing training for employees and managers as well as specialist training for organisational leaders to integrate anti-racist principles across all levels of the organisation and address employee backlash and concerns;

- a requirement to develop and communicate clear goals, measurable outcomes, accountability, evaluation and continuous quality improvement.

As demonstrated in these case studies, a well-conducted self-assessment is an essential step in identifying race-based discrimination in the workplace and creating an action plan to reduce such discrimination. Assessment identifies the needs and priorities of an organisation in tailoring interventions to reduce race-based discrimination. The process is a useful starting point to gain a deeper understanding of current practice and provides a baseline assessment from which further activity can be developed and measured against (Trenerry and Paradies 2012a). An audit tool appropriate for this purpose has recently been developed and piloted in two Victorian local councils (Trenerry and Paradies 2012b). A tool developed by the Lewin group (The Lewin Group 2002) adapted by the Centre for Culture, Ethnicity and Health into a range of tip sheets may be of particular relevance in the health care context.  

Cultural competency/anti-racism training requires formal training through stand-alone courses as well as informal mentoring and on-the-job training; should focus on attitudes, beliefs and behaviours; should incorporate both cultural awareness to facilitate improved communication and interaction with Aboriginal people as well as examination of one’s own prejudices and ways to address racism in the workplace. The aim of such training is to ensure individuals understand stereotyping, prejudice and bias and how to respond to racism; acknowledge and examine one’s own racial identity and biases/prejudices but be willing to ‘make mistakes’ from stance of cultural humility; and understand affirmative action and diversity (e.g. similarities between and differences within groups); practice and promote empathy for (and dispel false beliefs about) diverse groups in society; support others to practice values such as a ‘fair go’ for all Australians and advocate for a more inclusive Australian identity; and foster opportunities for positive engagement between people from different racial, ethnic, cultural and religious groups (Paradies, Chandrakumar et al. 2009; Trenerry, Franklin et al. 2010).

Given evidence that up to a fifth of participants have increased levels of racial prejudice following diversity training (Paradies, Chandrakumar et al. 2009; Trenerry, Franklin et al. 2010), it is important that cultural competency/anti-racism training are based on sound theory and practice. Such training should avoid an authoritarian style; create a safe space of trust, support, acceptance and respect where emotional responses can be addressed; use action-oriented approaches and multimedia formats, free discussion critique, analysis and self-exploration; focus on discrimination as a general concept and specifically addresses behaviour. It is also vital that training is tailored to each specific organisation and link to operational goals; enjoys strong, visible and consistent support from management; is delivered by trainers with experience in organisational change; and is complemented by broader organisational change (Paradies, Chandrakumar et al. 2009; Trenerry, Franklin et al. 2010).

Research from the United States describes a range of approaches to reducing racial bias among health care providers in particular (Burgess, Van Ryn et al. 2007). In particular, the following have been recommended to ensure individuated impressions of patients and unbiased clinical decision-making: developing an internal motivation to treat all patients without racial bias; understanding the psychological basis and historical context of racial bias; enhancing confidence and regulating emotional responses; increasing perspective-taking and empathy; and building partnerships with patients (Burgess, Van Ryn et al. 2007). There is also evidence that patients are more satisfied with their care when providers try to take their perspective into account (Blatt, LeLacheur et al. 2010). Figure 3 outlines a model developed to improve understanding of unconscious bias among health care providers. Training programs based on these principles have been effective in ‘breaking the habit’ of prejudice (Devine and al. 2012).

**Figure 3: Educational strategies for increasing awareness about unconscious bias**

There are recent and ongoing projects in Australia to improve hospital care for Aboriginal and Torres Strait Islander patients, notably the *Managing Two Worlds Together* (Dwyer et al. 2011b) and *Improving the culture of hospitals* (Willis, Wilson et al. 2010) projects as well as emerging research focused on effective anti-racism and cultural competence/safety training for health professionals (Durey 2010; Downing, Kowal et al. 2011; Durey, Thompson et al. 2011).

The *Managing Two Worlds Together* project is particularly relevant given a focus on patient journeys for rural and remote Aboriginal patients in the Adelaide public hospital system. In stage 1, the project found “patients sometimes feel that their cultural values and needs are not respected” and that “staff sometimes struggle to communicate across differences in cultures, worldviews and experiences”. Although policies may be in place to “guide health care providers in caring for Aboriginal patients” these are not operationalised in a way that allows positive patient journeys for rural and remote Aboriginal patients (Dwyer et al. 2011b). During 2012, stage 2 will involve working with partner organisations to develop and/or document strategies
to improve the health care journeys for country Aboriginal patients.

Perhaps the most developed action to address racism in health care is being taken by Hunter New England Health in NSW. This project involves staff education and training, leadership, consultation, negotiation and partnerships. Figure 4 provides an overview of the comprehensive approach adopted by Hunter New England Health to address both individual and institutional racism (Martin and DiRienzo 2012).

**Figure 4:** Overview of strategies adopted by Hunter New England Health to address individual and institutional racism

(Martin and DiRienzo 2012)

**Recommendations**
References


