deeble institute

Deeble Institute for Health Policy Research

# Issues Brief

**no: 60**
**16 September 2025**

# Measuring what really matters for Aboriginal and Torres Strait Islander Peoples – racism and cultural safety in healthcare

**Dr Elissa Elvidge | 2025 Jeff Cheverton Memorial Scholar**
Post-doctoral Research Fellow
College of Health, Medicine and Wellbeing
School of Medicine and Public Health
The University of Newcastle
Hunter Medical Research Institute
E: Elissa.Elvidge@Newcastle.edu.au

**Adj AProf Rebecca Haddock**
Executive Director | Knowledge Exchange
Deeble Institute for Health Policy Research
Australian Healthcare and Hospitals Association

Sponsors of the Jeff Cheverton Memorial Scholarship

phn BRISBANE NORTH
An Australian Government Initiative

phn NORTH WESTERN MELBOURNE
An Australian Government Initiative

ahha australian healthcare & hospitals association

## Acknowledgement

We would like to acknowledge the Awabakal, Worimi and Ngunnawal people as the traditional custodians of the land where we live and work. We pay our deep respect to the Elders past and present and their continuing connection to culture and country. We acknowledge Aboriginal and Torres Strait Islander culture as the oldest continuing culture in the world. Aboriginal and Torres Strait Islander people never ceded sovereignty and we recognise the ongoing impacts of colonisation and systemic racism on the health and wellbeing of Aboriginal and Torres Strait Islander people.

In the creation of this policy brief, I would like to extend my heartfelt gratitude to those who have supported me throughout this journey. To my family, your love, humour and encouragement have always been my anchor, providing strength when challenges arose.

Yin Paradies thank you for your thoughtful edits. Your ongoing support and guidance since my PhD are sincerely appreciated. I would also like to acknowledge Karen Nicholls, Peter O'Mara, Geraint Rogers, Yeena Thompson and Nathan Towney for your kindness and generous mentorship.
Shout out to Wukul Yababng, NIHLA Brains Trust, teams SAHMRI, Thurru and Wollotuka for your friendships and the opportunities to collaborate. All of your insights and ideas have enriched this work. Our yarns have inspired me to delve deeper, strive for greater understanding and use this work to try to create meaningful change.

Finally I would like to extend my heartfelt gratitude to the Deeble Institute and my mentor and co-author Rebecca Haddock, whose expertise and unwavering encouragement have profoundly impacted my journey in policy writing. Your ability to guide me with insightful feedback while fostering a safe space for creativity has been invaluable. You have not only shared your knowledge but have also instilled in me the confidence to explore new ideas and approaches. Your mentorship has been a transformative experience, and I am incredibly grateful for your support and this opportunity.

### Author positionality statement

Elissa Elvidge is a non-Indigenous post-doctoral research fellow whose work focuses on improving clinical and public health outcomes through community-led research partnerships. As a woman of colour of Mauritian and Anglo-Australian descent, she has lived experience of racism and privilege, which informs her interest and scholarship in cultural safety and racism research. For over a decade, Elissa has worked to build strong and respectful relationships with Aboriginal communities, negatively racialised groups and health organisations across Australia.

Rebecca Haddock is a non-Indigenous policy intermediary and academic whose work is grounded in a commitment to health system reform that advances equity and improves outcomes for all communities.

## Key messages

Institutional racism within Australian hospitals is a critical public health issue that profoundly impacts Aboriginal and Torres Strait Islander peoples. This racism is not merely a collection of isolated incidents; it's a systemic problem that affects patients at both an individual and societal level. Experiences of racism and culturally unsafe care create significant barriers to accessing healthcare, directly impact the quality of care received, and impair clinical decision-making. This lack of safety in the system contributes to poorer health outcomes, lifelong harm, and in some cases, preventable deaths.

Despite being a key policy priority, Australian hospitals have largely failed to systematically and robustly measure the experiences of Aboriginal and Torres Strait Islander patients. To ensure accountability, legal enforcement mechanisms are needed, along with the designation of specific roles within health services responsible for addressing racism and promoting culturally safe care.

A widespread lack of understanding and recognition of racism and cultural safety as social determinants of health undermines the ability of the current and future healthcare workforce to provide safe care. Establishing a national accreditation scheme for cultural safety training is crucial for ensuring consistent, high-quality, and evidence-based education across all healthcare settings.

Hospital executives and policymakers often show a reluctance to meaningfully acknowledge and address racism. This lack of accountability allows systemic inequities to persist and undermines efforts to create a safe environment. A transparent and accessible reporting system, overseen by an autonomous body outside of the hospital structure, is essential to ensure accountability and drive real change. Without a systematic way to measure and monitor cultural safety and racism, it is impossible to know if current initiatives are working.

While tools exist to assess institutional racism, they are not consistently applied, which limits accountability and progress. A national consensus on performance indicators for measuring racism and cultural safety must be developed, led by Indigenous health organisations and subject matter experts.

Meaningful engagement between healthcare leaders and Aboriginal and Torres Strait Islander communities is currently lacking. To align with national standards, hospitals must engage with consumers, families, and communities in culturally appropriate ways. This includes ensuring participation is representative, and that individuals are appropriately compensated for their time and valuable expertise.

## Recommendations

1

Recommendation 1

**Establish a national framework for cultural safety and anti-racism.**
A national framework is needed to define and guide cultural safety, with standards and a clear, Indigenous-led vision for eliminating racism in healthcare.

2

Recommendation 2

**Mandate and standardise cultural safety and anti-racism education and training.**
Healthcare professionals need mandatory, standardised, and rigorously evaluated anti-racism training that includes critical self-reflection and is co-designed by Aboriginal and Torres Strait Islanders.

3

Recommendation 3

**Implement independent and transparent complaints and reporting mechanisms.**
To build trust and accountability, independent, accessible, and culturally safe systems are required for reporting racism, with clear oversight and consequences for perpetrators.

4

Recommendation 4

**Strengthen data collection and measurement of racism and cultural safety.**
Systematic data collection on patient and staff experiences of racism and cultural safety must be a mandatory part of hospital accreditation to drive meaningful change.

5

Recommendation 5

**Enhance meaningful community engagement and shared decision-making.**
Healthcare institutions must move beyond token gestures and establish genuine partnerships with Indigenous communities, appropriately compensating them for their expertise in shaping policies and services.

# Table of Contents

Acknowledgement ..... 1
Key messages ..... 2
Recommendations ..... 3
Introduction ..... 6
The impact of racism on health and healthcare ..... 7
Racism and culturally unsafe care as a barrier to healthcare access ..... 7
Clinical decision making and quality of care ..... 8
The socioeconomic and physiological impacts of racism ..... 8
Impact of racism on health ..... 9
Government responses and accountability ..... 10
Strategic policy priority ..... 10
Government legislative framework ..... 10
Antidiscrimination in healthcare ..... 11
Organisational level responses to racism ..... 12
Limitations of racism and complaints data ..... 12
Measuring and monitoring racism ..... 14
Measurement of cultural safety ..... 14
Education and training for a culturally safe workforce ..... 16
Limited knowledge of cultural safety impedes policy implementation ..... 16
Poor understanding of cultural safety in mainstream health ..... 16
Cultural safety in health equity ..... 17
Improving cultural safety knowledge to strengthen health policy ..... 18
Decolonising and redefining cultural safety education and training ..... 18
Cultural safety requires critical self-reflection ..... 19
Approaches to Indigenous health policy and training are inconsistent ..... 20
NSW Health Respecting the Difference ..... 20
Evidence based cultural safety training ..... 20
Strengthening accountability and policy implementation ..... 22
A reluctance to acknowledge racism in health ..... 22
Ineffective reporting and complaints ..... 22
Data integrity and organisational accountability ..... 23
Anti-racism policy ..... 23

Institutional racism in hospitals ..... 23
Strategies to address racism ..... 24
Implementing and evaluating anti-racism and cultural safety policies ..... 25
Inconsistent implementation ..... 26
Meaningful engagement with Aboriginal and Torres Strait Islander communities in healthcare ..... 28
National Safety and Quality Health Service Standards (NSQHSS) ..... 28
Canadian accreditation model ..... 29
Conclusion and recommendations ..... 31
References ..... 34

## Introduction

Racism in healthcare is a public health issue. Racism is defined as the expression of prejudice within a context of power disparity (Paradies, 2018).

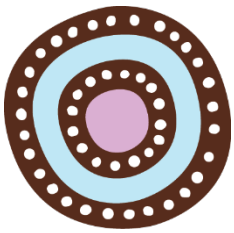
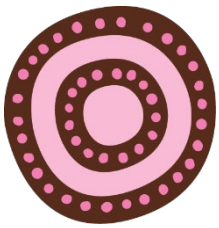
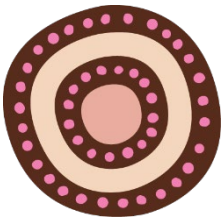
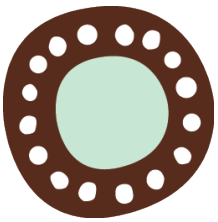
Within hospitals, power disparities are unavoidable. Clinical decisions must be taken by those with specialist expertise, placing healthcare workers in positions of considerable authority when interacting with those seeking care. However, healthcare worker-patient relationships provide little protection where service providers hold prejudicial views (Brown et al., 2023). Inaccurate assumptions about the cause of health complaints, failure to appraise clinical needs objectively, reluctance to offer certain types of treatment, and dismissal of priorities or concerns raised by patients all contribute to disparities in outcomes for members of minority groups and often, traumatic experiences of care (Paradies et al., 2014).

For Aboriginal and Torres Strait Islander peoples, experiences of racism in healthcare are widespread and frequent (AHRC, 2024a; Polity Research and Reconciliation Australia, 2020; Temple et al., 2019). Indeed, almost one third of Aboriginal and Torres Strait Islander people have reported experiences of racism when accessing health services, with hospitals identified as a key location for interpersonal and institutional racism (Kelaher et al., 2014).

Moreover, Indigenous Australians are reporting racial discrimination by medical staff at nearly double the rate, from 2014 (11%) to 2022 (20%) (Nelson, 2022).

More recently, since the 2024 Voice Referendum, overall experiences of racism have increased with more people accessing support services (Anderson et al., 2023; SBS 2025).

In response, the Australian Government and peak health bodies have called for health services and health practitioners to eliminate racism and increase cultural safety as one way of addressing the impact of these issues (RACGP, 2025; AHRC, 2024B).

### Defining Racism and Cultural Safety

**Racism**

Racism occurs when prejudice is accompanied by the power to harm, oppress or discriminate, either by individuals, organisations or systems.

It is a system of beliefs, practices, and policies that operate to advantage those at the top of the racial hierarchy.

It can be considered as unjust covert or overt practices and structures that discriminate against a person or a group, resulting in inequity and unequal outcomes for people based on their 'race' or culture (regardless of intent).

Racism includes all the laws, policies, ideologies and barriers that prevent people from experiencing justice, dignity, and equity because of their racial (or cultural) identity (Paradies, 2018).

**Cultural Safety**

Cultural safety originated in Aotearoa (New Zealand) in the 1980s by Māori clinicians in response to feeling unsafe within the predominantly Western health system.

It acknowledges the barriers to clinical effectiveness arising from the inherent power imbalance between providers and patients.

It has since been conceptualised in the Australian context as a model of care, an approach to service delivery and an outcome of the quality of care provided (Best, 2014).

In 2019, the Australian Health Practitioner Regulation Agency (Ahpra) invited public consultation to seek feedback on a definition of cultural safety. According to the Ahpra definition, cultural safety must be determined by Aboriginal and Torres Strait Islander individuals, families and communities, while culturally safe practice is 'the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism'(Ahpra, 2019b).

## The impact of racism on health and healthcare

### Racism and culturally unsafe care as a barrier to healthcare access

Experiences of racism and culturally unsafe care can act as a barrier to accessing care. Experiences of racism are associated with patients reporting lower levels of healthcare-related trust, satisfaction and communication (Ben et al., 2017). For example, in 2023, the Australian Institute of Health and Welfare (AIHW) reported that 32% of Indigenous participants who did not access health services when they needed to, indicated that this was due to discrimination and experiences of culturally unsafe care (AIHW, 2023).

For many Aboriginal and Torres Strait Islander patients, both collective and individual experiences of mistreatment in hospitals have led to avoidance or delays in seeking care

(Yashadhana et al., 2020; Scrimgeour & Scrimgeour, 2007).

Any delays in seeking care can lead to poorer clinical outcomes.

The lack of confidence in the health system to provide safe and appropriate care contributes to high rates of 'failure to attend' or 'take own leave', including where those attending emergency departments 'did not wait' to receive treatment, 'left at their own risk ', or 'discharged against medical advice'(Oribin et al., 2024; Askew et al., 2021; Dwyer et al., 2016). For some patients these experiences are so distressing that they may discharge or avoid seeking care altogether knowing that this could lead to worsening health conditions or in some cases may have fatal consequences (Artuso et al., 2013).

As one Cultural Safety Survey Participant said: "We only ever go if we are really sick and can't travel to a different hospital. I know some elders who just don't go at all cause the treatment is so bad"(Elvidge, 2020).

Current framing of care disengagement often attributes responsibility to Indigenous patients rather than examining systemic drivers, such as cultural unsafety or discriminatory practices within hospitals. This misinterpretation reinforces prejudice and can lead to punitive denial-of-service measures, further entrenching inequities in access and outcomes (Durey et al., 2012). Racism, culturally unsafe care and the resulting barriers to equitable access have direct and compounding impacts on Indigenous health outcomes.

### Clinical decision making and quality of care

Racism interacts with cognitive biases, affecting clinicians' behaviour, clinical decision making and in turn, patient behaviour and experiences of care (Dehon et al., 2017; Van Ryn et al., 2011).

Australian studies have demonstrated that racism and bias compromise the quality of care received by Aboriginal and Torres Strait Islander patients in the diagnosis and treatment of a range of conditions (Cunningham, 2002). This includes disparities in the diagnosis, treatment and survival of cancer patients (Tapia et al., 2019; Gibberd et al., 2016; Diaz et al., 2015; Gibberd et al., 2015; Hall et al., 2004), cardiovascular disease risk screening and procedures (Lopez et al., 2014a; Lopez et al., 2014b; Coory & Walsh, 2005), referrals to cardiac rehabilitation (Hamilton et al., 2016) and organ transplantation (Dole et al., 2018; Cass et al., 2003).

In another example, Indigenous patients experience longer waiting times for elective surgeries, and are also less likely to have medication reviews on admission or follow-up appointments compared with non-Indigenous patients (O'Brien et al., 2021; Epari et al.,2010).

Disparities in quality of care are not observed among Indigenous patients who are incorrectly identified as non-Indigenous, suggesting that racism and clinician bias are likely key drivers of these inequities (Mahoney, 2017).

### The socioeconomic and physiological impacts of racism

Internationally, racism is recognised as a social determinant of health, directly impacting on health inequalities and health outcomes. Both the World Health Organisation (WHO) and the United Nations (UN) recognise the significant impacts of racism at the individual as well as

societal levels, and the importance of addressing racism as a fundamental human rights issue (WHO, 2024; Egede et al., 2024; Nakata, 2001).

First Nations peoples worldwide experience disproportionate impacts of racism, and in Australia this is particularly evident within the health system (Paradies, 2018).

Racist and culturally unsafe interactions within the health system are direct contributors to poor health outcomes, influencing both the quality of care provided and the willingness of members of communities to continue to engage with health services (Gatwiri et al., 2021; Kairuz et al., 2021; Kelaher et al., 2014).

The pervasive nature of institutional racism within the health system renders hospitals unsafe for many Aboriginal and Torres Strait Islander people, leading them to view both system and its staff as untrustworthy (Blignault et al., 2021). Racism also has a direct impact on health.

Psychological Impacts: Racism contributes to psychological distress through harmful cognitive and emotional responses, including fear, rumination, hyper-vigilance, anxiety and depression (Paradies et al., 2015). In addition, racism within healthcare settings has been linked to higher levels of psychological distress than racism experienced elsewhere (Kelaher et al., 2014).

Racism can also negatively impact health protective behaviours through the reduced participation in healthy activities (exercise and sleep) and can increase the likelihood of engaging in health risk behaviours (smoking, drug and alcohol consumption) as a psychological coping mechanism (Priest at al., 2013).

Physiological Impacts: The physiological impacts of racism arise through activation of the body's stress response and through increased engagement in health risk behaviours (Paradies et al., 2015). This leads to increases in blood pressure and an increased probability of developing chronic diseases, such as cardiovascular disease, asthma and diabetes (Powell-Wiley et al., 2022; Martinez et al., 2021; Kairuz et al., 2021; Ewen, 2025).

It has also been reported that women exposed to racism in the year prior to giving birth are more likely to have a baby with low or very low birth weight, a significant risk factor for adverse health outcomes across the life course later in life (Collins et al., 2004).

Racism can also result in physical injury, through racially motivated violence and hate crimes (Alexander, 2021).

Socioeconomic Impacts: At the systemic level, racism can lead to the denial of resources and services through the reduced access to education, employment, housing, and healthcare as well as increased exposure to risk factors such as unemployment, homelessness and avoidable contact with police (Berry,2020).

At a societal level, racism carries far reaching socioeconomic consequences, being associated with higher rates of disability, reduced social cohesion and inclusion, lower economic productivity and returns on educational investment (Elias et al., 2021).

# Government responses and accountability

## Strategic policy priority

Despite being a key policy priority at both the national and state levels, efforts to close the gap in health outcomes between Aboriginal and Torres Strait Islander and non-Indigenous Australians have largely failed (Commonwealth of Australia, 2024; Commonwealth of Australia, 2019; ABC, 2025; CoP, 2025).

This lack of progress reflects the persistence of underlying drivers of health inequity. For example, the AIHW estimates that over a third of health outcome disparity is attributable to the absence of cultural safety in health services as well as cultural and historical factors, such as racism and intergenerational trauma (AIHW, 2024).

Systemic shortcomings within the Australian health system have created services that are profoundly unsafe for Indigenous people, with the 2021-2031 National Aboriginal and Torres Strait Islander Health Plan recognising the urgent need for reform (Australian Government DoHA, 2021).

While the 2013-2023 Implementation Plan called for cultural safety to be embedded across the health system to advance health equity, progress has been inconsistent, leaving significant gaps in achieving this objective.

In addition, a critical weakness identified in the 2013–2023 Plan was the absence of indicators to measure cultural safety, underscoring that without robust metrics, progress cannot be tracked or accountability ensured (DoH, 2015).

## Government legislative framework

Across all levels of the Australian health system, numerous laws, policies, guidelines and position statements affirm a zero-tolerance approach to racism. For example, according to the Racial Discrimination Act (1975) it is unlawful to do or say something in public that is reasonably likely to offend, insult, humiliate or intimidate a person or group because of their race, colour, or national or ethnic origin.

Similarly, there are anti-discrimination laws in the workplace that state that it is illegal for employers to allow discrimination and harassment to occur within their organisations (Anti-Discrimination NSW, 2024).

Australian hospitals have a legal and ethical responsibility to provide racism and discrimination-free healthcare. This obligation stems from a number of legal instruments, including the Racial Discrimination Act 1975, which prohibits discrimination based on race, cultural descent, or national or ethnic origin in the provision of goods and services, including healthcare.

Nevertheless, a current class action has been filed against Queensland Health, alleging breaches of the Racial Discrimination Act 1975. The case centres on claims that Aboriginal and Torres Strait Islander patients received substandard care and had their concerns dismissed, raising broader questions about systemic practices and their impact on health equity (NITV, 2025).

Individual cases of racism, negligence, or malpractice have also been identified through coronial inquiries with some cases pursued through civil litigation (Newhouse et al., 2023). While many focus on the provision of substandard care rather than explicitly citing racial discrimination, they nonetheless raise concerns about equity and cultural safety.

For example, in a recent NSW case, the NSW Duty State Coroner found that an Aboriginal man died from a treatable condition following a flawed triage process at Cowra District Hospital, in an environment described as lacking cultural safety **(**About Regional, 2025).

*"Discrimination on the basis of race in the provision of health care and associated services is unlawful. This includes when a person is treated unfavourably because of their race (known as 'direct discrimination') or when an unreasonable requirement, condition or practice is imposed on a person and it has a disadvantageous impact on them because of their race (known as 'indirect discrimination'; see Equal Opportunity Act 2010 (Vic) ss 8, 9).22 A person who has experienced racial discrimination can lodge a complaint at their local antidiscrimination commission or at the Australian Human Rights Commission. Provided the complaint has substance and falls within the boundaries of the legislation, the agency will attempt to resolve the claim without the need for a formal court hearing (see Australian Human Rights Commission Act 1986 (Cth) s 46PH). The parties can agree to settle the complaint on their terms, which may include compensation, an apology, access to services that were denied or changes to a policy or practice." -Troung et al., 2021.*

Racial discrimination laws vary by state and territory, generally building on or adding to federal legislation. In Australia there are ten state and federal organisations who are responsible for handling complaints, including those of racism, against health services or health practitioners (Troung et al., 2021).

State and Territory anti-discrimination bodies typically handle healthcare complaints within their jurisdictions. With the exception of New South Wales and Queensland, health professions that have registered under the National Registration and Accreditation Scheme are required to comply with the Australian Health Practitioner Regulation Agency (Ahpra, 2019a) Code of Conduct which condemns discrimination and racism in practice (Milligan et al., 2021). Despite a seemingly universal zero-tolerance stance on racism, Indigenous peoples continue to experience high levels of racism. Notably, only one doctor has ever been deregistered for racist behaviour (Ahpra, 2023).

## Antidiscrimination in healthcare

Despite numerous policies aimed at preventing and managing workplace racism, enforcement is inconsistent and their effectiveness in deterring racist behaviour remains limited. Evidence from Indigenous staff, as well as patient and community accounts indicate that racism in Australian hospitals is a universal issue, occurring frequently, in a variety of forms and often going largely unchallenged (Elvidge, 2020; Johnstone & Kanitsaki, 2008). Racism negatively impacts the attraction, recruitment, retention and leadership opportunities of the Indigenous health workforce (CATSINaM, 2022).

**Overview of healthcare complaints process**

*"Complainants are generally advised to first raise a complaint directly with their health service provider, before referring the complaint to relevant state or federal organisations if they are not satisfied with the response. Complaints are then reviewed and either accepted or rejected for further action.*

*Actions include referral to another entity, local resolution, investigation, conciliation or restriction/suspension of health provider registration. Although we identified evidence of collaborations between state and national organisations responsible for the collection and reporting of health practitioner notifications, we are unaware of any similar collaborations between the state-based organisations primarily responsible for complaints relating to health services. Data collected as part of this complaints process form a critical resource for understanding experiences of racism within the healthcare system and how such complaints are handled".* - Troung et. al. 2021.

## Organisational level responses to racism

At the organisational level, mechanisms for reporting racism in hospitals face significant shortcoming. At the core of these issues lies the inherent power disparity between patients and hospitals where reporting pathways are poorly promoted, difficult to access, and marked by unclear processes. In addition, they rely heavily on the written format that demand high levels of literacy to navigate and may not be culturally appropriate (Elvidge, 2020; Troung et al., 2021).

Many Indigenous patients describe being reluctant to report racism out of fear of experiencing further repercussions, a lack of trust in the reporting process and hospital system (Wylie & McConkey, 2019).

There is also the potential for people to become further traumatised through the complaints and investigation process (Diop et al., 2021). This contributes to the significant underreporting of formal complaints, which in turn, fails to capture the high levels of racism in healthcare settings documented in both media reports and scientific studies (Johnstone & Kanitsaki 2010).

Most complaints that enter the formal reporting process are not independently investigated or acted upon, often being dismissed or minimised (Kirkland & Hyman, 2021). The handling of racism complaints in hospitals is affected by inherent biases, raising ethical concerns.

In response, Aboriginal Community Controlled Health Organisations (ACCHOs) and community groups have called for independent, accessible, and culturally safe reporting mechanisms (Peucker et al., 2023).

For example *Call It Out* is a program run by the Jumbunna Institute for Indigenous Education and Research (University of Technology Sydney) providing a simple and secure way for people to report incidents of racism and discrimination towards First Nations Peoples (Allison & Cunneen 2022).

## Limitations of racism and complaints data

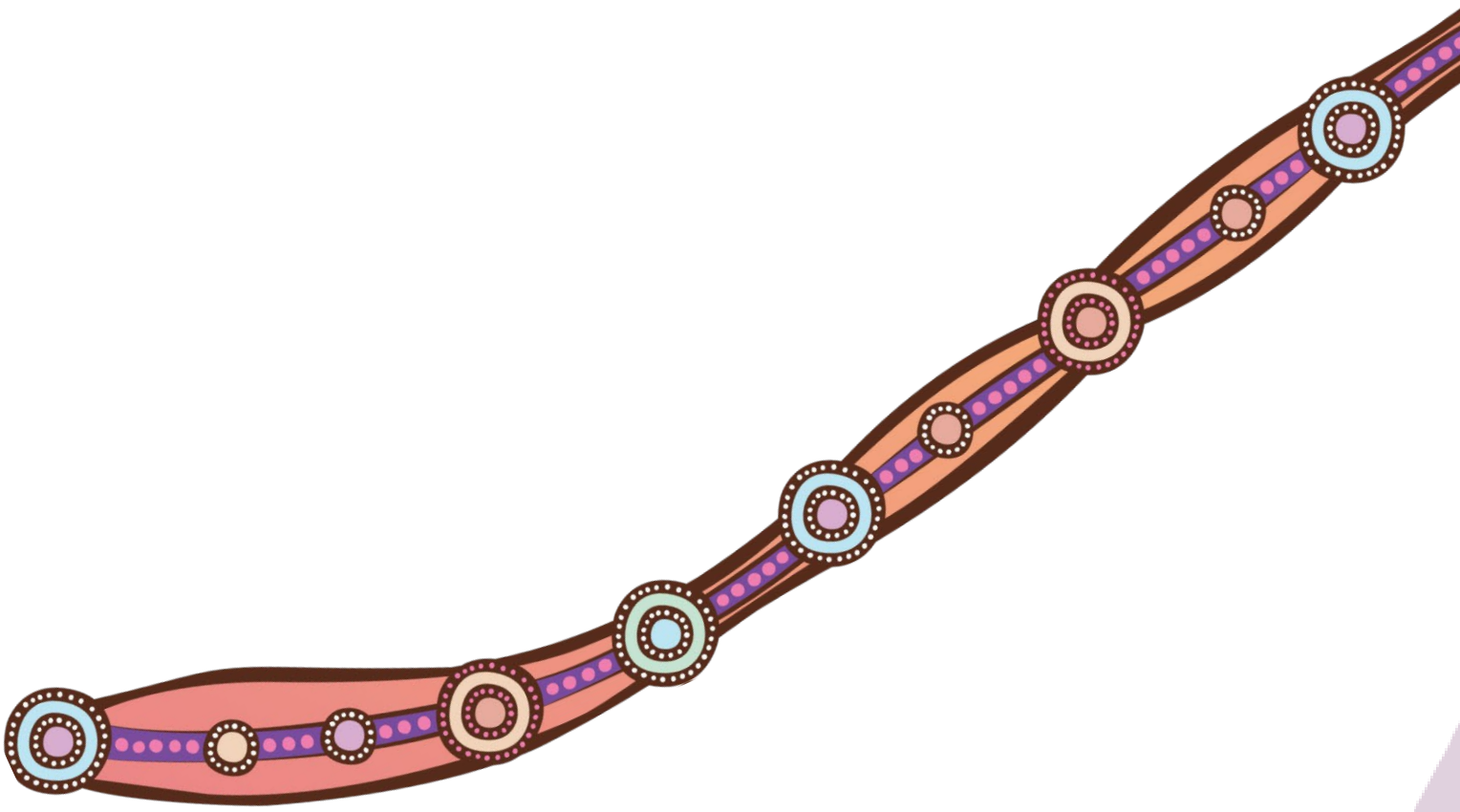
Although programs of this type are a useful way of collating evidence, as well raising awareness, there is ultimately no formal accountability mechanisms for those health services who are found to be racist, let alone any requirement for organisations to

demonstrate how they have responded to or acted on reports.

Health services have a duty of care to provide reporting systems for experiences of racism that are accessible and easy to navigate. These systems should offer multiple options for reporting (e.g. verbal and written) and provide confidential support coordinated by staff who are culturally competent and knowledgeable about racism and cultural safety (Smith & Simon, 2025).

Furthermore, any mechanism for reporting racism in hospitals should be pragmatic (similar to processes for reporting sexual harassment) and impartial.

At a federal level significant gaps exist in national data on ethnicity, race and racism. Unlike Canada, Aotearoa (New Zealand) and the United States, other than Indigenous status Australia doesn't have a standard way of classifying race and ethnicity. These deficiencies in data hinder efforts to address racism by limiting the capacity to evaluate the effectiveness of anti-racism and cultural safety initiatives (Demant et al., 2024).



# Measuring and monitoring racism

## Measurement of cultural safety

Without a robust and transparent basis to measure the cultural safety of and racism in Australian hospitals from the perspective of Indigenous individuals, identifying service failures, priorities for improvement, and the impact of remedial measures, is impossible.

Historically, approaches to assessing cultural safety in healthcare settings have been unsuccessful for one of two principal reasons. Either, they have failed to:

- preference the perspectives of those with lived experience of racism, or
- provide robust, reproducible measures that can guide systemic reform.

The National Agreement on Closing the Gap identifies four priorities regarding the delivery of safe and effective healthcare for all Australians:

- shared decision-making.
- community-control.
- transformation of government organisations; and
- improved data access for communities.

Achieving these goals, however, will provide little benefit if Aboriginal and Torres Strait Islander people remain unable to interact with health services safely. To assess the extent of cultural safety within existing services and to determine the impact of service reforms an appropriate and robust system of appraisal is essential (Elvidge et al., 2025).

To date, attempts to develop such systems have been one of two type:

- Health system-centred, metrics-based approaches
- End-user centred, experience-based approaches

**Health system-centred, metrics-based approaches** have been preferred by providers and administrators as they produce readily interpretable results (outputs) that help identify reform priorities (Hurst & Jee-Hughes, 2001).

However, such approaches typically employ high thresholds for defining racism (e.g. formal complaints), lack methodological transparency, and are susceptible to selective interpretation (Truong et al. 2021). Importantly, they fail to reflect the perspectives of those with lived experience of racism in healthcare.

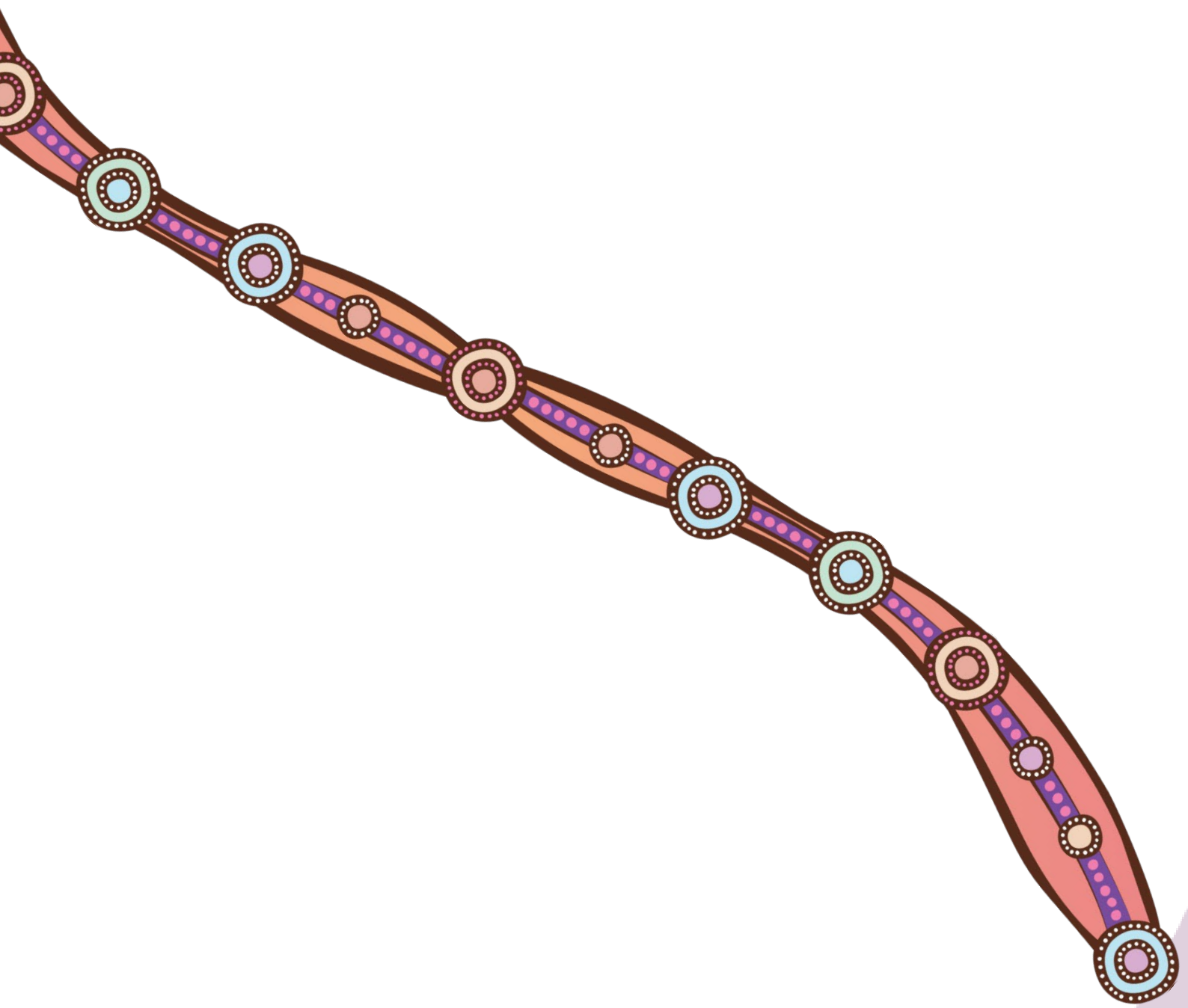
In contrast, **end-user centred, experience-based approaches** are increasingly being adopted, reflecting a growing recognition of the importance of lived experiences in the evaluating racism and cultural safety (Smylie et al., 2006).

However, in most cases, these approaches are wholly qualitative, with little capacity for ready comparison within or between settings, or to inform health service reforms directly (Joseph et al,. 2020).

Current approaches to measuring Aboriginal and Torres Strait Islander patient experiences are insufficient. The absence of an effective basis for appraising cultural safety within healthcare settings can be traced to the

inherent limitations of each of these two types of approaches.

To address this gap and inform effective service reform, it will be essential to systematically measure Aboriginal and Torres Strait Islander patient experiences using both quantitative and qualitative approaches in a in a rigorous way (Elvidge et al., 2020).



# Education and training for a culturally safe workforce

## Limited knowledge of cultural safety impedes policy implementation

While decades of research have focused on how power, privilege and racism in the health system propagate health inequalities, as of 2025, Australia still lacks a clear definition of cultural safety in health policies.

The absence of such a definition translates to a lack of awareness, understanding, and recognition of cultural safety as key social determinant of health and undermines the ability of the current and future health workforce to provide culturally safe care (Brumpton et al., 2022).

For these policies to be effective in addressing social and cultural determinants of health they need to be written by Aboriginal and Torres Strait Islander people (Veasy et al., 2025). Whether or not a healthcare experience is culturally safe is entirely determined by the patient and, in some cases, their family and community.

Shaped by the principles of the *Treaty of Waitangi*, cultural safety was developed as both a concept and an approach in the late 1980s by Māori nurses in Aotearoa (New Zealand) in response to the lack of cultural respect and consideration in the predominantly Pakeha (non-Indigenous) mainstream healthcare system (Ramsden, 1993; Taylor & Guerin, 2019; Ramsden, 2002).

Since then, cultural safety has been widely applied in health systems internationally, primarily with Indigenous populations, and utilised in social policy to include other marginalised communities that experience systemic discrimination (Brascoupé, 2009; Crameri et al., 2015; Blanchet et al., 2018).

In the Australian healthcare context, cultural safety primarily provides a decolonising model of practice based on communication, negotiation, power sharing and the acknowledgement of institutional racism. The delivery of culturally safe health services is crucial in enhancing personal empowerment and therefore should promote more effective and meaningful pathways to self-determination for Aboriginal people (Williams, 1999).

However, achieving self-determination through processes such as sovereignty and shared decision-making are impossible to achieve in the absence of any meaningful structural change in a system that is fundamentally unsafe (Bryant, 2024).

## Poor understanding of cultural safety in mainstream health

Cultural safety has been conceptualised as a model of care, a theory, a process, an approach to service delivery and an outcome of the quality of care provided (Gerlach, 2012). However, an element of conceptual ambiguity around the term has resulted in a lack of further attempts to clarify its definition, and in its ambiguous implementation at the organisational and systemic level (Cox & Best, 2022; Johnstone & Kanitsaki, 2007).

Only recently have a few consensual definitions of cultural safety emerged in Australia context, with some professional

health associations attempting to define cultural safety.

While Ahpra's definition focuses on culturally safe practice, conceptualising cultural safety from the health practitioner perspective, there is also a need to define what cultural safety means from the health policy and organisational level so that it can be effectively operationalised and implemented through service provision.

**Ahpra definition of cultural safety**

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.

Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism (Ahpra, 2019b).

Furthermore, a systematic review of cultural safety definitions found that any definition must also recognise both individual and organisational attributes essential for implementing cultural safety; and it must embed the principles of decolonisation as a foundation for advancing health equity (Curtis et al., 2019).

A culturally safe healthcare system is therefore one in which professionals and organisations engage in continuous self-reflection, self-awareness, and accountability.

## Cultural safety is health equity

Cultural safety is defined by patients and their communities and is measured by progress toward health equity. Achieving cultural safety also requires influencing workforce policies and organisational practices to reduce bias and promote equity within healthcare settings (Curtis et al., 2019).

Based on this definition of cultural safety, which has been practically applied and developed in Aotearoa (New Zealand) since 2019, refinements in understanding cultural competency, cultural safety, and Indigenous health have been made, especially in relation to regulatory bodies (Curtis et al., 2025).

The core of cultural safety, as has been argued, is the critical examination of power dynamics, including power and privilege. This approach emphasises that power must be shifted to patients and communities, enabling them to evaluate the cultural safety of their own healthcare.

This shift also highlights the need for healthcare systems to acknowledge and address power imbalances to create the conditions where culturally safe care is possible.

While self-reflection is a key aspect of cultural safety, relying solely on it for training and assessment is insufficient and that the challenge lies in developing structured tools and objective measures to evaluate cultural safety (Curtis et al., 2025).

Although training initiatives offer some guidance with components like clinical audits and transformative change plans, formal assessments, especially beyond workforce training, are lacking.

To ensure consistent and rigorous evaluation, future development in cultural safety education must prioritise creating robust assessment methods comparable to those used for other essential healthcare competencies (Mohamed et al., 2024).

## Improving cultural safety knowledge to strengthen health policy

Despite an emphasis on culturally safe service provision, Australian hospital staff continue to have a poor understanding of the term and its application.

For example, qualitative research carried out with hospital staff from across NSW, and across a range of roles, found that while the majority of staff were aware of the term cultural safety but could not define it. There were also staff who candidly expressed racist views during interviews (Elvidge, 2020).

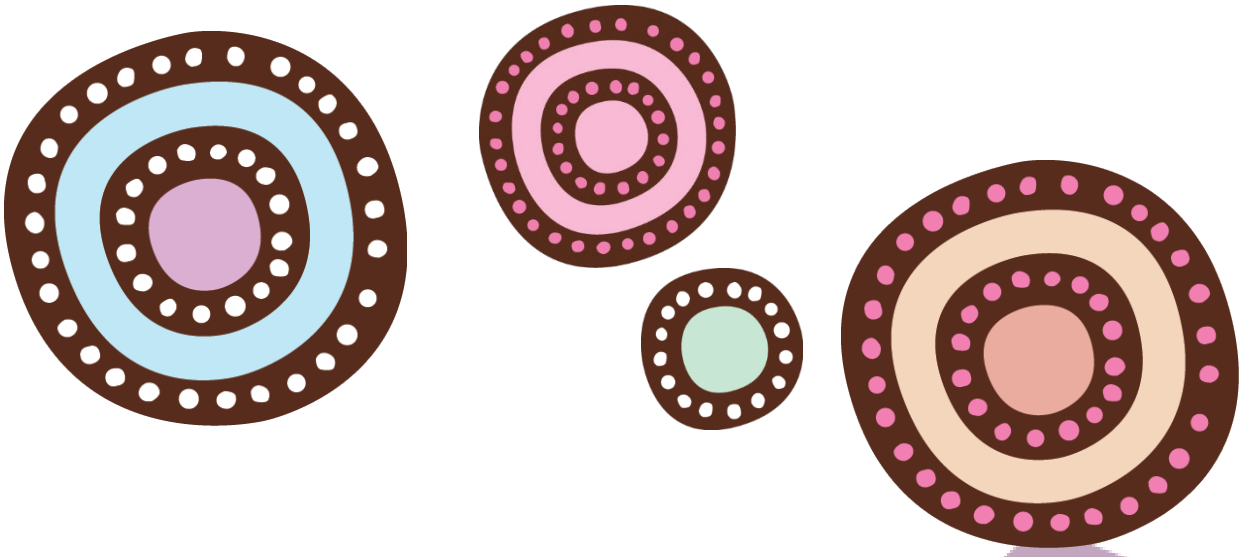
Addressing bias and racism, both at the institutional and individual, is challenging but not impossible. It requires a fundamental shift in medical culture and the health system where instead of Indigenous health inequalities being portrayed as a reflection individual and community deficits, they are instead characterised as a deficit of an unsafe and inequitable health system.

## Decolonising and redefining cultural safety education and training

Staff education and training for cultural safety is an essential first step in enabling individual health professionals to deliver culturally appropriate care (CATSINaM, 2017; Gurm & Cheema, 2013). Yet training, identified as cultural safety training, often does not cover the basic elements of cultural safety (Mohamed et al., 2024).

Unlike other culture-based approaches, cultural safety cannot be easily 'taught', nor can health professionals attain a definitive certification in cultural safety (Rix et al., 2024; Arieli et al., 2012). Instead, it represents a lifelong process of learning and unlearning. What constitutes culturally safe care varies between individuals, evolves over time, and is influenced by context (Hendry et al., 2025).

What one community see as culturally safe care might be different to another so any assessment of cultural safety must be place based and engage with service users in an iterative way as issues and priorities change.



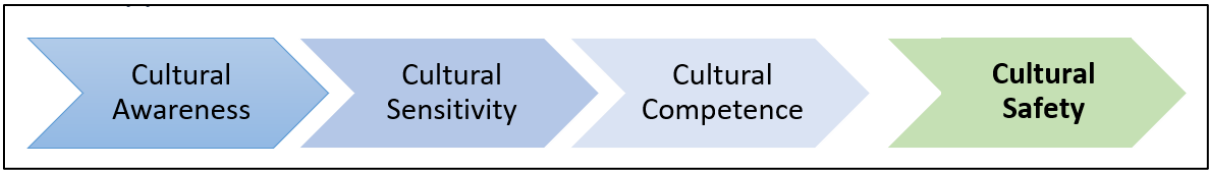



*Figure 1. Cultural continuum of learning (Dell et al., 2016)*

Basic-level cultural training programs aim to develop cultural awareness by highlighting how culture influences both the delivery and experience of care, forming the foundation for further learning along the cultural continuum.

**Cultural awareness** is considered a prerequisite for health service education, as it underpins deeper understandings of culturally responsive approaches.

**Cultural sensitivity** emphasises the importance of recognising and responding to patients' unique cultural needs, with some training providers incorporating cultural immersion experiences to enhance awareness and sensitivity.

**Cultural competence** represents a more advanced stage, focusing on education at both individual and organisational levels and enabling institutions to integrate cultural knowledge into service delivery, sometimes referred to as cultural capability training.

A key distinction between cultural competence and **cultural safety** is that competence is often framed as an endpoint, defined by organisations or training providers, rather than cultural safety which determined by the individuals receiving care (Canadian Government, 2023)**Cultural safety requires critical self-reflection**

## Cultural safety requires critical self-reflection

Critical self-reflection is a defining factor that differentiates cultural safety from cultural competence and other entry level culturally based approaches (Browne et al., 2009). Yet, critical self-reflection is often the missing element in standard cultural safety training courses (Mohamed et al., 2024).

Cultural safety requires healthcare professionals to reflect not only on the patient's culture and experience of health and illness but also on their own cultural perspectives and how they may influence their care and treatment of the patient. This process involves self-reflection on one's own cultural identity (Hall et al., 2023).

It also requires an understanding of the power imbalances inherent in the relationship between clinicians and patients, especially when the clinician is from a dominant culture and the patient is from a marginalised group; and for individuals to reflect on how their own cultural perspectives and unconscious biases may influence the way they provide care (Dawson et al., 2022; Baker & Giles, 2012).

From a cultural safety perspective, when staff regularly engage in critical self-reflection on their care practices, they become better equipped to build trust with patients, and to recognise and respond to racism, both interpersonal and institutional (Kurtz et al., 2018). Cultural safety acknowledges that the way in which routine care is provided may not

suit all patients particularly if they are Indigenous or from a non-Anglo Australian background.

There is a need for cultural safety training to recognise the role of colonisation, cultural bias, privilege and power in the design, administration and delivery of health services. Internationally, reflection and cultural safety is built into routine practice.

For example, in Aotearoa (New Zealand), the Health Practitioners Competence Assurance Act 2003 (HPCA Act), specifically section 118(i), mandates standards for clinical and cultural competence, including interactions with Māori, for all health practitioners. As part of retaining professional registration midwives are required to reflect on their care provision and demonstrate how they believe they have provided culturally safe care.

## Approaches to Indigenous health policy and training are inconsistent

In Australia, there are fundamental limitations in the design of Indigenous health policies and health service performance frameworks. This is due to the limited, or no involvement of, Aboriginal and Torres Strait Islander people in their design; and which is further exacerbated by tokenistic consultation with first nations people, misrepresented as co-design.

This is partly driven by short development timeframes and limited resourcing for Indigenous-led policy initiatives (Veasey et al., 2025; Bryant, 2024).

For example, policy frameworks addressing racism and cultural safety require hospital staff to undergo various forms of training. Yet there are no consistent standards, quality control or a standardised platform for accrediting cultural safety training in Australia. This absence of quality standards has led to a range of different approaches with varying degrees of evaluation and efficacy (Hardy et al., 2023).

### NSW Health Respecting the Difference

Respecting the Difference is a mandatory cultural awareness training program for all NSW Health staff, designed to improve cultural competency and promote respectful, responsive, and culturally safe healthcare for Aboriginal people.

However, an evaluation of the Respecting the Difference education program (commissioned by NSW health) identified significant shortcomings in its implementation, uptake, and overall effectiveness. Institutional commitment, resourcing limitations, trainer expertise, and the quality and structure of the content were also identified as major challenges. In addition, the training across this program was often delivered by Aboriginal staff, some of whom were reassigned from frontline duties. In doing so, Indigenous staff were repeatedly exposed to racism and culturally unsafe environments themselves, with little recognition or support (Power, 2015).

Despite these findings program, Respecting the Difference, continues to be implemented in NSW.

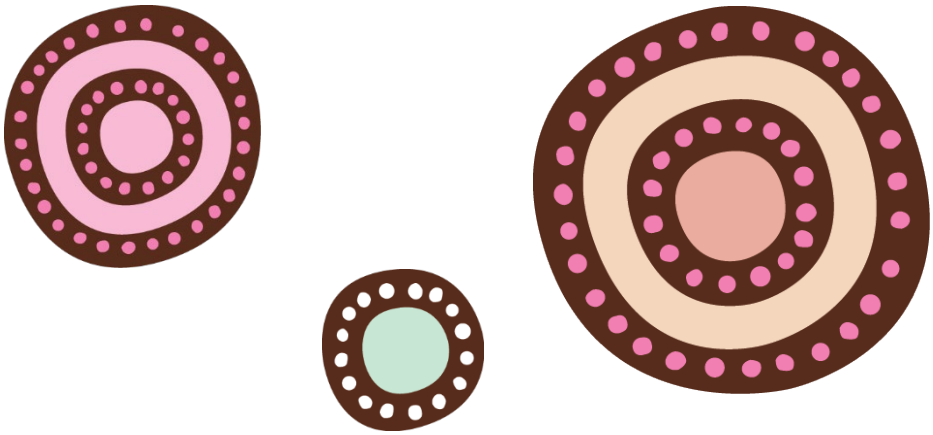
## Evidence based cultural safety training

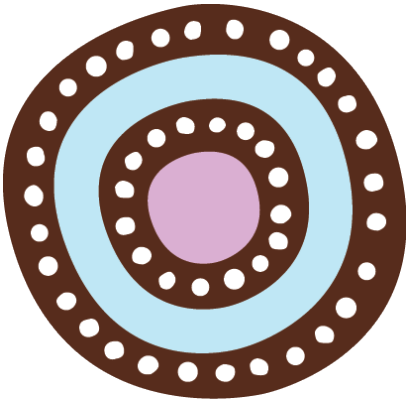
In Australia cultural safety training is unregulated and there are no standards for content or for trainers to have any specific teaching qualification. Evaluation of training is very rarely undertaken. Consequently, it is unclear if education and training to deliver these programs translates into a meaningful

understanding of cultural safety (Muller et al., 2024).

A systematic review of cultural safety training interventions for healthcare professionals in Australia, Canada, Aotearoa (New Zealand) and the United States found that there was very little evidence that training for non-Indigenous health professionals effectively improves their ability to provide quality, non-discriminatory care to Indigenous patients (Hardy et al., 2023). However, more rigorous research is needed to understand how cultural safety training impacts clinical outcomes (Demant et al., 2024). The research should also evaluate how well such training aligns with the health and community priorities of Aboriginal and Torres Strait Islander peoples at local, regional, and national levels.

Of those cultural safety training programs that are evaluated, most rely on self-reported measures, typically assessing changes in participants' attitudes, knowledge, or confidence through pre- and post-training surveys, rather than examining their impact on clinical outcomes (Muller et al., 2024).





# Strengthening accountability and policy implementation

## A reluctance to acknowledge racism in health

Racism in health services continues to be largely disregarded at both the interpersonal and institutional levels, despite, the historical and societal impacts of racism being acknowledged (Watego et al., 2022). The tendency to downplay racism in health care settings is described as the 'illusion of non-racism in health care' or the perpetual myth that racism rarely occurs in formal settings such as hospitals (Johnstone & Kanitsaki, 2009).

Collective ignorance of racism is pervasive within health institutions, posing a significant and harmful challenge. Australian and international qualitative studies found that irrespective of roles, healthcare professionals overall, have a poor understanding of racism, as well as a tendency to minimise its impact (Wright & Haysom, 2023).

While there's growing recognition of racism's role in healthcare disparities internationally, our understanding of its prevalence in health care settings in Australia and how to effectively measure it remains limited. More advanced strategies are needed to record complaints, monitor racism and inform interventions to address racial inequities in health outcomes.

## Ineffective reporting and complaints

Reporting on racism in healthcare is significantly hampered by mechanisms that are often inaccessible and culturally unsafe, leading to a widespread underreporting of incidents. Systems for making formal complaints about racism are ineffective (Dafny et al., 2025).

Barriers to and limitations of this process include a lack of universal procedures across organisations and jurisdictions. In the Australian healthcare system, the process for reporting is unclear, difficult to navigate and there is no accountability or independent oversight over the manner in which reports are arbitrated.

For those individuals that report incidents of racism, there is a risk that those managing healthcare complaints do not have a sufficient understanding of racism to be able to make accurate assessments. This results in valid complaints being dismissed before they are registered, adding to the issue of data integrity and underreporting (Troung et al., 2021).

Staff lack the knowledge and confidence to properly assess racism complaints, likely because the everyday definition of racism is limited to a conscious dislike of people based on race, manifesting in overt behaviours.

To address this knowledge gap, staff responsible for registering, handling, and responding to racism complaints should undergo education and training that includes a clear definition of what constitutes racism. In addition, this training should stress that racism is not just confined to discrete acts but is also related to the collective norms of the dominant culture, a system in which individuals are socialised from an early age and throughout their lives. Increasing awareness in health services around instances of

institutional, covert and culture-based manifestations of racism is needed.

## Data integrity and organisational accountability

Data from racism complaints reveals a deeply embedded policy issue within the health system. That is, racism in the Australian health system creates a vicious cycle where the absence of a shared understanding and robust systems to address racism leads to poor data integrity, which in turn erodes organisational and government accountability.

This lack of accountability then ensures the systemic issues of racism persist, continuing to harm patients, staff and communities. Moreover, it allows those in positions of power in the health system to continue to deny the existence of racism and its impacts (Sim et al., 2021).

This denial of the presence and prevalence of racism in turn reduces the scope for institutional responses to racism and cultural safety. This is complicated by the inherent conflict of interest when institutions and departments investigate themselves. If complaints are substantiated that this could leave the institution open to litigation (Goetz, 2022).

There have also been instances where the mismanagement of complaints has resulted in reinforcing racism and racist practices. For example, there have been several cases where those who report racism or those who experience racism are reprimanded rather than the perpetrator (Elvidge, 2020).

## Anti-racism policy

While there are options for making complaints externally through professional bodies these options are less visible to the general public and carry limitations. For example, the Human Rights Commission's complaints handling process was deemed ineffective in the 2024-2025, Auditor-General's report. This conclusion was based on the rising number of complaints being terminated or discontinued (Australian National Audit Office, 2025).

Ahpra recently published their Aboriginal and Torres Strait Islander Anti-Racism Policy (2025), which includes guidelines for handling racism complaints that are trauma informed and grounded in the principles of Indigenous sovereignty, governance and culture.

Unlike other policy documents it provides practical definitions of racism along with real world examples of workplace racism.

Furthermore, Ahpra's policy outlines individual employee responsibilities for responding to racism with culturally informed resolution pathways and comprehensive complaints management guidelines (Ahpra, 2025).

## Institutional racism in hospitals

Addressing interpersonal racism by improving the accessibility and accountability of formal complaints processes is one part of a multifaceted strategy for addressing racism in healthcare. It has been argued that common definitions and institutional responses to racism fail to address structural racism (Atrey, 2021).

Although the cumulative data from individual complaints can form part of overall indicators of organisational and institutional racism other structural level indicators should also be utilised (Demant, 2024). For example, disaggregating health outcome and quality of care disparity data could form part of broader

indicators of institutional and structural racism.

There are existing tools for measuring and monitoring institutional racism. For example, the Bukal Institutional Racism Matrix, an organisational assessment tool designed to audit indicators of institutional racism in the public health system (Bourke et al, 2018). The Matrix assesses characteristics such as:

- Indigenous participation in health service governance,
- Closing the Gap policy implementation,
- staff participation in cultural competency training and community engagement.

The Matrix aims to identify the institutional barriers to health equity for Aboriginal and Torres Strait Islander people, so that health services can address the barriers through strategies that are designed to combat institutional racism.

To date the Matrix has been used to assess 16 health facilities in Queensland and 10 health districts in South Australia (Marrie, 2017; Health Performance Council, 2020).

It should be noted that follow up studies to ascertain whether institutional racism scores had decreased post matrix assessment are not yet publicly available.

## Strategies to address racism

Culturally safe, robust and transparent mechanisms for reporting, measuring and monitoring racism are a key step for the government to work towards achieving the ambitious goal of eliminating racism in the Australian health system.

Without comprehensive and reliable data on the levels of and nature of racism it is impossible to see if current anti-racism initiatives are effective. Although policies and public statements about a zero tolerance for racism are a necessary starting point it is the results of the actions, resourcing and implementation of these policy statements which are the true indicators of progress towards this goal. Anti-racism requires more than being opposed to racism. It requires a conscious effort and deliberate actions to identify and challenge racism at both the individual and systemic level (Watego et al., 2025).

Racism, at every level whether conscious or unconscious, is considered a social determinant of health and can lead to access barriers, poor-quality health care and adverse psychological and physical effects (Kelaher et al., 2014; Paradies, 2018). The more that racism remains unacknowledged, unchecked and unchallenged, the less culturally safe hospitals will be and health disparities will continue to grow.

An anti-racism strategy is an “action oriented, educational and/or political strategy for systemic and political change that addresses issues of racism and interlocking systems of social oppression” (Hassen et al., 2021).

Anti-racism actions can come in many forms, including:

- individual transformation,
- organisational change,
- community change,
- movement-building,
- anti-discrimination legislation and
- racial equity policies in health, social, legal, economic and political institutions

This definition acknowledges the multiple ways that anti-racism action can occur (Hassen et al., 2021).

# Implementing and evaluating anti-racism and cultural safety policies

Policies to address racism and cultural safety often lack rigorous evaluation and assessment, making it unclear whether initiatives are effective in achieving their intended outcomes. Without measurable impact, policy efforts risk being ineffective or failing to address systemic issues.

A comprehensive implementation plan and guide is needed to operationalise policy objectives at the service provision level, ensuring policies translate into meaningful action and measurable improvements. Government reports and expert commentators have highlighted shortcomings in health policy implementation as a key reason for limited progress in Closing the Gap.

The most recent Productivity Commission report found that only four of 19 targets were on track, with none relating to health outcomes (Australian Government Productivity Commission, 2025).

Similarly, the NSW Auditor General's 2025 performance audit of the Governance of the National Agreement on Closing the Gap is NSW found that there was a need to increase the accountability of NSW Government agencies for implementing the Priority Reforms of the National Agreement (Audit Office of New South Wales, 2025).

Health policies that are designed to improve Indigenous health outcomes and cite the need to address racism and cultural safety lack guidance for real world implementation.

Yet there are several high-profile cases that point to the ineffectiveness of health policies where Aboriginal patients and communities have taken health services to court for institutional racism and culturally unsafe care.

- In 2025, a class action lawsuit was filed against the State of Queensland, alleging discriminatory conduct towards Aboriginal and Torres Strait Islander people by the North West and Torres and Cape Hospital and Health Services. The claim alleges a failure to address systemic racism in hospitals and health services over a 30-year period, despite investigations and inquiries
- In 2025, a racial discrimination lawsuit filed by residents of Wadeye, a remote Aboriginal community in the Northern Territory, against the NT government has been settled, with the residents claiming they were unlawfully denied adequate healthcare.
- Between 2016-2020, The National Justice Project have worked on multiple cases where First Nations people experienced racism and culturally unsafe health care. There were at least 18 cases that related to negligent or inadequate healthcare for First Nations people.
- Several coronial Inquests cited implicit racial bias, systemic racism in health care and compromised quality of care are key contributing factors (Coroner's Court of Victoria, 2000; Coroner's Court of New South Wales, 2019; Coroner's Court of Queensland, 2023; Coroner's Court of New South Wales, 2024).

These examples demonstrate that racism in healthcare is not just an isolated incident but is embedded within the structures and practices of the healthcare system, and that current policy approaches designed to address racism are not working.

## Inconsistent implementation

The lack of detail around how to operationalise health policies renders them ineffective as government bodies, health services and executives who are responsible for enacting these recommendations are left to interpret and implement them in an ad hoc manner. This extemporary policy implementation leads to great variation in how different jurisdictions and individual services approach how these issues are addressed, how health services are designed and delivered.

**Queensland Health:** The Queensland Health Equity Strategy is a key part of the Queensland government's commitment to closing the gap. The Strategy aims to achieve health equity for Aboriginal and Torres Strait Islander peoples by eliminating institutional racism within the healthcare system, increasing access to healthcare services and delivering sustainable, culturally safe and responsive healthcare.

The Strategy is being implemented through a process of co-design and co-delivery with Aboriginal and Torres Strait Islander communities and stakeholders. This implementation will be facilitated through partnerships between the health system, First Nations communities, traditional owners and other relevant services.

A key feature of the framework is that it was legislated through amendments to the Hospital and Health Boards Act 2011 and the Hospital and Health Boards Regulation 2012 and requires hospital and health services to partner with Aboriginal Torres Strait Islander peoples and organisations to design, deliver and monitor the delivery of healthcare in Queensland (Queensland Health, 2021).

However, the recommendations and implementation strategies are broad and approaches are varied with each service required to develop individual strategies and action plans. Given the limited grasp of racism at the government and institutional level, the general resistance to systemic approaches addressing it, and the scarcity of Indigenous anti-racism training programs in Australia it's unclear from these plans how services will fulfil their legislative obligations (Watego et. al, 2025).

**SA Government:** In 2023 the South Australian government's Office of the Commissioner for Public Sector Employment, launched an anti-racism strategy. This strategy focuses on creating a public sector workforce (including health) that is culturally capable and rejects racism. It includes an action plan which aims to address historical, structural and ongoing racism. The SA strategy identifies five key priorities and actionable goals. These include strategies such as mandatory anti-racism training, improving complaints processes, embedding anti-racism into leadership and decision-making (OCPSE, 2023).

A point of difference with this approach and other policies is that it also emphasises accountability and evaluation as it states "The success of the strategy depends on continuous research, evaluation, and monitoring. Evidence must underpin assessment of what works for whom and why. It is important for the public sector to celebrate success and use the lessons learnt for future plans." (pp 19) In the strategy it clearly identifies public sector chief executives as accountable for the implementation of the strategy and goals and that a formal review of the strategy will be undertaken after three years of implementation.

Conversely, in the National Aboriginal and Torres Strait Islander Health Plan and National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan there is there is little or no consideration for rigorous evaluation of policy uptake and implementation, hindering our understanding of their effectiveness. These national health policies do not link goals and objectives to strategies for implementation or performance indicators to evaluate implementation or impact. Policies that proport to address anti-racism and cultural safety have historically lacked follow-through or consistency in application and have been critiqued for not addressing the root causes of racism and culturally unsafe care.

the Australian Human Rights Commission report, The National Anti-Racism Framework: A roadmap to eliminating racism in Australia Report, (024) highlight short comings in policy implementation and provides recommendations to address these limitations, including::

- The Australian Government should prioritise creating a national anti-racism Framework with two distinct Implementation Plans. One plan should focus on the unique experiences of First Nations peoples. Both plans must address anti-racism efforts across all sectors, including health, media, arts, justice, and data.
- The Framework should be built on an intersectional, community-centred understanding of racism that incorporates truth-telling, acknowledging both commonalities and differences in how racism impacts various communities. This approach should guide all anti-racism actions.
- Finally, a nationally recognised definition of First Nations Cultural Safety, with minimum standards for implementation across all sectors, should be developed.

However, without effective implementation, clear lines of accountability and measurable impact, the goals put forward in Aboriginal and Torres Strait Islander health policies limit their capacity to be effectively operationalised and respond to systemic issues.

# Meaningful engagement with Aboriginal and Torres Strait Islander communities in healthcare

Cultural safety in a healthcare involves respecting the cultural beliefs, values, and practices of Aboriginal and Torres Strait patients and integrating those beliefs into policy and practice (Mackean et al., 2020). This requires understanding and valuing Indigenous cultural protocols, knowledge systems, community structures and experiences of accessing healthcare.

However, policymakers, government bodies and hospital executives often resist meaningful engagement with Aboriginal and Torres Strait Islander communities, limiting opportunities for meaningful dialogue on racism and culturally safe care (Thorpe et al., 2016; Davy et al., 2016).

Typically, engagement with Aboriginal and Torres Strait Islander people occurs through Indigenous peak health bodies, advisory committees and consumer representatives who often sit on boards (Luke et al., 2020; Howse & Dwyer 2016). This standard approach to engagement often lacks depth and genuine representation of lived community experiences.

Nevertheless, there are several policies and health service standards that recommend that hospitals and health services engage with communities and consumers in a culturally appropriate, comprehensive and reciprocal manner (DoHA, 2021; Australian Government, 2020; ACSQHC, 2021).

Over the years there have been calls to address Indigenous health inequalities through policy including accreditation standards so that they can more effectively assess and embed cultural safety in health services (Laverty et al., 2017).

## National Safety and Quality Health Service Standards (NSQHSS)

The Australian Commission on Safety and Quality in Health Care are the national body who are responsible for overseeing the National Safety and Quality Health Service Standards accreditation of public and private hospitals in Australia. Standard 2 Partnering with Consumers, has particular relevance for Aboriginal and Torres Strait Islander communities who experience significant health disparities and often face systemic health access barriers (ACSQHC, 2021).

A key aspect of Standard 2 is the emphasis on partnering with consumers to improve the safety and quality of healthcare services. For Aboriginal communities, this means focusing on cultural safety and equity of access. Standard 2 calls for healthcare organisations to actively engage with consumers in a meaningful way and moving beyond tokenistic consultation and establishing true partnerships built on respect, trust, and shared decision-making.

Therefore, engagement processes that inform healthcare design and delivery must be culturally safe and respectful, recognising the unique cultural needs and preferences of Aboriginal and Torres Strait Islander peoples. This includes using appropriate language, ensuring accessibility of information, and

creating welcoming and inclusive environments.

Consultations should ideally be conducted in culturally appropriate settings and facilitated by individuals with a deep understanding of cultural safety.

Standard 2 acknowledges the potential for power imbalances between healthcare providers and consumers. This is particularly relevant for communities who have experienced trauma and disempowerment within the healthcare system.

Engagement processes should actively address these power imbalances by ensuring Aboriginal and Torres Strait Islander consumer voices are heard and respected, and that communities have real influence over decision-making and accreditation assessment.

Standard 2 encourages diversity in consumer representation, ensuring that the views of different community groups are considered. This includes actively seeking out and engaging with Aboriginal and Torres Strait Islander consumers from diverse nations and backgrounds including age, gender and geographical locations.

These Standards promote co-design and collaboration between healthcare providers and consumers in the development and delivery of services. This approach is particularly important for ensuring that healthcare services are culturally appropriate and meet the specific needs of communities. Notably Standard 2 emphasises the importance of seeking feedback from consumers and using this feedback to improve services.

This includes establishing mechanisms for Aboriginal and Torres Strait Islander communities to provide feedback on their experiences of care and ensuring that this feedback is taken seriously and acted upon.

However, even with this recommendation in the standards there is no framework for what these feedback mechanisms should look like and the standards do not require health services to demonstrate that they have these processes.

There are no specific guidelines or requirement in the current Australian standards for what constitutes comprehensive and appropriate engagement with Aboriginal and Torres Strait Islander communities. Guidance for how to renumerate and acknowledge consumers or community for participating in these engagement activities is also absent.

A limitation of the current approach to the assessment of the NSQHS Standards is the absence of uniform performance indicators or defined minimum requirements for demonstrating compliance during accreditation.

### Canadian accreditation model

In Canada there are approximately 1.8 million Indigenous people, representing 5% of the total population. This includes just over 1 million people who identify as First Nations, 620,000 people identify as Métis and nearly 70,000 people identify as Inuit (Statistics Canada, 2024).

Like Aboriginal and Torres Strait Islander peoples in Australian First Nations peoples in Canada face significant health disparities

compared to the non-Indigenous population and stem from complex social, economic, and historical factors, including the lasting impacts of colonisation and systemic racism.

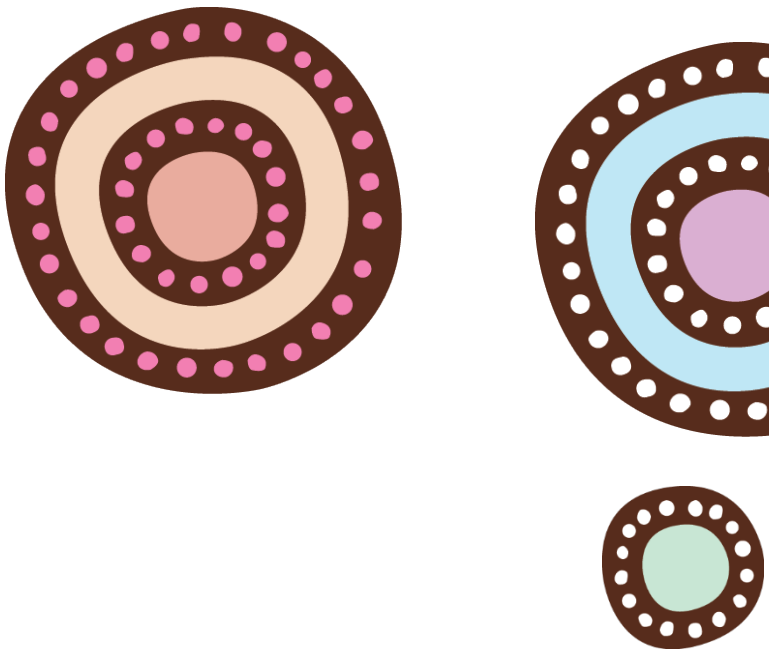
Health disparities include a shorter life expectancy, higher rates of infant and maternal mortality, higher rates of chronic diseases, mental health issues and suicide rates are disproportionately high (Greenwood et al., 2018; Kirmayer & Brass, 2016).

By contrast, Accreditation Canada offer a much more rigorous approach to Indigenous consumer and community engagement. Unlike the Australian models, Accreditation Canada uses a variety of methods to encourage and assess compliance including the British Columbia Cultural Safety and Humility standard, developed in partnership with the First Nations Health Authority. The standard has an explicit focus on addressing systemic racism which includes providing health services with resources, education, and training to support organisations in implementing cultural safety practices.

In Canada, health services seeking accreditation undergo a rigorous assessment process involving document review, on-site visits, and interviews with staff, patients, and community members. Surveyors evaluate the organisation's policies, procedures, and practices against the cultural safety and humility standard. Accreditation results are often made public, influencing an organisation's reputation and public trust (Health Standards Organization, 2022).

This transparency encourages health service organisations to take the standards seriously. Government funding or contracts may be tied to achieving or maintaining accreditation, providing a financial incentive for compliance.

In Australia, The Australian Commission on Safety and Quality in Health Care (ACSQHC) should consider adopting this accreditation model to create greater accountability and transparency in the delivery of Aboriginal and Torres Strait Islander healthcare.



# Conclusion and recommendations

Racism in Australia's healthcare system is a systemic and persistent problem with devastating consequences for the health and well-being of Aboriginal and Torres Strait Islander peoples. Despite numerous policies and laws in place, a lack of clear definitions, consistent standards, and effective oversight has made current efforts to combat racism largely ineffective.

True reform requires a fundamental change in approach, moving away from fragmented, superficial measures toward a unified, data-driven, and Indigenous-led strategy. By standardising education, strengthening accountability, and genuinely empowering communities to shape their own healthcare experiences, Australia can begin to dismantle institutional racism and build a health system that is safe, trustworthy, and equitable for all.

## Recommendation 1: Establish a national framework for cultural safety and anti-racism

The Australian Government should lead the development and implementation of a comprehensive national framework dedicated to cultural safety and anti-racism within the healthcare system. This framework is crucial because, as Australia currently lacks a clear, consistent definition of cultural safety, leading to ambiguous and ineffective implementation.

The framework should not be a single document but a coordinated effort across all levels of government and health bodies, with a primary focus on the unique experiences of First Nations peoples.

A core component must be the establishment of a nationally recognised, Indigenous-led definition of First Nations Cultural Safety, with accompanying minimum standards for its implementation in clinical practice, policy, and administration.

This definition must be determined by Aboriginal and Torres Strait Islander individuals, families, and communities, and should be the cornerstone for all anti-racism initiatives.

By building this framework on an intersectional and community-centred understanding of racism, it will guide action beyond simple awareness and address the root causes of systemic harm, thereby fostering genuine truth-telling and acknowledging the diverse ways racism impacts various communities across the country.

## Recommendation 2. Mandate and standardise cultural safety and anti-racism education and training

To address the documented poor understanding of racism and cultural safety among healthcare professionals, it is imperative to mandate and standardise cultural safety and anti-racism education. The current ad-hoc, unregulated nature of cultural safety training in Australia is demonstrably ineffective.

All health professionals, from students in higher education to practitioners in specialist colleges, must undergo rigorous, mandatory training. This education should not be a one-

off event but a lifelong process of learning and unlearning, with a central focus on critical self-reflection.

Training must empower professionals to critically examine their own biases, cultural perspectives, and the power imbalances inherent in the clinician-patient relationship. Furthermore, the design and delivery of these programs must be genuinely co-designed with Indigenous leaders and educators, moving beyond tokenistic consultation.

To ensure accountability and effectiveness, the impact of this training must be rigorously evaluated using validated, evidence-based tools, such as the Wathaara scale, which measure a deeper understanding of cultural safety principles beyond self-reported attitudes (Armao et al., 2025).

### Recommendation 3. Implement independent and transparent complaints and reporting mechanisms

The current systems for reporting racism in healthcare are ineffective, inaccessible, and culturally unsafe, leading to a significant underreporting of incidents. The power imbalance between patients and institutions, coupled with a fear of reprisal and a lack of trust, means that formal complaints often fail to reflect the true prevalence of racism.

To rectify this, the government must mandate the creation of independent, accessible, and culturally safe reporting mechanisms. These systems should be located outside of the direct control of the hospital or health service to avoid the inherent conflict of interest that currently exists, as highlighted by the fact that institutions are investigating themselves.

These new mechanisms must be pragmatic and offer multiple options for reporting (e.g., verbal, written, and online) to reduce literacy barriers.

A key feature would be independent oversight by a body with a clear mandate and sufficient knowledge of both interpersonal and systemic racism to ensure that all complaints are thoroughly investigated, with clear pathways for action and consequences for perpetrators.

This will not only increase accountability but will also help build trust with Indigenous communities, signalling a genuine commitment to addressing racism.

### Recommendation 4. Strengthen data collection and measurement of racism and cultural safety

A fundamental weakness in Australia's approach to addressing racism is the lack of comprehensive and reliable data. Without this data, it is impossible to evaluate the effectiveness of policies or track progress in achieving health equity.

To address this, a national strategy must be implemented to strengthen data collection on racism and cultural safety. This should include mandating that all health services collect and publicly report on data related to patient and staff experiences of racism and culturally unsafe care.

Routinely collected data on service utilisation, hospital admissions, clinical procedures, patient outcomes, discharge rates, and readmission rates must be disaggregated by Indigenous status and made publicly available. This disaggregated data will elucidate disparities in the quality of care and may serve

as critical indicators of institutional racism and cultural safety at the organisational level.

A revision of the existing National Safety and Quality Health Service (NSQHS) Standards is also essential. This revision should incorporate uniform performance indicators for cultural safety, as determined by Indigenous communities, and require hospitals to demonstrate compliance during their accreditation process.

The collection of this data must be guided by the principles of Indigenous data sovereignty with data access for communities, ensuring that this information is shared with and owned by Indigenous peoples, as articulated in the National Agreement on Closing the Gap.

This systemic approach to data collection will provide a robust evidence base for identifying service failures, informing targeted interventions, and holding organisations accountable for their performance.

### Recommendation 5. Enhance meaningful community engagement and shared decision-making.

To ensure that healthcare policies and services are genuinely culturally safe, it is critical to move beyond the current practice of tokenistic consultation and embed meaningful engagement with Aboriginal and Torres Strait Islander communities.

Policymakers and hospital executives often resist deep engagement, relying instead on advisory committees that may not represent the lived experiences of all community members. As such, the revised NSQHS Standards and government health policies should require a minimum standard for comprehensive and reciprocal engagement.

This includes mandating that health services establish dedicated, remunerated community engagement positions and committees with genuine decision-making authority.

Furthermore, hospitals should be required to transparently report on how community feedback has been incorporated into their policies and practices. This includes demonstrating how they have addressed issues related to racism and cultural safety raised by communities during consultations.

By appropriately resourcing and empowering communities to participate in the design, delivery, and monitoring of healthcare, this recommendation will foster true partnerships built on respect and shared responsibility, a necessary step towards creating a more equitable and culturally safe health system.

The issues and recommendations outlined in this brief have the potential to provide a foundation for future health policy that will contribute to improving both the accessibility and cultural safety of hospitals with and for Aboriginal and Torres Strait Islander people across Australia.

Without rigorous data and transparent evaluation processes, we risk perpetuating further systemic inequity and the continuation of implementing solutions that do not consider or address the needs of Aboriginal and Torres Strait Islander peoples. It is imperative that we hold our health policy frameworks and consequently, the health systems accountable; prioritising measurable outcomes that reflect the lived experiences of Indigenous peoples.

The real test of this will be in practice, where Aboriginal and Torres Strait Islander communities instead of organisations will be the judges of whether health services are culturally safe.

## References

About Regional. (2025). *First Nations man could have survived if not for 'flawed' process at Cowra Hospital*. Published 23 August 2025. https://aboutregional.com.au/first-nations-man-could-have-survived-if-not-for-flawed-process-at-cowra-hospital/485117/

AIHW: Australian Institute of Health and Welfare. (2023) Cultural safety in health care for Indigenous Australians: monitoring framework, AIHW, Australian Government, Canberra, Australia. Accessed 28 June 2025, Available from: https://www.aihw.gov.au/getmedia/6dcae6be-4798-428c-9092d8d9e3b55fb9/Cultural-safety-in-health-care-for-Indigenous-Australians-monitoring framework.pdf?v=20250206105619&inline=true

AIHW: Australian Institute of Health and Welfare (2024). Determinants of health for First Nations people. Accessed 13 August 2025, Available from: https://www.aihw.gov.au/reports/australias-health/social-determinants-and-indigenous-health

Alexander LD. (2021). *How race impacts physical injuries and psychological distress for victims of hate crimes*, Doctoral Dissertation, Walden University.

Allison F and Cunneen C. (2022) *Call It Out Racism Register. The First Six Months*, Jumbunna Institute for Indigenous Education and Research, University of Sydney. Accessed 2 June 2025: https://callitout.com.au/wp-content/uploads/2022/11/Call-It-Out-Six-Month-Report-Final.pdf

Anderson I, Paradies Y, Langton M, Lovett R and Calma T. (2023). Racism and the 2023 Australian constitutional referendum. *The Lancet*, 402(10411), 1400-1403. https://doi.org/10.1016/s0140-6736(23)01954-2

Anti-Discrimination New South Wales. (2024) *Your rights and responsibilities as an employer*, Last updated: 04 March 2024. Accessed 12 July 2025 https://antidiscrimination.nsw.gov.au/organisations-and-community-groups/your-rights-and-responsibilities-as-an-employer.html

Arieli D, Friedman VJ and Hirschfeld M J. (2012). Challenges on the path to cultural safety in nursing education. *International Nursing Review*, 59(2), 187-193. https://doi.org/10.1111/j.1466-7657.2012.00982.x

Armao J, Saunders V and West R. (2025). Assessing the effectiveness of cultural safety education reform for Indigenous health: Construct and criterion validity of the Wathaara scale. *First Nations Health and Wellbeing-The Lowitja Journal*, 3, 100081. https://doi.org/10.1016/j.fnhli.2025.100081

Artuso S, Cargo M, Brown A and Daniel M. (2013). Factors influencing health care utilisation among Aboriginal cardiac patients in central Australia: a qualitative study. *BMC Health Services Research*, 13(1), 83. https://doi.org/10.1186/1472-6963-13-83

Askew D A, Foley W, Kirk C and Williamson D. (2021). "I'm outta here!": a qualitative investigation into why Aboriginal and non-Aboriginal people self-discharge from hospital. *BMC Health Services Research*, 21(1), 907. https://doi.org/10.1186/s12913-021-06880-9

Atrey, S. (2021). Structural Racism and Race Discrimination, *Current Legal Problems*, Volume 74, Issue 1, Pages 1–34. https://doi.org/10.1093/clp/cuab009

Audit Office of New South Wales. (2025). Governance of the National Agreement on Closing the Gap in NSW (Report No. 407). Parliament of NSW. Accessed 16 July 2025 https://www.audit.nsw.gov.au/sites/default/files/documents/FINAL%20REPORT%20-%20Governance%20of%20the%20National%20Agreement%20on%20Closing%20the%20Gap%20in%20NSW.pdf

ABC: Australian Broadcasting Corporation (2025). *Disturbing Closing the Gap report shows there's been little political will to address inequality in the wake of the failed Voice referendum*. Published 13 March 2025. Accessed 12 July 2025 https://www.abc.net.au/news/2025-03-13/closing-the-gap-report-data-fail-address-indigenous-inequality/105046662

ACSQHC: Australian Commission on Safety and Quality in Health Care (2021). National safety and quality health service standards (2nd ed.). ACSQHC, Australian Government, Canberra, Australia. Accessed 10 May 2025 https://www.safetyandquality.gov.au/sites/default/files/2021-05/national_safety_and_quality_health_service_nsqhs_standards_second_edition_-_updated_may_2021.pdf.

DoHA: Australian Government Department of Health and Aged Care. (2021). National Aboriginal and Torres Strait Islander Health Plan 2021–2031. Accessed 12 June 2025 https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031

Australian Government Productivity Commission, *New Closing the Gap data shows focus on Priority Reforms by governments needed to see real improvement*, Media Release. Accessed 12 June 2025 https://www.pc.gov.au/closing-the-gap-data/media-releases/new-closing-the-gap-data-march-2025

Australian Government (2020). National agreement on closing the gap, July 2020, National Indigenous Australian Agency, Canberra. Accessed 7 August 2025. Available from https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap

Australian Government. Racial Discrimination Act 1975, Commonwealth. Accessed 10 September 2025. Available from https://www.legislation.gov.au/C2004A00274/2015-12-10/text

Ahpra: Australian Health Practitioner Registration Agency (2019a). Code of Conduct. Accessed 7 August 2025. Available from https://www.ahpra.gov.au/Resources/Code-of-conduct/Shared-Code-of-conduct.aspx

Ahpra: Australian Health Practitioner Registration Agency (2023) Doctor banned for discriminatory and offensive behaviour, Published 2 Nov 2023. Accessed 7 August 2025 https://www.ahpra.gov.au/News/2023-11-02-Doctor-banned-for-discriminatory-and-offensive-behaviour.aspx

Ahpra: Australian Health Practitioner Regulation Agency & National Boards (2019b). Have your say: how should we define 'cultural safety'? Published April 2019, Accessed 7 August 2025, Available from: https://www.ahpra.gov.au/News/2019-04-03-cultural-safety.aspx

Ahpra: Australian Health Practitioner Regulation Agency (2025). Aboriginal and Torres Strait Islander Anti-Racism Policy. Accessed 10 September 2025, Available from: https://www.ahpra.gov.au/documents/default.aspx?record=WD25%2f34654&dbid=AP&chksum=QWFlHdkKtFKaflxKr%2bCAzw%3d%3d

AHRC: Australian Human Rights Commission (2024a). An anti-racism framework: Voices of First Nations Peoples. Accessed 2 September 2025, Available from: https://humanrights.gov.au/our-work/race-discrimination/publications/anti-racism-framework-voices-first-nations-peoples

AHRC: Australian Human Rights Commission (2024 b), The National Anti-Racism Framework: A roadmap to eliminating racism in Australia (Report, November 2024). Accessed 2 September 2025, Available from: https://humanrights.gov.au/sites/default/files/202411/NARF_Full_Report_FINAL_DIGITAL_ACCESSIBLE.pdf

Australian National Audit Office, *Management of Complaints by the Australian Human Rights Commission*, Auditor-General Report No.24 2024–25. https://www.anao.gov.au/sites/default/files/2025-02/Auditor-General_Report_2024-25_24.pdf

Baker AC, Giles AR. Cultural safety: a framework for interactions between Aboriginal patients and Canadian family medicine practitioners. *Journal of Aboriginal Health*. 2012;9(1):15–22. https://doi.org/10.18357/ijih91201212390

Ben J, Cormack D, Harris R, Paradies Y. Racism and health service utilisation: a systematic review and meta-analysis. *PLoS ONE*. 2017;12(12):1–22. https://doi.org/10.1371/journal.pone.0189900

Berry RR. (2020). Identifying structural racism as a barrier to community wealth building. In Community Wealth Building and the Reconstruction of American Democracy (pp. 221-244). Edward Elgar Publishing.

Best O. (2014). The cultural safety journey: An Australian nursing context. In Yatdjuligin: Aboriginal and Torres Strait Islander nursing and midwifery care, Cambridge University Press, Australia.

Blanchet Garneau A, Farrar H, Fan H, Kulig J. (2018). Applying cultural safety beyond Indigenous contexts: insights from health research with Amish and Low German Mennonites. Nursing Inquiry. 2018;25(1):e12204. https://doi.org/10.1111/nin.12204

Blignault I, Norsa L, Blackburn R, Bloomfield G, Beetson K, Jalaludin B and Jones N. (2021). "You can't work with my people if you don't know how to": Enhancing transfer of care from hospital to primary care for Aboriginal Australians with chronic disease. *International journal of environmental research and public health*, 18(14), 7233. https://doi.org/10.3390/ijerph18147233

Bourke C J, Marrie H and Marrie A. (2018). Transforming institutional racism at an Australian hospital. *Australian Health Review*, 43(6), 611-618. https://doi.org/10.1071/AH18062

Brascoupé S, Waters C. (2009). Cultural safety: exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *Journal of Aboriginal Health*. 2009;5(2):6–41. https://jps.library.utoronto.ca/index.php/ijih/article/view/28981/23928

Brown CE, Marshall AR, Snyder CR, Cueva KL and Young BA. (2023). Perspectives about racism and patient-clinician communication among black adults with serious illness. *JAMA Network Open*, 6(7), e2321746-e2321746. doi:10.1001/jamanetworkopen.2023.21746

Browne, A. J., Varcoe, C., Smye, V., Reimer-Kirkham, S., Lynam, M. J., & Wong, S. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. Nursing Philosophy, 10(3), 167-179.

Brumpton K, Evans R, Ward R, and Sen Gupta T. (2022). A consistent definition of cultural safety within Australian health professional education: a scoping review. *AlterNative: An International Journal of Indigenous Peoples*, 18(3), 436-444. https://doi.org/10.1177/11771801221118950

Bryant N. (2024). Introducing Indigenist Critical Policy Analysis: A rights-based approach to analysing public policies and processes. Australian Journal of Social Issues, 59(4), 824-843. https://doi.org/10.1002/ajs4.350

Canadian Government. (2023). Common Definitions on Cultural Safety: Chief Public Health Officer Health Professional Forum, Accessed 2 June 2025, Available from: https://www.canada.ca/en/health-canada/services/publications/health-system-services/chief-public-health-officer-health-professional-forum-common-definitions-cultural-safety.html

Cass A, Cunningham J, Snelling P, Wang Z and Hoy W (2003). Renal transplantation for indigenous Australians: identifying the barriers to equitable access. *Ethnicity & Health*. 8(2):111–9. https://doi.org/10.1080/13557850303562

CoP: Coalition of Peaks (2025). Circuit breaker needed as the cycle of failure continues in 2020 Closing the Gap report, Published 13 February 2020, Accessed 4 September 2025, Available from: https://www.coalitionofpeaks.org.au/media/circuit-breaker-needed-as-the-cycle-of-failure-continues-in-2020-closing-the-gap-report

Collins Jr J W, David R J, Handler A, Wall S and Andes S. (2004). Very low birthweight in African American infants: the role of maternal exposure to interpersonal racial discrimination. *American journal of public health*, 94(12), 2132-2138. https://doi.org/10.2105/AJPH.94.12.2132

Commonwealth of Australia (2019), Department of the Prime Minister and Cabinet, Closing the Gap Retrospective Review, Published March 2018, Accessed 2 September 2025, Available from: https://www.niaa.gov.au/sites/default/files/documents/publications/closing-gap-retrospective-review-accessible.pdf

Commonwealth of Australia. (2024). Commonwealth Closing the Gap 2023 Annual Report and Commonwealth Closing the Gap 2024 Implementation Plan. Accessed 11 June 2025, Available from: https://www.niaa.gov.au/sites/default/files/documents/2024-02/ctg-annual-report-and-implementation-plan.pdf

CATSINaM: Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (2022), 'gettin em n keepin em n growin em': Strategies for Aboriginal and Torres Strait Islander nursing and midwifery education reform, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Brisbane, Accessed 10 September 2025, Available from: www.catsinam.org.au

Coory MD, Walsh WF. (2005). Rates of percutaneous coronary interventions and bypass surgery after acute myocardial infarction in Indigenous patients. *Medical Journal of Australia*. 182(10):507–12. https://doi.org/10.5694/j.1326-5377.2005.tb00016.x

Coroner's Court of New South Wales (2019). Inquest into the death of Naomi Williams [Internet]. 2019 Jul 29; 2016/2569. Accessed 2 September 2025, Available from: http://www.coroners.justice.nsw.gov.au/Documents/Naomi%20Williams%20findings.pdf

Coroner's Court of New South Wales (2024). Inquest into the death of Mr Dougie Hampson. Sydney: State Coroner's Court of New South Wales, p 59. Accessed 2 September 2025, Available from: https://coroners.nsw.gov.au/documents/findings/2024/Inquest_into_the_death_of_Ricky_Dougie_Hampson

Coroner's Court of Queensland (2023). Inquest into the deaths of Yvette Michelle Wilma Booth, Adele Estelle Sandy, Shakaya George, ("RHD Doomadgee Cluster"). Cairns: Coroners Court of Queensland, p 130. Accessed 2 September 2025, Available from: https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/770109/cif-booth-sandy-george-20230630.Pdf

Coroner's Court of Victoria (2000). Inquest into the death of Ms Tanya Day. Melbourne: Coroner's Court of Victoria. Accessed 2 September 2025, Available from: https://www.humanrights.vic.gov.au/legal-interventions/coronial-inquest-intothe-death-of-tanya-day-apr-2020/

Cox L and Best O. (2022). Clarifying cultural safety: Its focus and intent in an Australian context. *Contemporary nurse*, 58(1), 71-81. https://doi.org/10.1080/10376178.2022.2051572

Crameri P, Barrett C, Latham JR, Whyte C. (2015). It is more than sex and clothes: culturally safe services for older lesbian, gay, bisexual, transgender and intersex people. Australasian Journal on Ageing. 2015;34:21–5. https://doi.org/10.1111/ajag.12270

Cunningham J.(2002). Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous. *Medical Journal of Australia*. 176(2):58–62. https://doi.org/10.5694/j.1326-5377.2002.tb04284.x

Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine SJ and Reid P.(2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health*. 2019;18(1):1–17. https://doi.org/10.1186/s12939-019-1082-3

Curtis E, Loring B, Jones R, Tipene-Leach D, Walker C, Paine S J and Reid P (2025). Refining the definitions of cultural safety, cultural competency and Indigenous health: lessons from Aotearoa New Zealand. International Journal for Equity in Health, 24(1), 130. https://doi.org/10.1186/s12939-025-02478-3

Dafny H A, Snaith N, McCloud C, Waheed N, Cooper P and Champion S. (2025). Racism during clinical placement, the perpetrators, impact, advocating and reporting. *Nursing Ethics*, 09697330251317675. https://doi.org/10.1177/09697330251317675

Davy C, Cass A, Brady J, DeVries J, Fewquandie B, ... and Brown A. (2016). Facilitating engagement through strong relationships between primary healthcare and Aboriginal and Torres Strait Islander peoples. *Australian and New Zealand Journal of Public Health*, 40(6), 535-541. https://doi.org/10.1111/1753-6405.12553

Dawson J, Laccos-Barrett K, Hammond C and Rumbold A. (2022). Reflexive practice as an approach to improve healthcare delivery for indigenous peoples: a systematic critical synthesis and exploration of the cultural safety education literature. *International journal of environmental research and public health*, 19(11), 6691. https://doi.org/10.3390/ijerph19116691

Dehon E, Weiss N, Jones J, Faulconer W, Hinton E and Sterling S. (2017). A systematic review of the impact of physician implicit racial

bias on clinical decision making. *Academic Emergency Medicine*, 24(8), 895-904. https://doi.org/10.1111/acem.13214

Dell E M, Firestone M, Smylie J and Vaillancourt S. (2016). Cultural safety and providing care to Aboriginal patients in the emergency department. *Canadian Journal of Emergency Medicine*, 18(4), 301-305. doi:10.1017/cem.2015.100

Demant D, Manton D, Manton J and Saliba B and Avery S. (2024). Health inequities in Australia: A scoping review on the impact of racism on Indigenous and other negatively racialised communities' health outcomes and healthcare access. School of Public Health, Faculty of Health, University of Technology Sydney. Commissioned by the Australian Human Rights Commission.

DoH: Department of Health (2015). Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, Australian Government, Canberra, 2015 https://www.health.gov.au/sites/default/files/documents/2020/12/implementation-plan-for-the-national-aboriginal-and-torres-strait-islander-health-plan-2013-2023.pdf

DoHA: Department of Health and Aged Care (2021). National Aboriginal and Torres Strait Islander Health Plan 2021–2031. Australian Government, Canberra. https://www.health.gov.au/sites/default/files/2025-01/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031_0.pdf

Diaz A, Whop LJ, Valery PC, Moore SP, Cunningham J… Garvey G (2015). Cancer outcomes for Aboriginal and Torres Strait Islander Australians in rural and remote areas. *Australian Journal of Rural Health*. 2015;23(1):4–18. https://doi.org/10.1111/ajr.12169

Diop M S, Taylor C N, Murillo S N, Zeidman J A, James A K and Burnett-Bowie S AM. (2021). This is our lane: talking with patients about racism. *Women's Midlife Health*, 7(1), 7. https://doi.org/10.1186/s40695-021-00066-3

Dole K, Casilli A, Tinsley N, Collett J and Majoni SW. (2018). Improving access to renal transplantation among Indigenous patients with end-stage renal disease: a review from the top end of northern Australia where graft and patient outcomes have generally been poor. *Transplant Journal of Australasia*. 2018;27(1):14–22. https://search.informit.org/doi/10.3316/informit.513405648083905

Durey A, Thompson S C and Wood, M. (2012). Time to bring down the twin towers in poor Aboriginal hospital care: addressing institutional racism and misunderstandings in communication. *Internal Medicine Journal*, 42(1), 17-22. https://doi.org/10.1111/j.1445-5994.2011.02628.x

Dwyer J, O'Donnell K, Willis E and Kelly J. (2016). Equitable care for indigenous people: every health service can do it. *Asia Pacific Journal of Health Management*, 11(3), 11-17. https://doi.org/10.1111/j.1445-5994.2011.02628.x

Egede L E, Walker R J and Williams, J S. (2024). Addressing structural inequalities, structural racism, and social determinants of health: a vision for the future. *Journal of General Internal Medicine*, 39(3), 487-491. https://doi.org/10.1007/s11606-023-08426-7

Elias A, Mansouri F and Paradies Y. (2021). Racism in Australia today (pp. 169-209). Singapore, Palgrave Macmillan.

Elvidge E. (2020a). An Aboriginal Cultural Safety Framework for New South Wales Hospitals, Doctoral dissertation, University of Newcastle, Australia. Accessed 7 September

2025, Available from: https://openresearch.newcastle.edu.au/ndownloader/files/54329210
Elvidge E, Paradies Y, Aldrich R and Holder C. (2020). Cultural safety in hospitals: validating an empirical measurement tool to capture the Aboriginal patient experience. Australian Health Review, 44(2), 205-211. https://doi.org/10.1071/AH19227
Elvidge E, Taylor S L, Harvey K, Thompson Y, Armao J, Rogers, G. B., ... and Paradies, Y. (2025). Empirical assessment of cultural safety within Australian hospitals highlights the impact of access to Aboriginal hospital liaison officers on the experiences of Aboriginal patients. *First Nations Health and Wellbeing-The Lowitja Journal*, 3, 100061. https://doi.org/10.1016/j.fnhli.2025.100061
Epari K P, Mukhtar AS, Fletcher DR, Samarasam I and Semmens J B (2010). The outcome of patients on the cholecystectomy waiting list in Western Australia 1999–2005. *ANZ journal of surgery*, 80(10), 703-709. https://doi.org/10.1111/j.1445-2197.2010.05428.x
Ewen AM (2025). The Influence of Racial Discrimination as a Chronic Stressor on Type 2 Diabetes Risk and Self-Management Behaviors among Black Adults: A Scoping Review. *Current Diabetes Reports*, 25(1), 12. https://doi.org/10.1007/s11892-024-01570-2
Gatwiri K, Rotumah D and Rix E. (2021). BlackLivesMatter in healthcare: racism and implications for health inequity among Aboriginal and Torres Strait Islander peoples in Australia. *International Journal of Environmental Research and Public Health*, 18(9), 4399. https://doi.org/10.3390/ijerph18094399
Gerlach AJ. A critical reflection on the concept of cultural safety. *Canadian Journal of Occupational Therapy*. 2012;79(3):151–8. https://doi.org/10.2182/cjot.2012.7
Gibberd A, Supramaniam R, Dillon A, Armstrong BK, O'Connell DL. (2015). Are Aboriginal people more likely to be diagnosed with more advanced cancer? *Medical Journal of Australia*. 202(4):195–9. https://doi.org/10.5694/mja14.00701
Gibberd A, Supramaniam R, Dillon A, Armstrong BK and O'Connell DL (2016). Lung cancer treatment and mortality for Aboriginal people in New South Wales, Australia: results from a population-based record linkage study and medical record audit. *BMC Cancer*. 16(1):289. https://doi.org/10.1186/s12885-016-2322-1
Goetz E G. (2022) Racism in the Hospital: A Report to the Service Employees International Union Healthcare Minnesota and Iowa, Published August 2022, Accessed 10 September 2025, Available from: https://www.cura.umn.edu/sites/cura.umn.edu/files/2023-01/RITH%20Report%20v5%20-%20low%20res.pdf
Greenwood M, De Leeuw S and Lindsay N. (2018). Challenges in health equity for Indigenous peoples in Canada. *The Lancet*, 391(10131), 1645-1648. DOI:10.1016/S0140-6736(18)30177-6
Gurm BK and Cheema J. Cultural safety assessment of an urban Canadian hospital. Journal of Cultural Diversity. 2013;20(4):177–83. PMID: 24575593
Hall S, Holman CDJ, Sheiner H. (2004) The influence of socio-economic and locational disadvantage on patterns of surgical care for lung cancer in Western Australia 1982–2001. *Australian Health Review*. 27(2):68–79. https://doi.org/10.1071/AH042720068
Hall K, Vervoort S, Del Fabbro L, Rowe Minniss F, Saunders V, Martin K., ... and West, R.

(2023). Evolving beyond antiracism: Reflections on the experience of developing a cultural safety curriculum in a tertiary education setting. *Nursing inquiry*, 30(1), e12524. https://doi.org/10.1111/nin.12524

Hamilton S, Mills B, McRae S and Thompson S. Cardiac rehabilitation for Aboriginal and Torres Strait Islander people in Western Australia. *BMC Cardiovascular Disorders*. 2016;16(1):150. https://doi.org/10.1186/s12872-016-0330-3

Hardy B J, Filipenko S, Smylie D, Ziegler C and Smylie J. (2023). Systematic review of Indigenous cultural safety training interventions for healthcare professionals in Australia, Canada, New Zealand and the United States. *BMJ open*, 13(10), e073320. https://doi.org/10.1136/bmjopen-2023-073320

Hassen N, Lofters A, Michael S, Mall A, Pinto A.D and Rackal J. (2021). Implementing anti-racism interventions in healthcare settings: a scoping review. *International journal of environmental research and public health*, 18(6), 2993. https://doi.org/10.3390/ijerph18062993

Health Performance Council (South *Australia) (2020). Institutional racism — Audit of South Australia's Local Health Networks.* Accessed 12 July 2025, Available from: https://www.sahealth.sa.gov.au/wps/wcm/connect/5ee65c42-ce05-49d9-92e4-ffe5fd54964c/2020-09+-+Institutional+racism+audit+of+South+Australia%E2%80%99s+local+health+networks.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-5ee65c42-ce05-49d9-92e4-ffe5fd54964c-pv8

Health Standards Organization. (2022). British Columbia cultural safety and humility standard. Accessed 10 September 2025, Available from: https://www.hc-sc.gc.ca/hcs-sss/alt-strat/work-travail/cult-cult/index-eng.php.

Hendry J, Guercio G D, Smith D B, Louie A, Henry B and Jongbloed K. (2025). Unlearning clubs: creating environments of cultural safety, anti-racism, and trustworthiness in population and public health. *BMC Public Health*, 25(1), 1-11. https://doi.org/10.1186/s12889-025-22034-6

Howse G and Dwyer J. (2016). Legally invisible: stewardship for Aboriginal and Torres Strait Islander health. *Australian and New Zealand Journal of Public Health*, 40(S1), S14-S20. https://doi.org/10.1111/1753-6405.12358

Hurst J and Jee-Hughes M. (2001). Performance measurement and performance management in OECD health systems (No. 47). OECD Publishing.

Johnstone MJ and Kanitsaki O. (2009) The spectrum of 'new racism' and discrimination in hospital contexts: a reappraisal. *Collegian*.16(2):63–9. https://doi.org/10.1016/j.colegn.2009.03.001

Johnstone MJ and Kanitsaki O. (2008). Cultural racism, language prejudice and discrimination in hospital contexts: an Australian study. *Diversity and Equality in Health and Care*, 5(1). ISSN 2049-5471

Johnstone M J and Kanitsaki O. (2007). An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context. *Journal of transcultural nursing*, 18(3), 247-256. https://doi.org/10.1177/1043659607301304

Johnstone MJ and Kanitsaki O. (2010). The neglect of racism as an ethical issue in health care. *Journal of Immigrant and Minority Health*, 12(4), 489-495. https://doi.org/10.1007/s10903-008-9210-y

Joseph AL, Kushniruk AW and Borycki EM. (2020). Patient journey mapping: current practices, challenges and future opportunities in healthcare. *Knowledge management & e-learning*, 12(4), 387. https://doi.org/10.34105/j.kmel.2020.12.021

Kairuz CA and Casanelia L M, Bennett-Brook K, Coombes J and Yadav UN. (2021). Impact of racism and discrimination on physical and mental health among Aboriginal and Torres Strait islander peoples living in Australia: a systematic scoping review. *BMC Public Health*, 21(1), 1302. https://doi.org/10.1186/s12889-021-11363-x

Kelaher MA, Ferdinand AS, Paradies Y. Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities. *Medical Journal of Australia*. 2014;201(1):44–7. https://doi.org/10.5694/mja13.10503

Kirkland A and Hyman M. (2021). Civil rights as patient experience: How healthcare organizations handle discrimination complaints. *Law & Society Review*, 55(2), 273-295. https://doi.org/10.1111/lasr.12554

Kirmayer LJ and Brass G. (2016). Addressing global health disparities among Indigenous peoples. *The Lancet*, 388(10040). https://doi.org/10.1016/s0140-6736(16)30194-5

Kurtz DLM, Janke R, Vinek J, Wells T, Hutchinson P and Froste A. (2018). Health sciences cultural safety education in Australia, Canada, New Zealand, and the United States: a literature review. *International journal of medical education*, 9, 271. doi: 10.5116/ijme.5bc7.21e2

Laverty M, McDermott DR and Calma T. (2017). Embedding cultural safety in Australia's main health care standards. *The Medical Journal of Australia*, 207(1), 15-16. doi: 10.5694/mja17.00328

Lopez D, Katzenellenbogen JM, Sanfilippo FM, Woods JA, Hobbs MST, Knuiman MW, et al.(2014a) Disparities experienced by Aboriginal compared to non-Aboriginal metropolitan Western Australians in receiving coronary angiography following acute ischaemic heart disease: the impact of age and comorbidities. *International Journal for Equity in Health*. 13(1):93. https://doi.org/10.1186/s12939-014-0093-3

Lopez D, Katzenellenbogen JM, Sanfilippo FM, Woods JA, Hobbs MST, Knuiman MW, et al. (2014b) Transfers to metropolitan hospitals and coronary angiography for rural Aboriginal and non-Aboriginal patients with acute ischaemic heart disease in Western Australia. *BMC Cardiovascular Disorders*. 14(1):58. https://doi.org/10.1186/1471-2261-14-58

Luke JN, Ferdinand AS, Paradies Y, Chamravi D and Kelaher M. (2020). Walking the talk: evaluating the alignment between Australian governments' stated principles for working in Aboriginal and Torres Strait Islander health contexts and health evaluation practice. *BMC Public Health*, 20(1), 1856. https://doi.org/10.1186/s12889-020-09983-w

Mackean, T., Fisher, M., Friel, S., & Baum, F. (2020). A framework to assess cultural safety in Australian public policy. Health promotion international, 35(2), 340-351. https://doi.org/10.1093/heapro/daz011

Mahoney RP. (2017) Is identifying as Indigenous good for your health? Investigating the relationship between Indigenous status identification and management of cardiovascular disease, Doctoral dissertation. Queensland University of Technology, Australia. Accessed 20 June 2025, Available from: https://eprints.qut.edu.au/114077/

Marrie, A. (2017) *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services*, Report to Commissioner Kevin Cocks AM, Anti-Discrimination Commission Queensland. Accessed 12 July 2025, Available from: https://www.qhrc.qld.gov.au/__data/assets/word_doc/0017/16550/Health-Equity-Report-2017.docx

Martinez A, de la Rosa R, Mujahid M and Thakur N. (2021). Structural racism and its pathways to asthma and atopic dermatitis. Journal of Allergy and Clinical Immunology, 148(5), 1112-1120. https://doi.org/10.1016/j.jaci.2021.09.020

Milligan E, West R, Saunders V, Bialocerkowski A, Creedy D, Minniss FR., ... and Vervoort S. (2021). Achieving cultural safety for Australia's First Peoples: a review of the Australian Health Practitioner Regulation Agency-registered health practitioners' Codes of Conduct and Codes of Ethics. *Australian Health Review*, 45(4), 398-406. https://doi.org/10.1071/AH20215

Mohamed J, Stacey K, Chamberlain C and Priest N (2024). Cultural safety in Australia, Discussion paper, Lowitja Institute, Melbourne, Australia. Accessed 12 September 2025, Available from: https://www.lowitja.org.au/news/discussion-paper-cultural-safety-in-australia/

Muller J, Devine S, Geia L, Cairns A, Stothers K, Gibson P and Murray D. (2024). Audit tools for culturally safe and responsive healthcare practices with Aboriginal and Torres Strait Islander people: a scoping review. *BMJ global health*, 9(1). https://doi.org/10.1136/bmjgh-2023-014194

Nakata M N. (Ed.). (2001). Indigenous peoples, racism and the United Nations. Common Ground.

Nelson, D. (2022). Australian reconciliation barometer 2022: Full research report. Accessed 12 September 2025, Available from: https://www.reconciliation.org.au/wp-content/uploads/2022/11/2022-Australian-Reconciliation-Barometer-FULL-Report.pdf

Newhouse G, Dozer A, Janssen I and MacGregor N. (2023). Strategic Litigation and Racism in Healthcare. *Griffith Journal of Law & Human Dignity*, 11(2). https://doi.org/10.69970/gjlhd.v11i2.1262

NITV (2025). *Elders are working with lawyers coordinating a Racial Discrimination Human Rights Complaint*, Published 7 March 2025. Accessed 10 September 2025, Available from:https://www.sbs.com.au/nitv/article/these-elders-are-filing-a-racial-discrimination-human-rights-complaint-against-queensland-health/a50915m6j

O'Brien P, Bunzli S, Lin I, Bessarab D, Coffin J, Dowsey MM and Choong PF (2021). Addressing surgical inequity for Aboriginal and Torres Strait Islander people in Australia's universal health care system: a call to action. *ANZ journal of surgery*, 91(3), 238-244. https://doi.org/10.1111/ans.16557

OCPSE: Office of the Commissioner for Public Sector Employment (2023). South Australian Public Sector Anti-Racism Strategy 2023-28. Accessed 6 September 2025, Availablefrom:https://www.publicsector.sa.gov.au/__data/assets/pdf_file/0006/956355/OCPSE-Anti-Racism-Strategy.pdf

Oribin J, Fatima Y, Seaton C, Solomon S, Khan M and Cairns A (2024). Discharge against medical advice in rural and remote emergency departments views of healthcare providers. *Rural and remote health*, 24(3), 1-10.

https://search.informit.org/doi/10.3316/informit.T2024110600005090825360456
Paradies Y, Ben J, Denson N, Elias A, Priest N, Pieterse A, Gupta A, Kelaher M and Gee G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLoS One*. 2015 Sep 23;10(9):e0138511. https://doi.org/10.1371/journal.pone.0138511
Paradies Y. Racism and indigenous health. In McQueen DV, editor. Oxford research encyclopedia of global public health. Oxford, UK: Oxford University Press; 2018. p. 1–21. https://doi.org/10.1093/acrefore/9780190632366.013.86
Paradies Y, Truong M and Priest N. (2014). A systematic review of the extent and measurement of healthcare provider racism. *Journal of general internal medicine*, 29(2), 364-387. https://doi.org/10.1007/s11606-013-2583-1
Peucker M, Clark T and Claridge H. (2023). Mapping the Journey of (non-) Reporting in Response to Racism: A Change-oriented Approach to Reporting Barriers, Motives and Support Needs. *Journal of Intercultural Studies*, 45(3), 473–493. https://doi.org/10.1080/07256868.2023.2296026
Polity Research and Reconciliation Australia (2020). '2020 Australian Reconciliation Barometer' (Report, 2020) Accessed 2 September 2025, Available from: https://www.reconciliation.org.au/wp-content/uploads/2021/02/Australian_Reconciliation_Barometer_-2020_Summary-Report_web_spread.pdf
Powell-Wiley TM, Baumer Y, Baah FO, Baez AS, Farmer N, Mahlobo CT., ... and Wallen, GR. (2022). Social determinants of cardiovascular disease. *Circulation research*, 130(5), 782-799. https://doi.org/10.1161/CIRCRESAHA.121.319
Power, T (2015) The Aboriginal Cultural Training Framework: Respecting the Difference Implementation Process Evaluation Report – 2013. Accessed 6 September 2025, Available from: https://www.health.nsw.gov.au/workforce/aboriginal/Publications/respecting-difference-evaluation.pdf
Priest N, Paradies Y, Trenerry B, Truong M, Karlsen S and Kelly Y. (2013). A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people. *Social science & medicine*, 95, 115-127. https://doi.org/10.1016/j.socscimed.2012.11.031
Queensland Health and Queensland Aboriginal and Islander Health Council (2021). Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework. Brisbane: Queensland Health and Queensland Aboriginal and Islander Health Council. Accessed 12 September 2025, Available from:https://www.health.qld.gov.au/__data/assets/pdf_file/0019/1121383/health-equity-framework.pdf
Ramsden I. (1993). Cultural safety in nursing education in Aotearoa (New Zealand). *Nursing praxis in New Zealand inc*, 8(3), 4-10. PMID: 8298296.
Ramsden I. (2002). Cultural safety and nursing education in Aotearoa and Te Waipounamu (Doctoral dissertation, Victoria University of Wellington). Accessed 10 June 2025, Available from: https://www.iue.net.nz/wp-content/uploads/2024/01/RAMSDEN-I-Cultural-Safety_Full.pdf
Rix E, Doran F, Wrigley B and Rotumah D. (2024). Decolonisation for health: A lifelong

process of unlearning for Australian white nurse educators. *Nursing inquiry*, 31(2), e12616. https://doi.org/10.1111/nin.12616

RACGP: Royal Australian College of General Practitioners, *Racism in the healthcare system*, Position statement – March 2025, Accessed 5 September 2025, Available from:https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/health-systems-and-environmental/racism-in-the-healthcare-system

SBS (2025). *'No safe space': report highlights increase in racism after failed Voice referendum*' Accessed 10 September 2025, Available from:https://www.sbs.com.au/news/podcast-episode/no-safe-space-report-highlights-increase-in-racism-after-failed-voice-referendum/nz7w2yk9t

Scrimgeour M and Scrimgeour D. (2007). Health Care Access for Aboriginal and Torres Strait Islander People Living in Urban Areas, and Related Research Issues: A Review of the Literature, Cooperative Research Centre for Aboriginal Health, Darwin. Accessed 1 September 2025, Available from: https://www.lowitja.org.au/wp-content/uploads/2023/05/DP5_final-pdf.pdf

Sim W, Lim WH, Ng C H, Chin YH, Yaow CY, Cheong CWZ, ... & Chong CS. (2021). The perspectives of health professionals and patients on racism in healthcare: A qualitative systematic review. *PLoS One*, 16(8), e0255936. https://doi.org/10.1371/journal.pone.0255936

Smith CS and Simon LE. (2025). To do good and refrain from harm: Combating racism as an ethical and professional duty. *The Journal of the American Dental Association*, 156(2), 91-94. DOI: 10.1016/j.adaj.2024.08.003

Smye V, Josewski V and Kendall E. (2010). Cultural safety: An overview. First Nations, Inuit and Métis Advisory Committee, 1, 28. Accessed 11 June 2025, Available from: https://www.academia.edu/download/80869051/CULTURAL_20SAFETY_20AN_20OVERVIEW_20draft_20mar_202010.pdf

Smylie J, Anderson I, Ratima M, Crengle S and Anderson M. (2006). Indigenous health performance measurement systems in Canada, Australia, and New Zealand. *The Lancet*, 367(9527), 2029-2031. DOI:10.1016/S0140-6736(06)68893-4

Statistics Canada. (2024). Indigenous Peoples Technical Report Census of Population, 2021 (Cat. No. r 98-307-X, issue 2021001). Accessed 11 September 2025, Available from: https://www12.statcan.gc.ca/census-recensement/2021/ref/98-307/98-307-x2021001-eng.pdf

Tapia KA, Garvey G, McEntee MF, Rickard M, Lydiard L and Brennan PC. Breast screening attendance of Aboriginal and Torres Strait Islander women in the Northern Territory of Australia. *Australian and New Zealand Journal of Public Health*. 2019;43(4):334–9 https://doi.org/10.1111/1753-6405.12917

Taylor K and Guerin P. (2019).Health care and Indigenous Australians: cultural safety in practice. 3rd ed. London: Red Globe Press.

Temple J B, Kelaher M and Paradies Y. (2019). Prevalence and context of racism experienced by older Aboriginal and Torres Strait Islanders. *Australasian journal on ageing*, 38(1), 39-46. https://doi.org/10.1111/ajag.12604

Thorpe A, Arabena K, Sullivan P, Silburn K and Rowley K. (2016). Engaging first peoples: a review of government engagement methods for developing health policy. Discussion paper, Lowitja Institute: Melbourne, Vic.,

Australia. Accessed 3 July 2025, Available from: https://www.lowitja.org.au/wp-content/uploads/2023/05/Engaging-First-Peoples.pdf

Truong M, Allen D, Chan J and Paradies Y. (2021). Racism complaints in the Australian health system: an overview of existing approaches and some recommendations. *Australian Health Review*, 46(1), 1-4. https://doi.org/10.1071/AH21189

Van Ryn M, Burgess D J, Dovidio J F, Phelan S M, Saha S, ... and Perry S. (2011). The impact of racism on clinician cognition, behavior, and clinical decision making. Du Bois review: social science research on race, 8(1), 199-218. doi:10.1017/S1742058X11000191

Veasey A, Bryant N and Wenitong M. (2025). Indigenist Health System Reform Agenda. In Indigenous Research Knowledges and Their Place in the Academy (pp. 111-133). Cham: Springer Nature Switzerland.

Wategо C, Singh D, Newhouse G, Kajlich H and Hampson R. (2022). 'I catch the pattern of your silence'. *Meanjin*, 81(3), 105-111. https://search.informit.org/doi/10.3316/informit.703966619542372

Wategо C, Singh D, Yeh K Y, Kajlich H and Singh S. (2025). Taking up the challenge of eliminating racism in health care through talking about race (and culture). *The Medical Journal of Australia*, 223(1), 4. https://doi.org/10.5694/mja2.52678

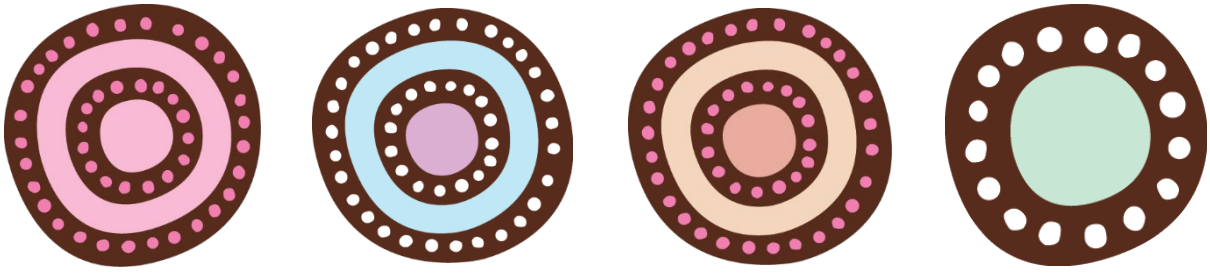
Williams R. (2009) Cultural safety—what does it mean for our work practice? Australian and New Zealand Journal of Public Health. 1999;23(2):213–4. https://doi.org/10.1111/j.1467-842X.1999.tb01240.x

WHO: World Health Organization. (2024). Tackling structural racism and ethnicity-based discrimination in health. World Health Organization: Geneva, Switzerland. Accessed 10 September 2025, Available from: https://www.who.int/activities/tackling-structural-racism-and-ethnicity-based-discrimination-in-health

Wright M and Haysom G. (2023). Managing patient complaints to improve your practice. *Australian Journal of General Practice*, 52(12), 848-851. doi: 10.31128/AJGP-07-23-6901

Wylie L and McConkey S. (2019). Insiders' insight: Discrimination against Indigenous peoples through the eyes of health care professionals. *Journal of racial and ethnic health disparities*, 6(1), 37-45. https://doi.org/10.1007/s40615-018-0495-9

Yashadhana A, Fields T, Blitner G, Stanley R and Zwi AB. (2020). Trust, culture and communication: determinants of eye health and care among Indigenous people with diabetes in Australia. *BMJ Global Health*. 2020;5(1). https://doi.org/10.1136/bmjgh-2019-001999



**Contact:**

Adj AProf Rebecca Haddock
Executive Director | Knowedge Exchange
Australian Healthcare and Hospitals Association Limited.
Email: rhaddock@ahha.asn.au

**Citation:** Elvidge E and Haddock R. 2025. Measuring what really matters for Aboriginal and Torres Strait Islander Peoples – racism and cultural safety in healthcare. Deeble Issues Brief 60. Australian Healthcare and Hospitals Association Limited, Australia.

**Artwork** by Wonnarua artist Carissa Paglino



*AHHA Ltd acknowledge the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. AHHA Ltd also pays our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.*