

Partnership for Justice in Health: Scoping Paper on Race, Racism and the Australian Health System

Chelsea Watego, David Singh, Alissa Macoun

Discussion Paper





About the artwork:

The artwork by Ngarrindjeri artist Jordan Lovegrove, represents The Partnership for Justice in Health (P4JH) and their vision “Aboriginal and Torres Strait Islander people enjoy health and wellbeing that is free of racism in the health and justice systems”. P4JH is shown by the large two meeting places in the centre of the artwork; a healing hand to represent health while the person with the scales represents justice. The meeting places and pathways on the outside not only represent different people, families and communities but are also in the shape of the journey the Freedom Riders travelled to draw attention to injustice and discrimination against our First Peoples of Australia in 1965. The patterns within this shape are illustrative of the combined systems and connections working together to address racism, improving health and justice outcomes.



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Contents

Background.....	iv
Introduction.....	1
Key Terms and Concepts.....	4
Review of Literature: Approaches to Research on Racism and Health.....	11
Political Directions: Anti-Racist Praxis and Race Criticality.....	28
Recommendations.....	39
References.....	42
Acronyms.....	48

Warning: Aboriginal and Torres Strait Islander people should be aware that this discussion paper may contain names, images and voices of persons who are deceased.



Background

The Partnership for Justice in Health (P4JH) is an alliance of self-determining Aboriginal and Torres Strait Islander academics, legal experts, and national peak health and justice organisations committed to working together to eliminate the impacts of racism on Aboriginal and Torres Strait Islander health and wellbeing. We formed in 2017 in response to the ongoing impacts of racism in the Australian health system following the death of Wiradjuri woman Naomi Williams and her unborn child at Tumut Hospital in NSW. Since this time, we have worked and grown together, building a shared understanding of race and racism, how these constructs function and the violence they inflict.

As leaders operating at the interface of the health and justice systems, we commit to harnessing our leadership, influence, and networks towards realising our vision 'Aboriginal and Torres Strait Islander People enjoy health and wellbeing that is free of racism in the health and justice systems'.

We will commit to working together to establish an ongoing national campaign to influence systemic change and eliminate racism across the health and justice systems, and ensure that Aboriginal and Torres Strait Islander peoples are at the centre of driving solutions, that includes:

- establishing, managing and maintaining an authoritative online hub or website
- providing access to and collaborating on research
- developing and distributing resources
- promulgating best practice evidence-based approaches
- providing referral, information and contacts and

managing the P4JH in line with the principles of Indigenous leadership, governance and self-determination. Members of the Partnership include:

- ABSTARR Consulting
- Associate Professor Chelsea Watego
- Australian Indigenous Doctors' Association
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Indigenous Allied Health Australia
- Institute for Collaborative Race Research
- Lowitja Institute
- National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
- National Justice Project



Acknowledgment

The Partnership for Justice in Health acknowledges and pays respects to the Annamila First Nations Foundation for their financial contribution. It also acknowledges the National Aboriginal Community Controlled Health Organisation (NACCHO) and the National Aboriginal and Torres Strait Islander Legal Services (NATSILS) for their contribution to the Partnership for Justice in Health.

Introduction

This discussion paper was first prepared as a scoping paper designed to assist the Partnership for Justice in Health (P4JH) consider what is offered by existing scholarship about race and racism in the health system, and in particular, to identify a research approach to support the Australian Government’s National Aboriginal and Torres Strait Islander Health Plan’s (NATSIHP) vision of ‘a health system free of racism’ (2013).

It was noted at the time that, in keeping with the field of health research more generally, NATSIHP did not provide an explicit analysis of the operations of race and racism in the Australian healthcare system and provided limited detail about how the goal of a health system free of racism was to be achieved. By contrast, the Lowitja Institute led efforts to address this long-standing omission through advocating for a stronger focus on racism within Indigenous health research, and investment in several national symposiums and commissioned research papers to further the field of inquiry (Anderson et al 2007, Paradies et al 2008). The scoping paper was intended to complement the Lowitja Institute’s effort as well as to guide the P4JH in conceiving a more concerted and cohesive national anti-racist health agenda.

Racism and anti-racism have been thrown into sharp relief by recent events, most notably the murder of George Floyd by a police officer in Minneapolis in 2020, the renewal of the Black Lives Matter (BLM) movement as a consequence, and the spate of continuing deaths in custody of Aboriginal and Torres Strait Islander people. This year marks the 30th anniversary of the handing down of the Final Report of the Royal Commission into Aboriginal Deaths in Custody. Whilst the present moment has highlighted police violence against racialised communities, the 1991 report strikingly concluded that of the 99 deaths investigated not one could be attributed to it. Instead, the recommendations worked to bring into focus the complicity of health and legal systems in racial violence and the “*glaring*

deficiencies...in the standard of care afforded to many of the deceased” (Johnston 1991). The coronial inquests into the preventable deaths of Aboriginal and Torres Strait Islander peoples in custody since the Royal Commission continue to reveal the ongoing deficiencies of both systems. Whilst conflating the legal and health system in this context is entirely to be expected as a death in custody will give rise to a legal response, such conflation can blur lines of responsibility that serve to confuse accountability. The health system has particularly benefitted in this regard. Coronial inquests examining the preventable deaths of Indigenous peoples attending health care services such as Ms Williams (NSW Courts 2016), combined with over a decade of policy failure to close the gap of health inequality, have highlighted how the health system – independently of the legal system – produces racialised health outcomes (Bond 2020).

Despite the heavy presence of race, it was only last year in 2020, that a coronial inquest into an Aboriginal death examined for the first time whether systemic racism was a potential contributing factor in the death of Aunty Tanya Day (Victorian Courts 2020). In her analysis, the Coroner, however, refused to make connections between statistical evidence about the over-representation of Aboriginal women in custody with Ms Day’s circumstances, and also decided that professional non-compliance with organisational policies or procedures would not necessarily be evidence of either unconscious bias or racism (Victorian Courts 2020). This refusal to conclude otherwise is contrary to the weight of evidence, especially that offered by the testimony of Aboriginal families and communities. The families and communities are not helped however by the vacillation of professional organisations, policy makers and NGOs in deciding how best to define

all things ‘race’. In 2021 the National Registration and Accreditation Scheme, for instance, launched the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy (2020–2025) which “sets clear directions for the Australian Health Practitioner Regulation Agency to ensure patient safety for Aboriginal and Torres Strait Islander people” by attending to the structural and individual health reform of health practitioners and the systems that regulate them (Bond et al 2020 p.429). Implied in this move is a commitment to understand how race functions in the structural and individual health reforms required and is a significant advance for those who have long advocated for just such an understanding. Yet where the Australian Health Practitioner Regulation Agency might be helped in this commitment by a statutory organisation charged with protecting and promoting human rights, it is instead waiting on that organisation to decide on what race and anti-racism looks like. Thus the Australian Human Rights Commission, which has called on the Federal Government to support the implementation of a National Anti-Racism Framework, has released a ‘concept paper’ to this end but has omitted key

definitions of concepts such as race, racism and anti-racism that describe the threats to human rights they are charged with upholding. This partial, uneven understanding of race on the part of the very agencies those grieving families might appeal to in their struggle for justice has frustrated the development of a coordinated anti-racist strategy. This paper seeks to address the staggered grasp of race by furnishing a basic understanding of race and anti-racism in ways that serve those at the sharp end of racialising practices. In so doing, it is hoped that we compensate for those organisations whose hesitancy will literally be the death of us.

Indigenous health offers a key site for understanding how race operates and too, is instructive in gauging how poorly race is understood in this place. For instance, NATSIHP (2013 p.14) identifies the relationship between racism and health as primarily and fundamentally an **individual health behaviourist** one: encounters with racism have a debilitating effect on Aboriginal and Torres Strait Islander peoples’ **confidence and self-worth**, impacting individuals’ **mental health** and the likelihood they will make

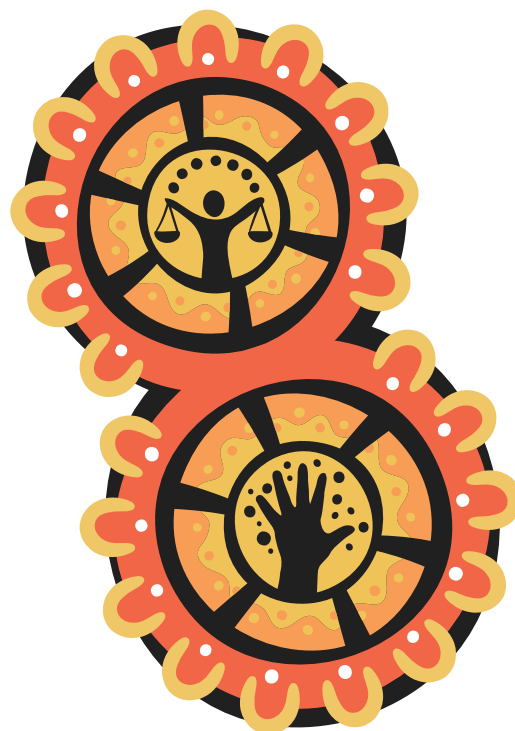
Source: ABC News Online (2020) Demonstrators marching from Town Hall to Belmore Park. (ABC News: Mridula Amin)



health risking lifestyle choices; racism further encountered in the health system can present a **barrier to accessing appropriate health services**, resulting in what NATSIHP (2013 p.51) defines as **systemic racism**, “*the failure of the health system to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin*”. This is said to compound a legacy of disadvantage arising from past colonial and discriminatory practices (2013 p.14). In NATSIHP then, racism is implicitly understood as a question of individuals’ prejudices or attitudes which adversely affect Aboriginal and Torres Strait Islander health behaviours, resulting in a failure by the health system to provide services equally and appropriately. There are limitations to this line of argument, notably the absence of an acknowledgment of the ongoing impact of dispossession and colonialism, the structuring impact of discriminatory government policies and practices and the prevalence and multiple expressions of racial violence. A stress on behaviourism will take our analysis only so far; beyond that, adherence to this line of thinking borders on scapegoating the very constituency initially vindicated.

We witness this too in the recently released Indigenous Health Research Fund’s Implementation Plan, where ‘a health system free of racism’ is repeated as a priority area, yet an analysis of the rationale, program objectives and proposed research questions construct race and racism as a ‘factor’ that contributes to health inequality, rather than foundational to its production (Department of Health 2020). That the priority area remains divorced from the other health priority areas reveals a constrained understanding of race, as does the absence of colonisation as a factor in ‘addressing the root causes of inequality’. In its absence, culture and cultural practices appears as something to be strengthened, yet a research investment that is not explicit about colonisation and the centrality of race to its ongoing work will fail in addressing what is at the root of Indigenous health inequality.

This paper seeks to disclose race in this place, in health and beyond. Beginning with an overview of some of the **core concepts in relation to race and racism**, we hope to develop a shared understanding of key terms and outline some central debates worthy of consideration in developing an anti-racist health and wider research agenda. Ideas about what race is, how it works—as well as what racism is, what it does and how—have been central to both the power of these phenomena and objections to them. Such



an understanding will help forge stronger anti-racist positions that acknowledge the suffering that attends race as well the daily acts of community resistance that invariably follow. We also **review and outline key approaches** that researchers have drawn on locally and internationally in order to explore race and racism with particular regard to the health system, recognising that these approaches rely on different understandings about race, health, and power. This paper identifies the kinds of insights that differing approaches provide and their underlying assumptions, to consider briefly the impacts and opportunities they can deliver.

The final section of this paper explores the key ways questions of **knowledge and political strategy** have been considered by anti-racist or race critical movements. Determining what kind of research will be necessary or useful is as much a question of strategy as it is a question of knowledge. We canvass some approaches to knowing about race through campaigning in order to compel action. This report is intended to inform strategic choices about the kinds of knowledge that might be useful in understanding and addressing the ways that race matters in the health system and beyond, and in any campaign seeking to challenge racism. While ultimately these strategic choices are choices for the activist and campaign, this paper outlines a range of options and approaches.

Key Terms and Concepts

This section provides key definitions of essential concepts in relation to race and racism, in order to develop a shared understanding of key terms and debates in the field. Like most concepts in the social sciences, these terms are often debated and contested. Academics across disciplines and locations use and define their terms slightly differently, and debates over the meanings of concepts can be an important part of the social and political struggles they explore and explain. This is particularly true in relation to race and racism—as claims about what race is, how it works, as well as what racism is, what it does and how, have been central to both the power of these ideas and resistance to them.

Race

Race refers to the idea that humans can be organised into biologically distinct ‘races’ of people with defined physical and social traits and capacities. This idea is a modern one, generally accepted as emerging from 16th–17th century Europe alongside the emergence of large scale European colonialism and the intellectual movement called ‘the enlightenment’ (Bernasconi 1980; Miles 1989, 1993; Goldberg 1993). The idea that diverse human societies could be organised into races and ranked hierarchically was at the centre of much European science from the 17th to the 19th centuries. It was fundamental to the natural and biological sciences, medicine, philosophy, as well as emerging social sciences – and was used extensively to justify **colonialism** and **racial violence** (Banton 1980, Goldberg 1993, Smedley & Smedley 2005, Frederickson 2002).


For more information about...

Racial science in the formation of modern health disciplines:

- Anderson, W. 2006, *The Cultivation of Whiteness: Science, Health and Racial Destiny in Australia*, Duke University Press, Durham.
- Brough, M. 2001, Healthy Imaginations: A social history of the epidemiology of Aboriginal and Torres Strait Islander health, *Medical Anthropology*, vol. 20(1): 65–90.
- Gravlee, C. 2009, How Race Becomes Biology: Embodiment of social inequality, *American Journal of Physical Anthropology*, vol. 139(1): 47–57.

Racial science was central to the development of contemporary health disciplines, many of which emerged from knowledge gained through implication in violent racial and colonial regimes involving dehumanising or spectacularising black bodies (see Gilman 1985, Ojunga 1993, Coates 2010, Spettel & White 2011). Medical science has long been concerned with constructing racial classifications and particularly the production of knowledge evidencing the racial inferiorities of Indigenous peoples (Rigney 2001, Thomas 2004, Anderson 2006). The ideas about **race**, **racial hierarchy** and **white supremacy** developed and expressed by racial science were popularised, and expressed widely in art, culture, literature, as well social and sexual mores, gender norms, religion, politics, law and other public discourse in Europe and European colonial societies around the world (see Said 1978, Young 2000, McClintock 1995, Stoler 1992).

Racial science—sometimes referred to as **scientific racism**—is now thoroughly discredited. After the end of World War II and growing public awareness of the holocaust, UNESCO’s statement ‘The Race Question’ (1950 p.8) noted that



For all practical social purposes ‘race’ is not so much a biological phenomenon as a social myth. The myth of ‘race’ has created an enormous amount of human and social damage. In recent years, it has taken a heavy toll in human lives, and caused untold suffering.

Scientists now agree that race does not biologically exist; while members of some racialised groups may share some limited genetic similarities, these are very significantly outweighed by genetic diversity (see Cavalli-Sforza 2001).

Race is now widely described as a **social construction** but this doesn’t mean that race is imaginary or not real. While race may not exist biologically, **it exists powerfully and materially because ideas about race formed, legitimised – and continue to form and legitimise – social, cultural and political structures, practices, and beliefs.** Representations of race in language, culture,


popular and academic discourse, personal and social interactions and other domains assign and negotiate the meanings attached to race. These meanings enable race to operate within, and be further made material in and by, social and political structures.

Groups are **racialised** – that is, they come to be understood, to see themselves and be seen and treated by others as a distinct racial category – through this process of **racialisation** (Omi & Winant 1986, Bonilla-Silva 1997, Garner 2009). Scholars have studied the ways that racialisations and racial hierarchies in different locations and contexts emerge to support dominant groups’ economic and political interests and imperatives (Omi & Winant 1986, Bonilla-Silva 1997, Frederickson 2002). For example, Wolfe (2006) notes the colonial project of the United States required both dispossession of Native Americans and a reliance on black slave labour, so colonisers’ racialisations defined Indigeneity as fragile and thus able to be quickly eliminated or defined away, in contrast with Blackness which was framed as a widely inclusive and resilient category. These ideas about race were backed up by scientific and cultural discourses, legal and political structures, and a vast apparatus of socially and state sanctioned violence and terror to entrench white supremacist colonial regimes. Ideas about race are in this way made tangible and material, encoded in social systems where they are contested, resisted, reframed and reinforced through political struggles.

Racism

Racism is a much more recent idea than race, with the concept emerging in the early 20th century (Banton 1970; Miles 1989, 1993; Bonilla-Silva 1997). Hesse (2011) argues the term was coined to critique Nazi racial science, specifically the politicisation of the biological sciences through eugenics and ethnic cleansing in fascism, an understanding of racism as a distorting racial ideology which was compatible with early American social scientific interest in **racial prejudice**. In 1945, Ruth Benedict formulated an initial and influential definition of racism as *“the dogma that one ethnic group is condemned by nature to congenital inferiority and another group is destined to congenital superiority”* (Benedict quoted in

Bonilla-Silva 1997 p.465). By the middle of the 20th century, racism came to be understood broadly as



... an attitude or theory that some human groups, socially defined by biological descent and physical appearance, were superior or inferior to other groups in physical, intellectual, cultural, or moral properties. (Van den Berghe 2007)

This understanding of racism as primarily attitudinal—related to racial hatred or to racial prejudices held by an individual or group—remains influential both popularly and academically. Conceptions such as overt and covert racism, implicit bias, interpersonal racism, elite racism, personally mediated racism, draw upon this framing.


For more information about...

Key race concepts:

- Bolaffi, G. 2003, Dictionary of Race, Ethnicity and Culture, SAGE, London.
- Cashmore, E. & ProQuest 2004, Encyclopedia of Race and Ethnic Studies, Routledge, London & New York.

Understandings of racism emphasising institutional or structural factors over individual prejudices have become more prevalent since emerging in the late 1960s. In 1967, Carmichael and Hamilton first used the term **institutional racism** to differentiate individual acts of racism or racial violence from the entrenched racism of policies and practices which maintain a racist social order but which are ignored or depicted as inevitable (for example, poverty and discrimination, segregation in slum housing, predatory lending, etc.). Carmichael and Hamilton (1967 p.4) argued that while individual racist acts or expressions are easily identifiable and widely condemned, racism inhering in institutions *“originates in the operation of established and respected forces in the society, and thus receives far less public condemnation”*.

Their concept wasn't initially widely adopted, but from the 1990s onwards institutional approaches to racism have increasingly been explored to explain the entrenched effects of race despite decades in which explicit expressions of racism or overt practices of racial discrimination have been—theoretically—legally and politically discouraged. In the UK's 1999 Lawrence Report (Home Office para 6.34), Sir William Macpherson's influential definition of institutional racism emphasised the role of racial prejudice in service delivery failures:



The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.

This definition again emphasises the role of racist attitudes and racial prejudice, although expressed through people operating within institutions and so encoded in the institution's collective behaviours and processes. Significant bodies of scholarship in health, education, housing, social and legal fields internationally—particularly in the US—explore race using this understanding of racism. These institutionally framed understandings of racism are concerned with explaining how racism can exist beyond the prejudiced individual; institutions can encode and enact racial prejudice and discrimination in their systems without the need for individual racists or white supremacists to act intentionally or express this motivation. In this way, patterns of race based outcomes (i.e., disproportionate imprisonment rates, employment outcomes, or health indicators) can be identified as resulting from racism without specifically emphasising discrimination or attitudinal drivers. These definitions are also occasionally qualified in some way (e.g., indirect or covert institutional racism) NATSIHP's (2013 p.51) definition of **systemic racism** as *“the failure of the health system to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin”* is drawn directly from McPherson's definition of institutional racism. While systemic racism as a term isn't as widely used in the international race literature as **institutional racism**, it appears to have been much more widely adopted in the Australian health research and policy context (for example Paradies et al 2008, Paradies & Cunningham 2009, Dwyer et al 2011, Lowitja Institute 2015).

There is significant conceptual slippage in the way the term systemic racism is used in the literature, possibly because multiple meanings are assigned to the idea of a **system**. The 'system' the term identifies is sometimes understood to be a designated set of institutions and practices (e.g., the education or health system). In this context, the term is often understood as synonymous with institutional racism (see Paradies et al 2008), except that referring to a 'system' may not invoke the accountability mechanisms of institutional governance and other hierarchies as specifically. In other uses, particularly internationally, the term systemic racism is used to indicate a deeper political structure underpinning or generating social relations, institutions, and ideas (e.g., the system of racial oppression, of global capitalism, etc.). In this

context, the term is seen as referring to situations where racism connects, generates and makes legible an entire sociopolitical system (Feagin 2006); this usage of systemic racism is often linked to critical race approaches (Feagin & Bennefield 2014) and to understandings of racism as structural or societal.

Race scholars have used concepts like **structural** or **societal racism** to express ways that racism can operate at the level of deep social structures (see for example Frederickson 1988, James 1996, Bonilla-Silva 1997). Bonilla-Silva (1997 p.474) argues some societies can be understood as **racialised social systems**; racial hierarchies in political, economic, and social life arising from the racialisation of groups and resulting social relations and practices are essential to the **racial structure** of these societies. In these societies, **racial ideologies**—widely understood as racism—become a kind of racial common sense that guides people and institutions in how to behave. All of these structures are subject to **racial contestation** which reveals groups and actors' objective racial interests.

With this kind of analysis, it's possible to identify that peoples' lives and health may be profoundly structured through and around race even when overt expressions of racism are discouraged by law or policy; also that white policy makers or service providers may be invested in minimising or ignoring the impact of race and racism on their practice—whether or not they are explicitly conscious of their own racial interests.

For more information about...

Race, peoplehood, nationhood and sovereignty

- Alfred, T. 2001, From Sovereignty to Freedom: Towards an indigenous political discourse, *Indigenous Affairs*, vol. 3: 22–35.
- Moreton-Robinson, A. 2015, *The White Possessive Property, Power, and Indigenous Sovereignty*, University of Minnesota Press, Minneapolis.
- Calhoun, C. 1993, Nationalism and Ethnicity, *Annual Review of Sociology*, vol. 19: 211.
- Anthias, F. & Yuval-Davis, N. 1992, *Racialized Boundaries: Race, nation, gender, colour and class and the anti-racist struggle*, Routledge, London & New York.

Some scholars have argued that in fact the prohibition or denial of race hatred or overt racism plays an important role in enabling race and racist social systems to operate. Anti-racist efforts often target overt racial prejudice, discrimination or violence, but these are not necessarily required for racial inequality or race-based domination to persist. Bonilla-Silva (2010) argues that claims to **colourblindness** are an ideology allowing the perpetuation of racial inequality and white dominance without individuals expressing racial prejudice. He contends (2010 pp. 26–30) this occurs in four main ways: **abstract liberalism** allows colour blind racists to invoke abstract ideas about 'equal opportunity' and 'individual choice' while ignoring existing power and resource distribution and opposing concrete proposals to reduce inequality; **naturalisation** allows whites to explain racial segregation as inevitable and natural; **cultural racism** explains racial inequality as arising from cultural or chosen factors within a racial group; and **minimisation** involves downplaying the impact and extent of racism. Many scholars have pointed out the ways that **white racial dominance** is often presented as deracialised and universal, deploying a language of tolerance, benevolence or humanitarianism to position white values and norms of behaviour as neutral and aspirational without being seen to explicitly invoke race (see, for example, Goldberg 1993; Moreton-Robinson 2000, 2015).

Understanding racism as a practice or attitude of individuals or even groups of individuals (in 'casual' remarks, prejudicial processes or violent acts) disconnected from deeper systems of racial dominance pathologises racism and constructs it as an aberration—distracting from the way race operates in and through existing social and political structures (Sivanandan 1990). If racism exists in the operation of race as essential to a social system, there is debate among scholars about whether it is possible or useful to distinguish between the two concepts (see Hesse 2011). A society structured through and upon race and racial dominance is itself inherently racist and will remain so until the violence inherent in these structures can be challenged or overcome - even as racial idiom in language, policy and the practice of racism changes.

Anti-racism

Definitions of anti-racism have been as varied as understandings of racism. As Bonnett (2000 p.4) notes, the term anti-racism can be minimally defined as *“those forms of thought and/or practice that seek to confront, eradicate or ameliorate racism”* which *“implies the ability to identify a phenomenon – racism – and do something about it”*. Activist and other efforts to combat racism have often manifested a specific focus on addressing racial prejudice and discrimination. This has often reflected a liberal focus on human or civil rights, and operated through a belief that education and access to legal remedies will reduce attitudinal and institutional racism.

A good example of this approach is the Australian Human Rights Commission’s National Anti-Racism Strategy 2012–2015 (AHRC 2012). Racism is often framed by anti-racist campaigns as a question of prejudice remediable through improved education, rewarding efforts towards social tolerance, and better access to redress or support through law and existing institutions. This approach is critiqued by those who adopt **critical race** approaches, as it focusses on addressing attitudes but not deeper social structures; racism is depicted as arising from ignorance rather than interests, and existing institutions are understood as legitimate arbitrators of and remedies for racism rather than also as projects and products of racial domination.

Critical Race Theory

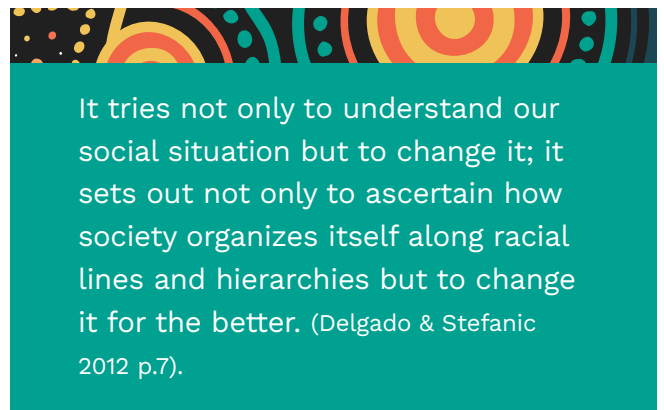
Critical Race Theory (CRT) is an approach to understanding and studying race, racism and power that emerged in the 1970s from critical legal scholarship and has now become influential in and across many other disciplines. Critical race approaches see race as a fundamental social and political structure, central to existing institutions and modes of social organisation.

According to Delgado and Stefanic (2012 pp.7–10), CRT has a number of basic tenets:

- Racism is ‘ordinary not aberrational’—built into the fabric of institutions and everyday life for most people and yet not widely acknowledged due to liberal colourblindness and so difficult to address;
- Racism serves to entrench white dominance and so functionally further the material interests of both white elites (directly) and working class whites (psychologically);

- Race is socially constructed, which means *“races are categories that society invents, manipulates or retires when convenient”*;
- Dominant society racialises groups differently when convenient in response to political and economic needs, which means racial imagery and stereotypes shift over time; e.g., a group that in one era may be depicted as simpleminded and happy to serve whites may in another be depicted as menacing or brutish and requiring control and repression;
- No person has a singular or unitary identity; intersectionality and anti-essentialism mean that *“everyone has potentially conflicting, overlapping identities, loyalties and allegiances”*;
- Racialised status brings with it a unique voice and understanding of race and racism because of experiences of oppression within a system based around white racial dominance.

Critical race theory also has a specifically activist dimension:



While some academics refer to CRT to indicate the specific body of scholarship emerging from the US legal context, others use terms like critical race or race critical more broadly to encompass a range of approaches concerned with understanding and critiquing race and whiteness as social and political systems (see Essed & Goldberg 2002). Emerging bodies of scholarship have sought to connect scholarship in critical race (which did not initially engage deeply with Indigenous sovereignty) and Indigenous studies scholarship (which has traditionalised emphasised culture, sovereignty and colonialism) in order to explore not only the racialisation of Indigenous peoples but the ways that race as a category operates to assert and legitimise colonial claims to sovereignty (see Brayboy 2005, Moreton-Robinson 2008).

Race and Culture

Since discussions of group differences through the lens of race had been problematised by the mid 20th century, **culture** has increasingly been a focus of analysis in health and social sciences. While not reducible to race, culture has often served as a euphemism for race (see further Bond 2007, Moreton-Robinson 2016). This phenomenon can involve recoding racist myths about racialised people as cultural truths arising from group practices and choices—a phenomenon sometimes known as **cultural racism** (Blaut 1992). While discussions about race necessarily involve conversations about power and racial hierarchies, addressing similar questions through a lens of culture can recode these as matters of simple difference.

Thomas et al (2014) note the abandonment of race in Australian health research from the 1950s onwards due to the failure to distinguish race biologically. In its place was the concept of culture and a research desire to capture ‘a vanishing way of life’. Importantly, the focus on culture in place of race has not deterred or halted the reproduction of racialised knowledge about Indigenous peoples. Rather, culture has been used to mask the material impact of race as a social construct, while simultaneously reproducing pervasive racialised logics about ‘the Aborigine’. The deviance and deficiencies of Aboriginal and Torres Strait Islander people once ascribed to biological racial inferiority can be explained as the result of

cultural factors and choices, and associated health disadvantages rationalised. Indigenous health inequality can thus remain an intractable part of the natural order of things, not via biological notions of race, but through racialised imaginings of Aboriginal cultural life.

Cultural Competence

Cultural competence is a term used widely in Australian health, education, social work and other human services fields to indicate an ability to operate and communicate effectively across cultures, often in relation to Indigenous peoples but sometimes within an overarching framework of **multiculturalism** or **diversity** more broadly. It is widely entrenched in many health domains and in policy frameworks. The term emerged from the United States in the 1980s in the context of conversations about treating and researching clients from diverse ethnic groups (Cross et al 1989, Gallegos et al 2008, Kohli et al 2010). It was initially framed by health professionals as encouraging institutions and colleagues to value diversity and develop an understanding of the cultural needs and practices of those from minority cultural groups, and involved self-assessment of institutional competence and practices when engaging with clients of diverse cultural backgrounds (Cross et al 1989). This model relies on developing practitioner expertise in and appreciation for the differences in beliefs, customs and needs of members of other cultures.





Cultural Safety

Cultural safety is a concept developed in 1989 at a nursing leadership hui by Māori nurses, as detailed and developed by Irihapeti Ramsden (2002) in her PhD thesis. This framework critiques concepts like transcultural nursing and cultural awareness—or cultural competency—which operate through developing practitioner expertise in generalisations about customs and practices of encultured ‘others’ (Ramsden 2002 pp.167–77). Cultural safety is the responsibility of a health practitioner but judged by the patient, and this is a key element of the model, which emphasises the requirement for practitioners to identify ways their cultural, professional and institutional location shapes the care they provide (Papps & Ramsden 1996, Ramsden 2002, Williams 1999, Brascoupé & Waters 2009). Through this focus on identifying, acknowledging and addressing power differentials, cultural safety by necessity involves questions about race and racism (Papps & Ramsden 1996 p.495, Ramsden 2002). However, there still appears to be an underpinning assumption that greater reflexivity by practitioners about their own culture and location will result in benevolent adjustments to health practice; like many *anti-racist frameworks*, this assumes that it is ignorance rather than the kinds of investments identified by **critical race theory** that generate racism.

Conclusion

There is a much richer debate around the concepts of cultural safety and cultural competency which have not been examined here, and indeed there are a range of other concepts such as cultural awareness, cultural sensitivity, and cultural humility which may also be included in such discussions. It is not the goal here to resolve such tensions, however in seeking to achieve ‘a health system free of racism’ consideration must be given to which framework that might be articulated. Given the entanglement of race and culture, and in particular the use of culture to disguise the realities of race, in its operation within the health system, an **‘anti-racist’** or **‘race-critical’** agenda might be worth considering more explicitly, within cultural safety or cultural competence or independently from. More than a terminology issue, such a decision should be based upon the ideology which underpins these concepts.

Review of Literature: Approaches to Research on Racism and Health

Rather than provide an exhaustive literature review, this section provides a short review of different approaches to research into race, racism and the health system, identifying the insights that they provide, and underlying assumptions that they depend upon. This will assist with informing stakeholders' strategic choices about the kinds of research that might be useful in understanding and addressing the ways that race matters in the health system, and in achieving a health system free of racism. Different research approaches ask fundamentally different questions, and give us different lenses for looking at race, racism and health.

They rely on different understandings of racism and how it operates, and make different assumptions about race, health, and power. All of these approaches can be useful and insightful in different ways. As outlined earlier, the ways we understand and define race and racism are contested and form part of the political struggles they seek to describe. Ideas about race and how it works reflect and reinforce a range of values, beliefs and strategic choices about how best to understand racial oppression as well as how to effectively resist or overcome it.

We have organised different research approaches into the following categories, cognisant of the fact that not all studies can fit neatly within them:

- **Quantification of racialised health outcomes**
 - Case Studies: Best practice examples
- **Quantification of racism in association with health**
 - Case Studies: Systematic reviews as quantification
 - Case Studies: Quantifying racism and implicit bias
- **Institutional Racism**
 - Case Study: Audits and assessments
- **Structural and systemic approaches to race and racism**
 - Case Studies: Testifying to racism and theorising about race
 - Case Studies: Structures, power and history

We should note here that we are primarily concerned with literature pertaining to racism within the health system, as opposed to racism and health outcomes more broadly. Further there is a body of literature relating to anti-racist education and training strategies targeted at health and medical students that is not explored here, given the focus of the P4JH objectives.



Quantifying racialised health outcomes

These kinds of studies seek to capture the significance of race as an influence on health by enumerating the relationship between Indigeneity and health conditions—often in terms of describing extent, likelihood, or impact in seeking to capture ‘determinants and disease patterns’ (see Gracey & King 2009). As others have identified, this model of research compiles a statistical picture of Indigenous peoples’ lives and experiences, documenting the impact of race on Indigenous bodies in tangible terms, implicitly arguing that this materiality proves or demonstrates that a problem exists and must be addressed. As Stone (1997 pp.183–205) notes, quantitative measures are often persuasive to policy makers because numbers impart authority and finality, implying that what is measured is both real and tangible. Despite this, numbers are fundamentally metaphors that attempt to describe reality, reflecting a range of human categorisations and decisions about what and how to count:

Every number is an assertion about similarities and differences. No number is innocent, for it is impossible to count without making judgments about categorization. Every number is a political claim about where to draw the line (Stone 1997 p.188).

As others have noted, the picture compiled by quantitative measures of racialised health outcomes can be problematic for a range of reasons. This approach doesn’t prioritise or reflect Indigenous peoples’ knowledge or understandings, almost always sees Aboriginal and Torres Strait Islander people framed against a non-Indigenous norm against which they can be determined to be fundamentally unhealthy, deficient or lacking, and implicitly constructs Indigenous bodies or communities as the location of required change (Pholi, Black & Richards 2009; Walter 2010). There is a very significant body of academic and policy literature in this category. Government policies approaches such as Closing the Gap rely upon and encourage this framing of health research, and this is a key focus of public health scholarship (which is concerned about health differentials within and across populations).

The Australian Institute of Health and Welfare (AIHW) generates extensive reporting in this vein, seeking to collect, collate, and link Australian Government held data for analysis in order to provide statistical evidence to inform policy. The AIHW website tells a statistical story about racialised health impacts on Indigenous people which is also routinely reported upon within *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* reports (AIHW 2018). A large number of reports and documents are compiled evidencing

- “significant gaps between Indigenous and non-Indigenous Australians”;
- “This disadvantage, or the ‘gap’ between Indigenous and non-Indigenous Australians, starts from birth and continues throughout life.”

Statistics are excerpted from recent reports, and scroll through ‘latest findings’ boxes across the screen:

- “Indigenous Australians experienced burden 2.3x the rate of non-Indigenous Australians”;
- “Over one third of Indigenous people with diabetes had not had an eye examination in the preceding 12 months”;
- “Tobacco use accounted for 23% of the gap in burden between Indigenous and non-Indigenous Australians.”

The routine reporting of persisting racialised health inequalities doesn’t appear to have inspired a race-critical research agenda; instead the statistical story of Indigenous health inequality has become a routine of health discourse in Australia.

The *Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011* (AIHW 2016) is an example of a study seeking to document racialised health outcomes. Released in 2016, it provides estimates of

what is deemed “*the non-fatal and fatal burden of disease for the Aboriginal and Torres Strait Islander population as well as estimates of the gap in disease burden between Indigenous and non-Indigenous Australians*”, identifying disease groups causing most health burdens to Indigenous people—often apportioned according to diseases of particular body parts. The report allocates a number to the burden of disease experienced by Indigenous people relative to non-Indigenous Australians, and identifies a proportion of this that may be addressed through modifying specific behaviours among Indigenous people.

This type of research often focuses on demonstrating that raced bodies bear a direct impact, rather than exploring the ways racial harm is generated by or delivered through institutions and social systems. As outlined above, this type of research configures Indigenous people as particularly affected by race, distinctively rendered unwell by race or racism; white patients are rarely depicted as experiencing advantageous health impacts due to racial privilege or colonial dominance.

Statistical portraits of deficit draw attention to the inequality that Indigenous peoples experience, but also run the risk of reproducing racialised imaginings of the dying race, documenting difference without explaining why or how such differences are produced (Brough 2001). Race represents an epidemiological variable, a label or classification that doesn’t necessarily reflect how identities are lived and enacted or detail the causes of inequalities. We are often left to ‘imagine’ what causal pathways might make race an epidemiological variable that predicts who gets sick or sicker. While causal pathways are frequently left unstated, race itself tends to be poorly theorised and is instead expressed through ideas about socioeconomic status, cultural norms and behaviours, or notions of biological inferiority that circulate in its place.

Example:

Mahoney, R. P. 2017, *Is Identifying as Indigenous Good for your Health? Investigating the relationship between Indigenous status identification and management of cardiovascular disease*, Professional Doctorate thesis, Queensland University of Technology.

Abstract: Improving the patient journey for Indigenous people has become an important focus to reduce the rates of cardiovascular disease and address underlying factors contributing to the disparities of care between Indigenous and non-Indigenous people. This study has demonstrated

that a culturally safe cardiac outreach service staffed by Indigenous and non-Indigenous people is capable of providing timely evidence-based care to the standards of best practice. The findings of this study indicate that racism at an interpersonal, individual, organisational and societal level contribute, interact and conspire to influence the Indigenous patient journey within mainstream health services. Identifying as Indigenous is not good for your health because, significantly, the patient journey commences with the collection of Indigenous status, an act of defining race that reinforces the disparity between Indigenous and non-Indigenous people.

Example:

Khanal, N. et al 2018, Disparity of Access to Kidney Transplantation by Indigenous and non-Indigenous Australians, *Medical Journal of Australia*, vol. 209(6), pp.261–66

Objective: To compare the likelihood of Indigenous and non-Indigenous Australians being placed on the waiting list for transplantation of a kidney from a deceased donor; to compare the subsequent likelihood of transplantation.

Design, setting and participants: Observational cohort study; analysis of data from the Australia and New Zealand Dialysis and Transplant (ANZDATA) Registry for patients aged 18–60 years at the start of renal replacement therapy, who commenced renal replacement therapy in Australia between 28 June 2006 and 31 December 2016.

Main outcome measures: Time to wait-listing; time to kidney transplantation after wait-listing.

Results: 10 839 patients met the inclusion criteria, of whom 2039 (19%) were Indigenous Australians; 217 Indigenous and 3829 non-Indigenous patients were active on the waiting list at least once during the study period. The hazard ratio (HR) for wait-listing (Indigenous v non-Indigenous patients, adjusted for patient- and disease-related factors) in the first year of renal replacement therapy varied with age and remoteness (range, 0.11 [95% CI, 0.07–0.15] to 0.36 [95% CI, 0.16–0.56]); in subsequent years the adjusted HR was 0.90 (95% CI, 0.50–1.6). The adjusted HR for transplantation during the first year of wait-listing did not differ significantly from 1.0; for subsequent years of wait-listing, however, the adjusted HR was 0.40 (95% CI, 0.29–0.55).

Conclusion: Disparities between Indigenous and non-Indigenous patients with end-stage kidney disease in access to kidney transplantation are not explained by patient- or disease-related factors. Changes in policy and practice are needed to reduce these differences.

The known: Indigenous Australians with end-stage kidney disease are less likely to receive a kidney transplant than non-Indigenous Australians, and those who undergo transplantation have waited longer for a donor organ.

The new: Indigenous patients were less likely than non-Indigenous patients to be added to the transplantation waiting list during the first year of renal replacement therapy; this disparity was not explained by differences in patient- and disease-related factors. The likelihood of transplantation during the first year of wait-listing was similar for both groups, but significantly lower for Indigenous patients in subsequent years. There are probably unmeasured confounding factors that influence wait-listing and transplantation rates.

The implications: Changes in policy and practice are needed to improve the access of Indigenous patients to kidney transplantation.

Quantification of racism in association with health

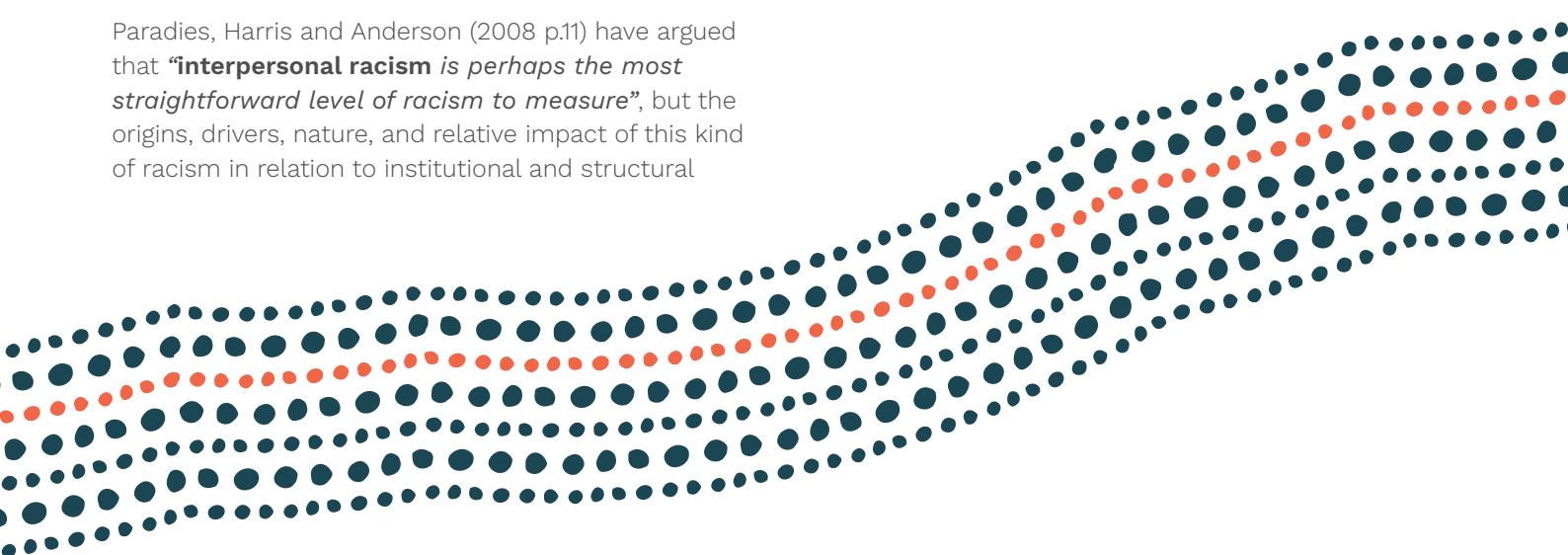
Quantification based approaches to racism are broadly concerned with **measuring the frequency of racism to determine numerically how much racism exists, or how often racism occurs**. There is a significant body of research in Australia and internationally that broadly seeks to quantify racism, to understand its prevalence and the extent to which it exists in the health system. Quantifying racism assumes that it is a discrete phenomenon that can be identified—by researchers or informants—in a form that can be measured. In order to quantify racism, researchers designing these studies—like those designing studies to measure racialised outcomes described above—make a range of decisions about what and where racism is, and how to most appropriately see and count it.

Often, these approaches understand racism as a problem of individual attitudes evidenced in problematic ideas, expressions or behaviours; these are factors which can then be measured. Implied here is a claim that race and racism effects health through the health system because racial prejudices held by health practitioners impair their ability to effectively treat Indigenous patients. Racism or racial prejudice among health practitioners can be measured or quantified in a range of ways; in the prevalence or impact of problematic prejudices (Cooper et al 2012, Hall et al 2015), or through clients' experiences of racist practitioners – sometimes described as '**self-reported**' or '**perceived racism**' (Brondolo et al 2003, Paradies 2008, Kaholokula et al 2010). Some variations on this approach also understand racism as evident in patterns of discriminatory or less favourable treatment. This kind of research seeks to identify patterns in the treatment of patients that indicate significant disparities in the kinds of care provided based on race, as Mahoney (2017) does above.

Paradies, Harris and Anderson (2008 p.11) have argued that "**interpersonal racism is perhaps the most straightforward level of racism to measure**", but the origins, drivers, nature, and relative impact of this kind of racism in relation to institutional and structural

forms remain unexplained and under-theorised in this literature. The question remains whether we are pre-emptively seeking to measure something of which we are yet to develop understanding. Krieger et al (2010 p.1491) revealed the limitations of relying upon self-reported racism to measure racism in their study which examined two measures of racism and its relationship to hypertension. They found that both measures (implicit and explicit) demonstrated an effect upon health independently of each other. They suggest that 'perceived racism' should not be conflated with 'self reports of racial discrimination' highlighting "*the importance of triangulating evidence derived from the stories that bodies tell and what people say*".

A range of systematic reviews have been conducted of racism research which takes self-reported racism as its measure, many by Paradies and colleagues (see Paradies 2006; Paradies, Harris & Anderson 2008; Paradies, Truong & Priest 2014; Truong, Paradies & Priest 2014). We have not attempted to duplicate or summarise this extensive work in this short paper, rather, we note and draw on recent examples of this kind of work in order to comment on some key issues arising. Providing quantitative accounts of racism in order to convey its prevalence or significance—and reviewing and synthesising this work for that matter—can provide an abstract and dehumanised account. This can allow academics to categorise types of racism or theorise about race in terms that name but don't explain these violences, or that don't reflect or respect the material, embodied realities of racialised people. Much quantitative work on race and racism in the health system is completely divorced from the actual experience of race and racism. Table after table; flow chart and variable combine to render the black body invisible and mute.





Case Studies: Systematic reviews



A systematic review of the extent and measurement of healthcare provider racism

Paradies, Y., Truong, M. & Priest, N. 2014, A Systematic Review of the Extent and Measurement of Healthcare Provider Racism, *Journal of General Internal Medicine*, vol. 29(2), pp. 364–87.

Paradies, Truong and Priest (2014) review research conducted from 1995 onwards into racism among healthcare providers. They identify 37 studies assessing interpersonal racism, compare existing measurement approaches to emerging best practice, and recommend further research be conducted. In this review, research is valorised and described as an important means of validating experiences of racism. There is an emphasis on the importance of statistical measurement generally, with a stress on comparing measurement techniques highlighted by the review with a view to discerning best practice. The conclusion of the review is that additional best practice research is required.

The review explores interpersonal racism, which is deemed identifiable and measurable, providing an account of prevalence and suggestions to ensure this phenomenon is measured correctly and appropriately. However, this focus on individuals' racial prejudice says nothing about how power relations are racialized, i.e. the structuring impact of race. Interpersonal racism suggests palatable remedies such as awareness training and cultural competency can address these issues at the level of the individual, without broader implication or change required in structures and institutions. The systematic review format anatomises the problematic through halting subheadings (objectives; data sources; study selection; data extraction etc), flow charts and tables to the point where the visceral experience of racism is lost completely.

Racism and health service utilisation: A systematic review and meta-analysis

Ben, J., Cormack, D., Harris, R. & Paradies, Y. 2017, Racism and Health Service Utilisation: A systematic review and meta-analysis, *PloS one*, vol. 12(12), p. e0189900.

This paper reviews a large number of quantitative empirical studies examining associations between self-reported racism and various measures of health service use. The research draws on more than 70 studies conducted primarily in the United States. Across the studies, the paper finds that racism was associated with negative patient experiences of healthcare, and reports on findings suggesting that despite no broad association with treatment outcomes it may be related to delaying/not getting healthcare and lack of adherence to treatment (although the authors deem these findings may not be statistically reliable). The authors identify limitations in the design, scale, and methods of studies reviewed, and suggest future research directions in the field.

The review is concerned with volume, evidencing a concern to stress the volume of data examined (70 studies, 250,850 participants, etc) as a means of validating the systematic review and ultimately, the experience of racism it reports. Again, the technical format of the paper, divided as it is into a welter of subheadings concerned to express the science of the research methods, 'inclusion criteria, 'screening' 'data extraction and coding', elides embodied experiences of racism. This sense is compounded by the register of address of the article, which is technical to the point of unintelligibility for non-statisticians, obfuscating rather than elucidating. Recommendations are concerned with implications for future research rather than implications for those studied. There is no clear sense in which these findings could be used by policymakers or put at the service of service users or community groups as a means of seeking redress.



Implicit bias in healthcare professionals: a systematic review

FitzGerald, C. & Hurst, S. 2017, Implicit Bias in Healthcare Professionals: A systematic review, *BMC medical ethics*, vol. 18(1), p.19.

This review examines evidence provided in 42 studies reported between 2003–2013 into healthcare professionals implicit biases towards patients, specifically biases relating to race/ethnicity, gender, age, or weight. The review finds evidence indicates that healthcare professionals exhibit the same levels of implicit bias (defined as ‘associations outside conscious awareness that lead to a negative evaluation of a person on the basis of irrelevant characteristics’) as the wider population. These biases influence diagnosis and treatment decisions and levels of care in some circumstances. The review indicates a need for more research into implicit bias, and greater consistency in research approaches.

Implicit bias is an increasingly common framing, one that psychologises racial prejudice while race again leaving racialised power relations untouched. Race and racism are not only rendered individual prejudices but also then emptied of any politics, thereby rendering the offending behaviours amenable to corrective training to align a practitioner’s unconscious or implicit racial bias with their conscious or explicit commitments (presumably to equality and non-discrimination). Again, an exhaustive review of technical matters concludes with an assessment that more research using better or best practice methods is necessary, with findings directed to other researchers.

Interventions to improve cultural competency in healthcare: a systematic review of reviews

Truong, M., Paradies, Y. & Priest, N. 2014, Interventions to Improve Cultural Competency in Healthcare: A systematic review of reviews, *BMC Health Services Research*, vol. 14(1), p.99.

This paper is a review of reviews. The paper summarises 19 existing reviews exploring outcomes of cultural competency interventions in health settings published between 2000 and 2012, in order to form a comprehensive understanding of the current evidence base. Most reviews studied reported moderate evidence of improvement in provider outcomes and in health care access/use outcomes, but weaker evidence for improvements in patient/client outcomes. The paper concludes that studies included in reviews commonly lack rigour and rely on self-reporting of outcomes which is not objectively measured and subject to a range of biases. It concludes with recommendations for future research.

This paper focuses on cultural competency—as ‘a recognized and popular approach’ to interventions with healthcare providers. The aim is to review existing reviews in order to ‘form a comprehensive understanding of the current evidence base.’ This is the same basic claim made by other reviews—that the research published and evidence base presented cannot alone speak for itself and requires an interpreter—but extended now also to reviews of that evidence. The act of interpretation gives researchers the authority to apply an interpretive model or set of categorisations to research findings, and to pronounce on the necessity for future research in an identified form of best practice. The key model under review (in this case, cultural competency) is not critiqued in itself, and findings directed to other researchers call for additional research to be conducted.



Case Studies: Quantitative accounts of Racism

Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S. & Nazroo, J. 2006, Effects of Self-reported Racial Discrimination and Deprivation on Māori Health and Inequalities in New Zealand: Cross-sectional study, *The Lancet*, vol. 367(9527), pp.2005–009.

This study aimed to assess the effect of self-reported racial discrimination and deprivation on health inequalities in Maori and Europeans in New Zealand. Data from the 2002/03 New Zealand Health Survey was used to assess prevalence of experiences of self-reported racial discrimination, and through statistical techniques, to assess the health impacts of this experience. The study found that racism contributes to inequalities in health between Māori and Europeans in New Zealand, and that attempts to improve Māori health should consider the health effects of racism.

Larson, A., Gillies, M., Howard, P. J. & Coffin, J. 2007, It's Enough to Make You Sick: The impact of racism on the health of Aboriginal Australians, *Australian and New Zealand Journal OF Public Health*, vol. 31(4), pp.322–29.

This study was based on a survey of randomly selected residents of a rural Australian town, with interpersonal racism measured by two questions on experiences in the past four weeks of negative racially based treatment that evoked an emotional or physical response, and health was measured according to mental and physical health component scores of the Short-Form 12 and self-reported fair or poor general health. Linear and logistic regressions modelled the effects of interpersonal racism on health, controlling for age, sex, socio-economic status and Aboriginality. The study found that Aboriginal respondents had lower health component scores, were more than twice as likely to report fair-to-poor general health, and 2.6 to 5.0 times more likely to report negative racially based treatment. After controlling for other variables, Aboriginal respondents who reported negative treatment were more likely to have poor health on all three measures. Non-Aboriginal respondents who reported experiencing negative treatment had lower mental health component scores. The paper concludes that experiencing racist treatment should be recognised as a social determinant of health, and that health care alone may not eliminate health inequalities in the absence of fundamental changes in how non-Aboriginal people behave towards Aboriginal people.


Sabin, D.J.A., Nosek, D.B.A., Greenwald, D.A.G. & Rivara D.F.P. 2009, Physicians' Implicit and Explicit Attitudes about Race by MD Race, Ethnicity, and Gender, *Journal of Health Care for the Poor and Underserved*, vol. 20(3), p.896.

This US study of healthcare providers' racial attitudes was one of those reviewed by Paradies, Truong and Priest (2014). This study measured physicians' implicit and explicit attitudes about race using the Race Attitude Implicit Association Test (IAT) for a large sample of test takers, including a sub-sample of medical doctors. Medical doctors, like the entire sample, showed an implicit preference for White Americans relative to Black Americans. The study examined these effects among White, African American, Hispanic, and Asian MDs and by physician gender, and found that strength of implicit bias exceeded self-report among all test takers except African American MDs. African American MDs, on average, did not show an implicit preference for either Blacks or Whites, and women showed less implicit bias than men. The authors concluded that future research should explore whether, and under what conditions, MDs' implicit attitudes about race affect the quality of medical care.

Ford and Airhihenbuwa (2010 p.30) posit that current public health approaches do not account for the complexity of racism's influence on health, including the production of knowledge about particular populations. Most public health approaches to the study of racism use tools that are more useful for measuring and analysing other readily distinguishable individual risk factors. In order to study and quantify racism, a researcher first has to define or identify it—to measure racism is to operationalise a set of understandings of what race and racism is, where, when, how and why it functions. These assumptions about race and racism are often buried in research published in this field, with significant political and strategic implications. Whether what is measured is important or useful, whether the understanding of race and racism being documented reflects Indigenous understandings and experiences, whether the findings, prescriptions or recommendations are ultimately effective in driving change or useful to anyone beyond a small community of researchers and technicians – can depend on the theorising of race and racism underlying the research.

Accounts of racism that seek to quantify individual attitudes or prejudices are seeking to provide an authoritative account of the phenomenon so that it may be addressed, but the utility of this account is directly linked to and ultimately limited by the assumptions about race on which it is based. Racism or prejudice at the level of individual attitudes may be easiest to measure—although it is when attitudes are linked to power and expressed through acts that they translate to impacts on clients. However, as noted above, this kind of research fundamentally collates or collects ideas or experiences reported by people who are the subjects of the research, enables the researcher to categorise or analyse these authoritatively, and determines the validity of reports through the quantities collected. Authority lives in the numbers, and is claimed by researchers—who provide the authoritative meanings of these numbers.

Processes of racialisation enabling individuals' racist prejudices or practices are also left unchallenged, as is the racism of institutions or systems (unless this is understood as limited to the sum of problematic individual attitudes). This means that the kinds of political interventions proposed are also limited. Understanding racism as a simple attitudinal and quantifiable phenomenon frames it as an aberration to be healed or treated – often at the level of the individual through disciplinary or educational action. There is no ability here to interrogate, challenge or question institutions or underlying social structures.



...it is critically important to understand experiences of racism described by Indigenous peoples as reflecting broader racist discourses, policies and practices, which are firmly entrenched in organizations and institutions, and in the dominant society through media, public conversations, and everyday practices. Situating these experiences in the wider socio-political landscape may preempt the denial of racism that might otherwise occur when the 'problem' of racism is constructed primarily as reflecting individual-level reactions or opinions. What is needed in future studies of racism as it pertains to Indigenous peoples' health will be strategies, accountability mechanisms, and interventions that can be maximally disruptive of: the deep-seated patterns of power and paternalism operating in health care; the racist and stigmatizing discourses about Indigenous peoples that remain pervasive; and the dismissive, unwelcoming and often demeaning practices and policies that so profoundly impact peoples' experiences. These are the areas where the problems must be located, and the research agenda advanced, if racism and other forms of discrimination are to be tackled and dismantled in the context of health care delivery. (Browne 2017 p.25).

Institutional Racism

There are increasing calls to attend to **institutional racism**, including in the NATSIHP, however there are fewer studies that draw upon this concept. Just as there is no clear definition of institutional racism—as outlined above, the concept is used to refer to the impact and accretion of prejudicial attitudes within organisational cultures and practices, as well as deeper structural processes and priorities—so there is no clear or consistent research approach to examining institutional racism.

Institutional racism has become an important policy language overseas, particularly in the UK context following the term's high profile use in the McPherson Inquiry as outlined above (see McKenzie 1999, Bhopal 2001, Culley 2001, Sashidharan 2001, McKenzie & Bhui 2007). As a result, much research in this field tends to focus on specific organisations or institutions, and provide audits of governance, resourcing and bureaucracy. This can be effective in documenting ways that tangible institutional practices differ from public policy approaches that stress non-discriminatory treatment. Studies often deploy languages of new public management or public sector accountability. In this approach, race and racism are identified as problematic practices that represent challenges for public administration and service

delivery; tools of public administration (accountability, transparency, monitoring, inclusive governance mechanisms, consultation or more effective communication) are then invoked as the solutions to these problems.

There is often an implicit assumption in the framing of this style of research that neutral, non-discriminatory treatment of all citizens is both the aim of government and the solution to racism, and that this can be achieved through more effective administration and governance. This would not necessarily capture or speak to situations where racial discrimination is an explicit or implicit intent of government policy (such as the Northern Territory Intervention), or to those situations where more effective administration or governance would have violent and damaging implications for Indigenous peoples (for example, the assimilation policies of the mid twentieth century). These approaches can be useful; in seeing racism in operation beyond individual attitudes, they provide an opportunity to document and interrupt discriminatory institutional processes. However, government—as the responsible management agency in whose terms findings are expressed—is often the audience for this type of research, and as such remains able to determine whether, when and how any change is made.





Case Studies: Audits and assessments

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 Qld.

Marrie developed a matrix to identify, measure and monitor 'racism in an institutional setting' within Queensland health and hospital services via publicly available information. The five criteria include: inclusion in governance, policy implementation, service delivery, employment and financial accountability. This audit was undertaken in response to the NATSHIP's vision of a health system free of racism. The report found that 10 out of 16 HHSs rate within the extreme range of institutional racism, with the remaining six in the very high range. While the report received some media attention, it does not appear to have ignited any concerted or collective response. Interestingly a review of the matrix undertaken by a senior public health scholar recommended that the name of the matrix "*be changed from 'Measuring institutional racism' to something like 'Institutional progress in health service delivery to Aboriginal and Torres Strait Islander people: a proposed instrument'*" (p.251). The suggested replacement of 'progress' in favour of 'racism' is suggestive of resistance to attending to racism, but also is made possible given the ambiguity surrounding the relationship of racism to the matrix measures.

Bourke, C., Marrie, H. & Marrie, A. 2018, Transforming Institutional Racism at an Australian Hospital – A case study, *International Journal for Quality in Health Care*, vol. 30(Supp Issue 2), pp.5–6.

Abstract: This study aimed to assess the progress of management of institutional racism at an Australian hospital. A 2014 case study detected an extremely high level of institutional racism at Cairns and Hinterland Hospital and Health Service (CHHHS) using an external assessment tool involving a matrix of five key indicators; inclusion in governance; policy implementation, service delivery, employment, and financial accountability. This case study revisits CHHHS to discover any changes within these indicators of institutional racism, finding that while progress has begun to be made in service delivery, governance inclusion, and employment, there has been no change in financial accountability or policy implementation. The study concludes that the use of an external assessment tool can be helpful to hospitals to begin transformation of institutional racism, as it provides both a stimuli for change and a means of detecting early signs of change.

Came, H., Doole, C., McKenna, B. & McCreanor, T. 2018, Institutional Racism in Public Health Contracting: Findings of a nationwide survey from New Zealand, *Social Science and Medicine*, vol. 199:132–39.

Abstract: Public institutions within New Zealand have long been accused of mono-culturalism and institutional racism. This study sought to identify inconsistencies and bias by comparing government funded contracting processes for Maori public health providers with those of generic providers. Qualitative and quantitative data were collected over a designated period through a nationwide telephone survey of public health providers. Descriptive statistical analyses were applied to quantitative responses and an inductive approach was taken to analyse data from open-ended responses in the survey domains of relationships with portfolio contract managers, contracting and funding. The quantitative data showed four sites of statistically significant variation: length of contracts, intensity of monitoring, compliance costs and frequency of auditing. Non-significant data involved access to discretionary funding and cost of living adjustments, the frequency of monitoring, access to Crown (government) funders and representation on advisory groups. The qualitative material showed disparate provider experiences, dependent on individual portfolio managers, with nuanced differences between generic and Maori providers' experiences. This study showed that monitoring government performance through a nationwide survey was an innovative way to identify sites of institutional racism. In a policy context where health equity is a key directive to the health sector, this study suggests there is scope for New Zealand health funders to improve their contracting practices.

Kline, R. 2014, *The Snowy White Peaks of the NHS: A survey of discrimination in governance and leadership and the potential impact on patient care in London and England*, Project Report, Middlesex University, London.

This report considers the extent of the gap between the diversity apparent in the NHS workforce and the local population, and that visible among NHS (National Health Service) Trust leaderships and senior management. The project was especially concerned with tracking ethnicity but also considered the under-representation of women. Project data demonstrated a very significant gap between the composition of Trust Boards and national NHS bodies, and the rest of the workforce and the local population to whom services are provided. Research evidence suggests this may well adversely impact on the provision of services and denies the NHS the potential contribution a diverse leadership could make. The report recommends the adoption of a management culture that emphasises valuing staff, particularly those from black and minority ethnic backgrounds, in order to improve patient outcomes and develop more inclusive and diverse leadership.



Race is conceptually underdeveloped in the health sciences...incorporating CRT into the study of human populations prompts us to go beyond the quantitative measures fetishized in medical and scientific research. We understand CRT to be inclusive of other disciplinary approaches and therefore synthetic in its analysis. Incorporating this approach to health science research involves understanding the benefits of mixed methods, qualitative analysis, and the role of narrative in articulating scientific claims. It involves an appreciation for the historical and philosophical implications of documenting biodiversity across the social body. Racism and racial inequalities are not exclusively scientific problems. Yet privileging quantitative methods in our understanding of biodiversity sustains the post-enlightenment fantasy that the "hard sciences" alone can address our social issues. What is needed within the health sciences are new theoretical and conceptual tools capable of recognising how bodies inherit not merely genes but power relationships, legacies of discrimination, the ideological effects of past social policy, and generational systems of belief.

(Bridges et al p.181)



Structural and systemic approaches to race and racism

Structural or systems based approaches are broadly concerned with uncovering the operation of race as a mode of social organisation, by exploring ways that race works systemically through and across a range of institutions, ideas, agents and processes, including within the health system. Research in this vein is often concerned with depicting the ways that race may operate in a range of registers and at a range of levels to produce a social system which racialises, or is violent or harmful or unhealthy for racialised people/s. As such, they tend to emphasise the connections between level of analysis, and centre either the impact of historical processes and/or the expert knowledge of those who have experienced race and racism as systems through analysis of testimonial accounts.

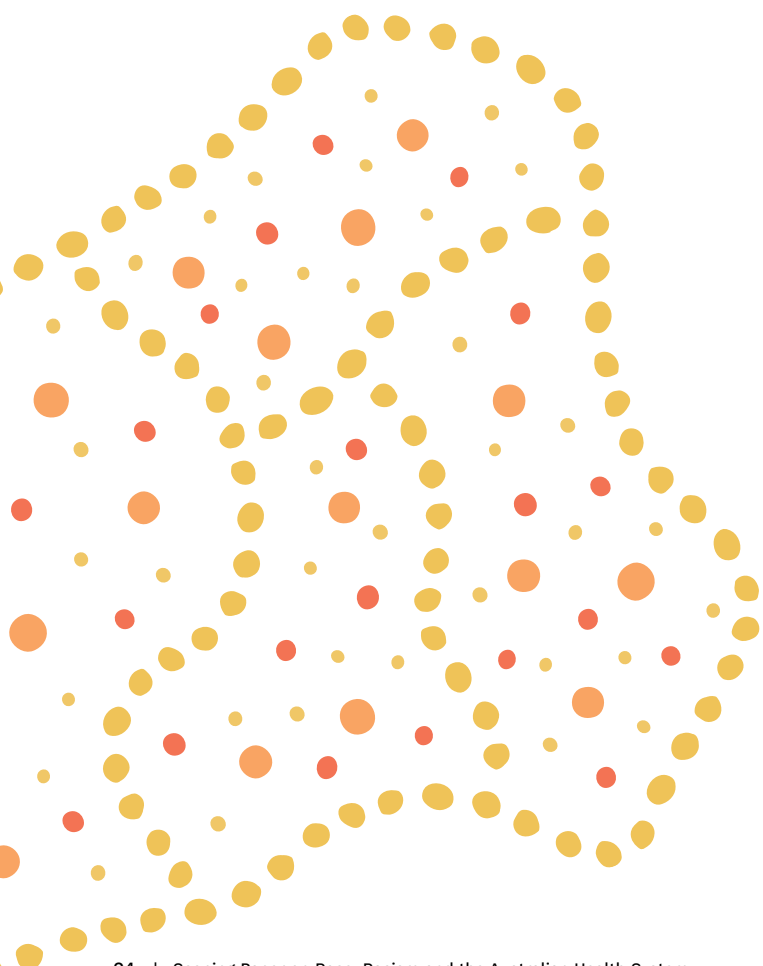
While the approaches above can narrate Indigenous people as either collections of diseased or body parts and problematic health conditions or as disembodied statistical measures, this approach to research often draws authority from privileging Indigenous peoples' knowledges and experiences of racism, in gathering and analysing testimony about the ways that systems of race and racism operate. These kinds

of approaches often seek to emphasise the way that race operates, rather than to address racism specifically. In attempting to develop a sophisticated understanding of ways that race shapes health and the health system—that systems and institutions operate and are experienced—these approaches explore ways that race shapes the world we move in, our knowledges about it, and ultimately our experiences of it.

These approaches gain their authority from the connections and insights they are able to draw from experiential accounts through drawing on social science and critical race theory. This can in itself be a technical register, so while some research in this tradition is more intelligible to non-specialists than statistical analysis, this is not always or necessarily the case. While in quantitative accounts, researchers assert authority based on their ability to collate and categorise quantities of experience, researchers providing systemic critiques gain their authority from the ability to connect events occurring or testimony provided to other knowledges in order to generate insights, or through providing an explanation of what is demonstrated that reveals or resonates with a deeper understanding of human experiences and social systems.

A significant strength in this approach is the ability to explore layers and intersections of institutions, ideas, and individual experiences; demonstrating a range of layers through which change can be achieved and at which change is necessary. Centring either the experiences of Aboriginal and Torres Strait Islander peoples either through history or contemporary testimony can provide accounts of race and racism that document and resonate with Indigenous peoples' knowledges of these phenomena. These approaches work through generating an insightful understanding of the account or phenomenon explored, rather than attempting to collate a neutral statistical account.

Systemic research approaches can provide an account of necessary change or resistance that is more complicated than addressing bad attitudes or poor funding. These approaches are more likely to provide insights in the deep and entrenched nature of racism, but as such may also be less likely to generate immediate policy responses. The story told can be overwhelming or totalising; illuminating the ways that race operates as a system is not necessarily compatible with an approach that suggests racism can be easily separated from institutions and addressed through policy. From a systemic lens, attaining NATSIHP's goal of a health system free of racism may require broader efforts towards building a social and political system that is alert to or free of race.





Case Studies: testifying to racism and theorising about race

Moreton-Robinson, A. 2007, Witnessing the Workings of White Possession in the Workplace: Leesa's Testimony, *Australian Feminist Law Journal*, vol. 26(1): pp.81–93

In this paper, Moreton-Robinson argues that the nation in Australia operates as a white possession, with investments in terra nullius reinforced by social institutions such as courts, universities, workplaces, and operating in everyday intersubjective relations between Indigenous and white subjects. Daily intersubjective relations “*are mechanisms by which the exercising of white possession is experienced by Indigenous people as racism*”. Moreton-Robinson explores testimony given in a racial discrimination case surrounding the treatment of Leesa, an Aboriginal nurse, “*to unpack the ways by which the gendered nature of white possession operates discursively manifesting as racism within the workforce*”. She links consistently discriminatory attitudes and behaviours by a range of people in the workplace operating independently that were revealed in testimony to a broader pattern in the white culture and ownership of the hospital; Leesa was ascribed racialised characteristics that enabled the institution to exclude her while claiming race-blindness, ultimately maintaining itself as a white possession.

Goodman, A. et al 2017, “*They treated me like crap and I know it was because I was Native*”: The healthcare experiences of Aboriginal peoples living in Vancouver’s inner city, *Social Science and Medicine*, vol. 178(April 2017):, pp.87–94.

Goodman et al aimed to explore the healthcare experiences of Aboriginal peoples who use illicit drugs and or illicit alcohol (APWUID/A) living in Vancouver’s inner city in order to examine how multiple accounts of stigma intersect and contribute to their experiences.

Abstract Excerpt: Using Indigenous methodologies, a community research team comprised of APWUID/A led the study design, data collection and analysis. Peer-facilitated talking circles explored community members’ experiences accessing healthcare services and patient-provider encounters. Using an intersectionality framework, our research demonstrated how healthcare inequalities among Aboriginal peoples are perpetuated by systemic racism and discrimination. Stigmatizing racial stereotypes were perceived to negatively influence both practitioner attitudes and clinical practice, and participants’ experiences of medical dismissal often resulted in disengagement from care or delay in care. The study’s findings suggest healthcare providers must understand structural and historical forces that influence racial disparities in healthcare and personal attitudes in clinical practice, and that adequate clinical protocols for pain management within the context of illicit substance use are urgently needed. Overall, the study argued that the valuation of Aboriginal peoples and cultures within healthcare is paramount to addressing the health gap between Aboriginal and non-Aboriginal Canadians.

Gordon-Burns, D. & Walker, H. P. 2015, Institutionalized Racism in the Public Health System, *New Zealand Journal of Occupational Therapy*, vol. 62(2), p.43.

Gordon-Burns and Walker outlines an experience of institutional racism within the health system at a micro interactional level. They detail their most recent process of engagement with an occupational therapist, analysing the experience to highlight the perpetuation of an institutionalised problem in a number of areas including the process of engagement and the resources used as a measurement of assessment. This paper explicitly recounts culturally flawed interactions at an already overwhelming time, and this is presented in the frame of confronting institutionalized racism.



Case Studies: Structures, power and history

Baily, Z., Krieger, N., Agénor, M., Groves, J., Linos, N. & Bassett, M. 2017, Structural racism and health inequities in the USA: Evidence and Interventions, *The Lancet*, vol. 389(April), pp. 1453–63.

Bailey et al argue that despite growing interest in understanding how social factors drive poor health outcomes, many responsible for defining and responding to the public discourse remain reluctant to identify racism as a root cause of racial health inequities. This US focussed paper uses a contemporary and historical perspective to discuss research grappling with the health implications. Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources. The paper argues that a focus on structural racism offers a concrete, feasible, and promising approach towards advancing health equity and improving population health.


Feagin, J. & Bennefield, Z. 2014, Systemic Racism and US Health Care, *Social Science & Medicine*, vol. 103: 7–14.

This paper draws upon social science theories of systemic racism to assess decades of empirical research on racial dimensions of U.S. health care and public health institutions. They argue that the oppression of people of colour has been systemic and rationalized for over five hundred years through a white racial framing—with its constituent racist stereotypes, ideologies, images, narratives, and emotions—which has been generated and sustained in part by racially exploitative medical and public health practices. The authors examine contemporary research on racial differentials in medical practices, white clinicians’ racial framing, and views of patients and physicians of colour to demonstrate the continuing reality of systemic racism throughout health institutions. They conclude that institutionalized white socioeconomic resources, discrimination, and racialized framing from centuries of slavery, segregation, and contemporary white oppression severely limit and restrict access of many Americans of colour to adequate socioeconomic resources—and thus to adequate health care and health outcomes. Dealing justly with continuing racial “disparities” in health and health care requires a conceptual paradigm that realistically assesses U.S. society’s white-racist roots and contemporary racist realities. They then identify public policies that have brought structural changes in racial and class differentials in health care and public health in the U.S. and other countries.



Researchers have drawn on a range of different approaches to explore race and racism in the health system. These approaches draw on theories of race and racism, though these are only sometimes made explicit. Research in each vein relies upon a range of different assumptions about the nature of race and racism, and contains a series of epistemological and political commitments and strategies that shape the impacts, targets, and opportunities that research can deliver.

While the breadth of international research into race and ethnicity across the disciplines is impressive, the Australian academy by contrast has lagged behind, with only a belated recognition that 'race' might matter. There has been of course an emergent literature of testimonies from Indigenous health professionals in more recent years that has appealed for more explicit attention to race and racism within the health system (Geia et al 2020; Rallah-Baker 2018; Bond, Singh & Tyson 2021; Bond 2005). These accounts are to be found in editorials, online blogs, podcasts, social media posts, and occasional special journal issues.



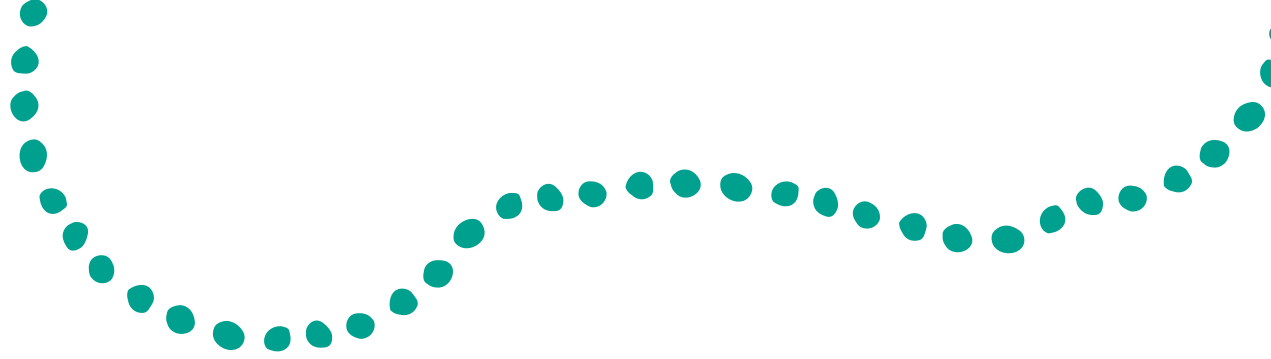
My own dealings with blatant racism, degradation, training delays, bullying, harassment and racial vilification are unfortunately considered an unremarkable experience amongst my Indigenous medical brethren. To many of us, racially motivated workplace violence is the norm. Institutionalised racism, unconscious bias and cultural insensitivity might sound like buzzwords people kick around, but they are real and their impact is real. (Rallah-Baker quoted in Bond et al 2019 p.392)

Despite furnishing clear evidence of racism within the health system, these Indigenous accounts have yet to receive critical attention or be afforded legitimacy in the ways commanded by the very small number of funded studies that capture through quantification a very narrow form of racism. In consequence, we have barely begun to conceptualise and understand the ways in which Australia, in common with all other Western states, uses 'race' as an implicit and blunt tool of governance (whether through mundane encounters and intersubjective relations that informally govern the operation of institutions, or in explicitly racialised government policy such as the 2007 Northern Territory Emergency Response). Whilst we can harness existing international research, which has done much conceptual heavy lifting for us, there is a need to commission new Australia specific research that understands the different and highly particularised ways in which race matters here; especially how the development of policy, the allocation of resources, and the delivery of services has been racialized so as to lend race meanings that work to the detriment of Aboriginal and Torres Strait Islander communities. Such an investment must foreground the experiential knowledge of Aboriginal and Torres Strait Islander peoples, within and outside of the health system, and who through testimony are theorising the operation of race in this place as a means of survival. Only then can we begin to fashion appropriate anti-racist responses that give substance to the National Aboriginal and Torres Strait Islander Health Plan's key objective of a 'health system free of racism and inequality.'

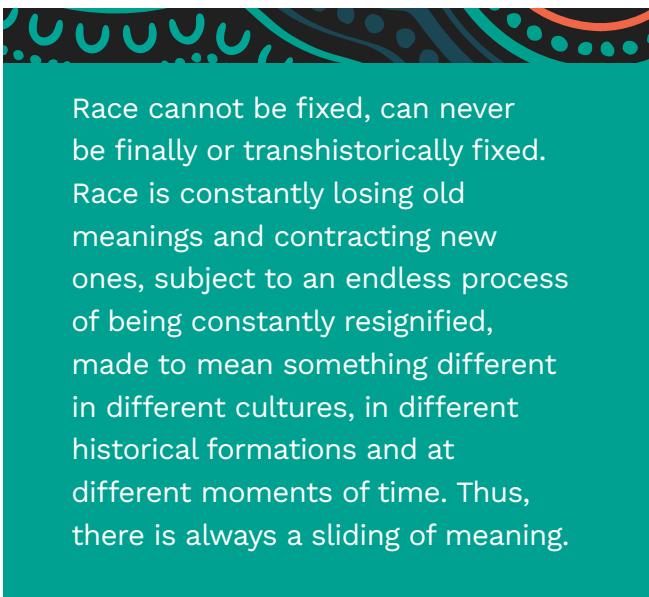
Political Directions: Anti-Racist Praxis and Race Criticality

The violence of race and racism in Australia has been blindingly obvious for a very long time. It's manifestations have become a matter of indisputable public record, particularly through coronial inquests into the deaths of Aboriginal and Torres Strait Islander peoples seeking health care. In the work undertaken by the National Justice Project, in complaints received by National Aboriginal and Torres Services (NATSILS), in the knowledge and experiences of members and leaders of every organisation that participates in the Partnership for Health Justice, there is to be found an urgent mandate to better understand and intervene in the operation of race and racism in the Australian health system. The question of how this intervention can be made in the most effective manner—what kind of knowledge or research is required and how can it be used—is largely a question of political strategy. In this section we explore some key ways these questions of knowledge and political strategy are canvassed and considered in anti-racist or race critical movements.

To be 'anti' something implies a degree of effort. To describe oneself as 'anti-racist' suggests one is prepared to act against racism, to do something about it. The question that such a self-identification invariably elicits is a practical one, 'how'? How do anti-racists oppose racism? How do they turn their opposition into action? (Bonnett 2000). There are many ways to strike an oppositional stance against racism. We would collectively characterise such responses as broadly anti-racist or race critical: *“those forms of thought and/or practice that seek to confront, eradicate and/or ameliorate racism”* (Bonnett 2000 p.4). Because 'race' can assume a variety of imbricated guises, masquerading as religion, biology, culture, or nation, for instance, it is a notoriously stubborn marker of regrettable difference. As a consequence, no one approach deployed in isolation may be effective, requiring instead a praxis or strategy that adopts a combination in order to resist and advance on several fronts. It is fair to say, though, that anti-racism remains under-theorised, especially in settler-colonial settings such as Australia where calls for race equality or better race relations fall considerably short of the facticity of violent dispossession and unceded sovereignty. Anti-racist efforts in such situations must not work to undermine the position of First Nations by insisting on a substantive multiculturalism as the principal means of ameliorating racism.



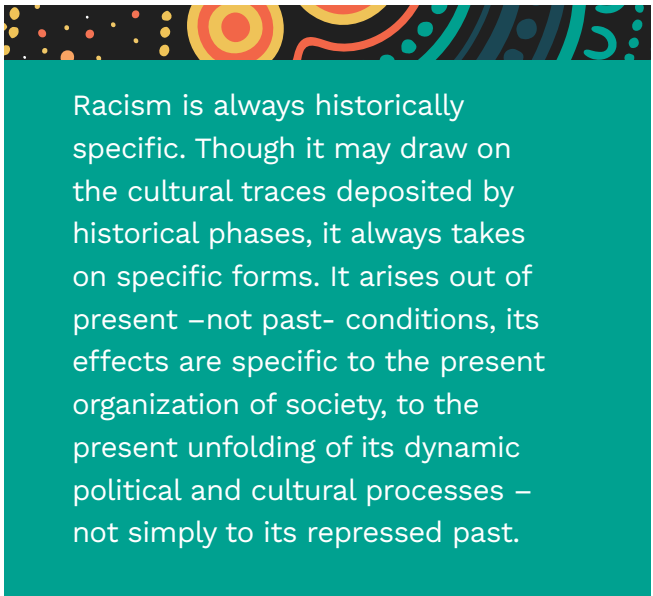
Stuart Hall, the cultural studies theorist, reinforces the sense that race cannot be considered as fixed and so invite a 'one size fits all approach' to its opposition. As Hall (1996 n.p) explained:



Race cannot be fixed, can never be finally or transhistorically fixed. Race is constantly losing old meanings and contracting new ones, subject to an endless process of being constantly resignified, made to mean something different in different cultures, in different historical formations and at different moments of time. Thus, there is always a sliding of meaning.

Hall's argument has important implications for our understanding of how best to oppose racism, for if the meaning of race is shifting according to wherever the phenomenon has historically alighted, our anti-racism or race criticality ought to be sensitive to the contemporary configurations of race and its cognate, racism. All too often race is assumed to be ahistorical and unchanging, so ensuring that our anti-racism

is 'outdated'. Additionally, we cannot assume that by casting our net internationally and hauling in a catch bursting with terms, definitions, strategies and policies, we can emulate approaches borne elsewhere under different social and economic conditions. We will need to work hard to adapt, refashion or, indeed, completely innovate new anti-racist or race critical approaches that properly account for an originary, unique racial violence that marked invasion and dispossession and continues in ever more sophisticated ways to deny sovereignty and ensure disparate life outcomes for Indigenous people. As Hall (1996 n.p) finally reminds us,



Racism is always historically specific. Though it may draw on the cultural traces deposited by historical phases, it always takes on specific forms. It arises out of present –not past- conditions, its effects are specific to the present organization of society, to the present unfolding of its dynamic political and cultural processes – not simply to its repressed past.

In terms of anti-racist approaches, Bonnett (2000) delineates six types that are apparent to him, which we have explained and applied here:

1. Everyday Anti-Racism

Here Bonnett is referring to the self-organisation of ordinary people against racial oppression, which often takes place outside control of the state and is unaligned to political parties. Much of this opposition will at some point be incorporated into the state through coalescence into a formal community organisation, with sympathetic state or municipal funding following. Moreover, because these organisations employ staff and run a variety of community organising programs, the radicalism that originally marked this quotidian anti-racist opposition is likely to be compromised because of a concern to ensure continued funding.

An example of this type can be found in the Australian Human Rights Commission's 'Let's talk race: A guide on how to conduct conversations about racism', developed in response to the documentary 'The Final Quarter' which captured the anti-racist stance AFL player Adam Goodes adopted on the sporting field (2019). The response, devised with the intention of complimenting the documentary through opening up a dialogue on racism, fell short of the measure of leadership demonstrated by Goodes on the field. In its refusal to address the underlying resistance among Australians to conversations about racism, as evidenced by the incessant booing of Goodes, the guide offers little comfort to those on the receiving end of racism, especially with its stultifying emphasis on policing the tone of what it considers to be 'productive' conversations around race. Unlike Goodes, who stopped a game and a nation to firmly say no to racism, the manual vacillates by stressing an anti-racist approach that should minimise feelings of guilt and discomfort.

2. Multiculturalism Anti-Racism

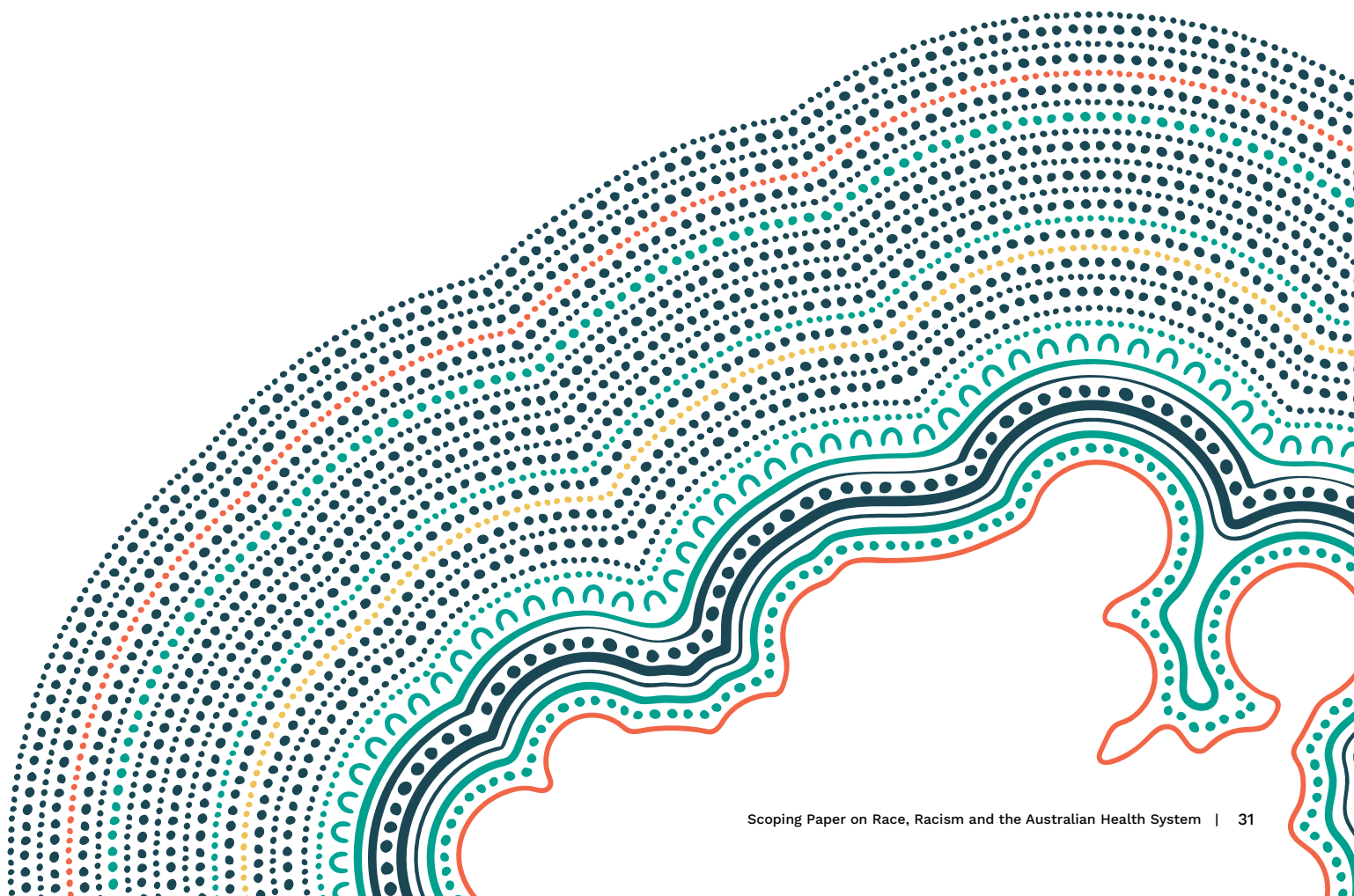
Here multiculturalism, both as policy and demographic fact, is regarded as a bulwark against racism by its stress on integration. We can observe this example with the Federal Government's decision in 1999 to rebrand the United Nations International Day for the Elimination of Racial Discrimination on the 21 March which marks the anniversary of the Sharpeville massacre in South Africa where 69 people were shot dead by police at a peaceful demonstration (United Nations 2021). Rather than commemorate the day as one of observance and solidarity with victims of racism and racial violence, Australians are instead encouraged to celebrate 'Harmony Day'. The day is one where, in lieu of explicit anti-racist messaging, we are encouraged to embrace

'inclusiveness' and 'a sense of belonging for everyone' (McDougall 2021). Multiculturalism as framed by liberal nation-states often elides First Nation status and can indeed be actively deployed in opposition to Indigenous sovereignty. Moreover, multiculturalism is often narrowly conceived with a concern only for the folk traditions as expressed through dress, music and food. Thus, this model of multiculturalism rarely engages with relations of power, economics or class and so serves to affirm the state's liberal virtue while grosser inequities remain untouched. Finally, multicultural policies have themselves become lightning rods for a racist backlash, with cultural diversity being held responsible for various neoliberal ills such as deindustrialisation and unemployment.

3. Psychological Anti-Racism

This approach seeks to engage with people's attitudes, specifically the way people internalise and give meaning to racial and racist ideas, and the racializing optics through which they subsequently see the world around them. Lately, attention has been paid to the 'unconscious', in the form of 'bias'. The Queensland Government (2020, n.p), for instance, defines unconscious bias as *"attitudes beyond our regular perception of ourselves and others which are reinforced by our environment and experiences and form the basis of our pattern of behaviour about diversity"*.

Whichever form of psychologising anti-racist approach is adopted, all seem to hold fast to the idea that anti-racism, as Bonnett states: *"is best effected at the level of consciousness: that to change how people feel about others and themselves is tantamount to changing society"* (2000, p.97). Remedial action here typically takes the form of some kind of training, usually offered by human resources departments or independent consultants and encompasses a range of 'cultural awareness, cultural competence, or diversity and inclusion' workshops. Such training has long been critiqued by some Black academics and activists for the universalist presumption that insists on the essential sameness of the human race, so rendering the training as a route to [white] emancipatory self-awareness. As one critic has pointed out, *"by reducing social problems to individual solutions, [Race Awareness Training] passes off personal satisfaction for political liberation"* (Sivanandan 1990 p.104).



4. Radical Anti-Racism

Here anti-racism is anti-capitalist, where there is a recognition that 'the functioning of the contemporary global economy is deeply embedded in histories and practices of racism' (Bonnett 2000). Recent race critical scholarship has often attended to these wider political concerns, though it must be added that such work is indebted to a number of historical, foundational texts. As the eminent race critical scholar, David Theo Goldberg (1993) has pointed out, 'these seminal texts reveal as much as anything else the interface of race and racism with other modes and structures, cultures and representations of social inequalities and exclusions.' The work of W.E.B Du Bois, is particularly insightful in this regard, 'reveal[ing] concepts and issues, frameworks and paradigms from which have flowed much of the more recent work in the race critical tradition' (1993).

To anti-capitalist we can add pro-abolition following the Black Lives Matter movement and note that this radical anti-racism often finds itself expressed on city streets, at rallies, marches and outside courthouses and watchhouses. In Meanjin, for instance, Gomeroi Kooma activist Ruby Wharton recently spoke of abolition as the only response to stopping Black deaths in custody.

...it's not about doing performative things within their system, but abolishing it...we can't demand incarceration of police when we are dying of the same system...as long as we walk in love we will be able to seek justice...this is not just about the frontline officers, but the bosses who are profiting.

(Ruby Wharton, Stop Black Deaths in Custody National Day of Action, 10th April 2021)



Source: (19) Ruby Wharton (@ruby_wharton) / Twitter

5. Anti-Nazi and Anti-Facist Anti-Racism

Where once this direct-action approach was considered an extreme response, with Nazism widely reviled across the political spectrum and safely consigned to history, recent developments perhaps suggest otherwise. Reference to the 'Final Solution' in the Australian Parliament (Karp 2018),

the emergence of the Australia First Party and One Nation Party, mean that white supremacist beliefs are openly declared now, and direct action has consequently returned. However, as egregious as these expressions of racism are, and are obviously not to be taken lightly, they do obscure long standing day to day and structural manifestations of racism which do not command the same kinds of immediate public attention and condemnation.

6. The Representative Organisation

Here we are referring to affirmative action programs such as seen as in the US, the specification of certain positions as requiring ‘race’ as a genuine occupational requirement. Specifically in Australia, government funded initiatives to recruit Aboriginal and Torres Strait islanders to the professions, e.g. More Aboriginal and Torres Strait Islander Teachers Initiative (MATSIITI) (University of South Australia et al 2012). As Bonnett (2000) points out, such an approach is premised on the belief that ‘victims of racism need economic and institutional power in order to lift themselves out of their marginal status.’ However, what is not considered here is the extent


to which those very same organisations subscribing to the notion of a ‘representative organisation’ remain institutionally racist. High attrition rates such as seen in the teaching profession and examples of racial discrimination, as documented by Aboriginal police officer Veronica Gorrie in her memoir ‘Black and Blue’, suggest that unless institutions take steps to address racism within their own ranks, the ‘representative organisation’ approach will remain largely a ‘tick box’ exercise that effects no substantive change.

To Bonnett’s anti-racist typology, we may add additional anti-racist approaches:

7. Statistical Documentation

Mooting statistics, curating data collections and drawing an analysis from those collections so as to unequivocally demonstrate racism is a positivist strategy long employed by anti-racists. Ida B. Wells (1862–1931), a former slave, African-American investigative journalist, educator, and a founder member of the National Association for the Advancement of Colored People (NAACP), documented the lynching of African-Americans in the United States (1892; 1895). She sought to document, using white sources, the nature, ‘reason’ and extent of lynching after a close friend and two others were lynched. She eventually published two pamphlets entitled ‘*Southern Horrors: Lynch Law in All Its Phases*’ (1892), and *The Red Record* (1895). In each Wells exhaustively listed all the known lynchings and in *The Red Record*, she closes the pamphlet with a chapter entitled ‘The Remedy’ in which she makes five recommendations to her readers: (1) she urges readers to bring the book to the attention of all their friends, and to (2) have church groups and civic groups pass anti-lynching resolutions and send copies where the lynchings occur; (3) she calls on her readers to bring attention to the South’s ‘refusal of capital to invest where lawlessness and mob violence hold sway’; and to (4) ‘think and act on independent lines in this behalf’; (5) and finally, she urges her readers to send resolutions to Congress to support an anticipated Bill to create an investigatory commission on lynching (which never came to pass) (1895 n.p).

Frederick Douglass, the 19th Century African-American Leader, was mindful of Wells’ approach when he expressed his gratitude to her for *The Red Record*:



Let me give thanks for your faithful paper on the lynch abomination now generally practiced against the coloured people in the South. There has been no word equal to it in convincing power. I have spoken, but my word is feeble in comparison. You give us what you know and testify from actual knowledge. You have dealt with facts with cool, painstaking fidelity, and left those naked and uncontradicted facts. Brave woman! You have done your people and mine a service which can neither be weighed nor measured. (p.189).

The Royal Commission into Aboriginal Deaths in Custody (1987–1991) broadly adopted the same approach as Wells in that all deaths within a specific time period were examined, a tabulation of suffering drawn up followed by a series of recommendations,

many of which have yet to be implemented (Johnston 1991). Lately, The Guardian newspaper has launched the 'Deaths Inside: Australian Indigenous Deaths in Custody' database (Allam et al 2021). The aim of the exercise, according to the newspaper, is to 'track Indigenous deaths in custody, make the information as accessible as possible, and to monitor systemic issues like the provision of appropriate medical care' (The Guardian 2018b).

Reliable statistics are necessary to fill in gaps in public knowledge, but the power to persuade cannot be assumed. The adjective 'post-truth', newly admitted to the Oxford English Dictionary and defined 'as relating to denoting circumstances in which objective facts are less influential in shaping public opinion than appeal to emotion and personal belief' (Kroet 2017), suggests that statistics are no longer incontrovertible.

8. Embodied Anti-Racism

This approach foregrounds an egregious, embodied example of racial violence in order to draw attention to the Black body and the viscera of racism. The community has an opportunity to pay their respects and publicly mourn the death, as well as to join the family in calling for justice. A wider movement against racism maybe catalysed as a consequence. The most famous example in this regard was the decision of Mamie Till-Mobley to display her murdered son, Emmett Till, in a glass topped open casket at his funeral in 1955 (National Museum of African American History and Culture 2020). Emmett Till had been so badly tortured by white racists, before being finally shot and tied to a 100lb cotton gin so that he could be disposed of in a local river, that his body was barely recognisable to his mother. The authorities attempted to keep the body from the public gaze by first nailing his coffin shut before securing it further with a padlock. On receiving his body Mamie Till asked for a hammer and broke the padlock before wrenching the lid open. Mamie insisted on an open casket because, in her words, "*I wanted the world to see what they did to my baby*" (Griffin 2015 n.p). Tens of thousands of people viewed Emmett's body, and photographs reached an international audience. The murder became emblematic of American racial violence and reenergised the civil rights movement. On being asked by the Reverend Jesse Jackson why she did what she did when the bus driver demanded that she move, Rosa Parks 'said she thought of going to back of the bus. But then she thought about Emmett Till and she couldn't do it' (National Museum of African American History and Culture 2020). The casket which held Emmett's body is now on display at the National Museum of African American History and Culture in Washington (Callard 2009).

Locally, we have witnessed grieving Aboriginal and Torres Strait Islander families seek to reveal to a broader public the violence that their loved ones were subject to, in the hopes of effecting change. Ms Dhu's family fought to release the CCTV vision of her final moments, despite the coroner's claim that it would cause further trauma to them (Neuweiler 2016). Ms Dhu, was a Yamatji woman who died in police custody in Western Australia in 2014. The family were successful in having the footage released to show how poorly she was treated. Ms Dhu's Uncle Shaun Harris stated "*they can't hurt us anymore, but they can traumatise us more by still holding back the truth... there will never be any justice unless there is truth and accountability*" (Neuweiler 2016). The Coroner's report found that both the police force and medical institutions failed to discharge the duty of care owed to Ms Dhu but did not refer her case to prosecutors (Western Australia Courts 2016). While an approach that emphasises drawing attention to the state's brutality cannot guarantee an empathetic response, there is nevertheless a heightened Indigenous resistance to racism following such cases. We do not understand the dynamics at work in these community responses, especially their mobilising effect and how they advance anti-racism in ways other forms do not. More research needs to be undertaken to gauge the galvanising impact of Indigenous community resistance campaigns.

9. Anti-racism as Art

This approach is an extension of the embodied anti-racism approach where creative activists, such as poets, artists, novelists, playwrights and musicians use their art to highlight individual racial injustices. In the case of Emmett Till, songs by Bob Dylan and Joan Baez demanded justice; Gwendolyn Brooks, the first African-American to receive the Pulitzer Prize, wrote a famous poem imagining the murder from the perspective of the white woman allegedly insulted by Till; and there have been numerous plays, art installations and lately, an opera.

The Justice for Ms Dhu campaign has similarly been supported by artists, as Klippmark and Crawley, (2018) note. In solidarity with Ms Dhu and her family, a group calling itself 'allies of Ms Dhu', and made up of artist and activists, nightly projected images of Ms Dhu and her family onto public building that played a part in her death or were otherwise significant. The project has been described by one participant (in Klippmark & Crawley 2018 p.705) as "*an attempt, aesthetic and political – modest, incomplete, mournful, angry – to return Ms Dhu to the world from which she was taken too young*". He further explained:

Each evening, a small group of people load into their car with a projector and laptop, and travel Perth's streets. They find prominent or symbolically resonant buildings – the East Perth lockup, the Western Power building, the Telstra Building, among others. They stop and point the projector, and giant, haunting images of Miss Dhu light the walls and overlook the city.

We can also observe anti-racism as art in the scholarly and creative work of Gomerol scholar Alison Whittaker, who draws on poetry and her legal training to illuminate the violence of colonial processes and the routine denial of justice to Indigenous peoples (Whittaker 2018).

10. Anti-Racism as Black Lives Matter

Black Lives Matter was founded in 2013 following the murder of African American high school student, Trayvon Martin, and the acquittal of the accused, George Zimmerman (Black Lives Matter 2020). A loose political movement that has spread across the globe, Black Lives Matter gathers to protest against police brutality and racial violence more generally. The movement has been given further impetus following the killing of George Floyd by a Minneapolis police officer in 2020. George Floyd's words, as he was being pressed to the street by his neck, were 'I can't breathe', and this plea has since become the refrain of a wave of protests that followed, spread and continues throughout the world.

In this place, BLM and anti-racism have condensed around Aboriginal and Torres Strait Islander deaths in custody and their families. These families, including David Dungay Jr's family reminded the world, that he too screamed 'I can't breathe' twelve times as he was restrained face down by up to 5 prison officers (The Guardian 2018a). We note too, that Indigenous families have recently come together to form the Dhadojowa Foundation to provide strategic and culturally appropriate support for Aboriginal families whose loved ones have died in custody and are still making appeals to meet with the Prime Minister to offer a way forward (Hayman-Reber 2021). These families are demonstrating an anti-racist leadership as only those who have known death at the hands of the systemically racist legal and health care systems



can. In response, an array of anti-racist expression has been fostered that is unique to this racial formation and not elsewhere. As such it is possible to speak of an Indigenist response to BLM: Indigenous Black Lives Matter.

In Australia, many rallies and marches took place that spoke both locally and globally to the Black Lives Matter movement. In Meanjin, for instance, a rally and march took place on 4th July 2020. Organised by the Warriors of the Aboriginal Resistance (WAR) and Stop Black Deaths in Custody Committee, the gathering heard appeals, calls and demands that were characterised as follows:

We heard an appeal to a shared humanity. We heard their calls to move beyond counting and naming our dead, to instead a plea to hear their stories, to humanise them. We heard demands to abolish violent and oppressive systems, so that we may build anew, a society that needs not be reimagined, but a society that must remember what it first was to be human in this place – from those who became human here. (Bond 2020 n.p).

Black deaths in custody and care continue unabated and have become the principal issue through which Black Lives Matter is articulated. Additionally, abolition of prisons and defunding the police have become topics of serious discussion and calls for the formal study of race in Australian higher education have become louder. So long as there is no substantive progress in these areas, Black Lives Matter will continue to generate 'appeals, calls and demands' that challenge the moral probity claimed by the state and its institutions.

The constellation of anti-race and race critical forms at this moment, as they relate to research, indicates that the boundary between academic researcher and activist have not held. An exemplar in this regard is the Jumbunna Institute of Indigenous Education and Research, which harbours a team *"that prides itself on frank and fearless advocacy driven by the Indigenous communities it serves"* (Jumbunna Institute of Indigenous Education and Research 2019). Led by Distinguished Professor Larissa Behrendt, Professor of Law and Indigenous Research, and herself author of several milestone reports and staunch anti-racist who has mandated others to break the binary of academic/activist, Jumbunna

hosts Indigenous researchers who are forging an anti-racism that is in direct response to the needs of families and communities. The aforementioned Alison Whittaker, for instance, Gomerioi poet and legal researcher, works to support families as they seek justice through the legal system and also tirelessly reports on coronial proceedings so that community, researchers and activists maybe kept informed. Her essays, academic journal articles, reviews and poetry create an elaborate nexus through which we glean sophisticated understandings of this juncture that are unafforded through single attempts alone.

A collective of interdisciplinary scholars from the University of Queensland, Queensland University of Technology and Australian National University led by Associate Professor Chelsea Watego have formed an Indigenist Health Humanities collective which includes as part of its work an Indigenous critical race and health justice agenda that focuses on attending to the nature and function of race, as well as recognising health as a fundamental human right. Funded by the Australian Research Council, the collective seeks to build a community of public intellectuals capable of advancing a more transformative scholarship required to effectively address this moment. Additionally, Amy



McQuire, Darumbal and South Sea Islander, journalist, PhD candidate and member of this collective is another who models the public intellectual who is appreciative of the need to canvass various forms, in this case academic research, journalism and the struggle for justice. Her reporting into miscarriages of justice, her podcast, The Curtain Podcast and her research into women who have been failed by the very systems meant to protect them have a combinational anti-racist effect that works as a movement would in amplifying the voices of the unjustly treated. As with Whittaker, McQuire's work does not fashionably claim itself to be a novel approach to praxis, but it is certainly unapologetically Black in its insistence on justice. It is also relational, with an acute concern for those around her, in life and in death. It is this relationality above all that marks Indigenous Black Lives Matter.

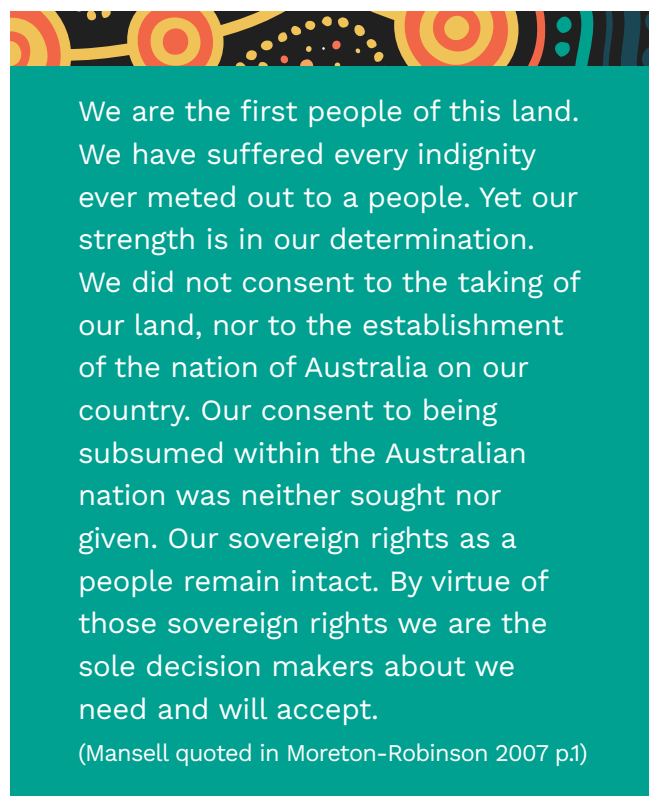
Conclusion

In determining which kinds of research and anti-racist strategy will be necessary, then, know also that personal experience and those of others have beaten a path that leads to questions of strategy and research that are not subordinate to the vagaries of grant funding or race critical concerns borne of other racial formations. Questions asked by grieving families and personal testimonies are entirely valid and likely concern power and its distribution in this settler-colonial setting. Asking the question that is true to one's self and community is the first step in any anti-racist or race critical endeavour worthy of being first human, first raced in this place.

In terms of deciding which anti-racist approach to adopt in response to an episode or set of circumstances, it may be of benefit to consider the efficacy of previous and present national anti-racist efforts which have been resourced in ways denied grassroots mobilisations. The National Anti-Racism Strategy (2015) and the recent Australian Human Rights Commission Concept Paper for a National Anti-

Racism Strategy (2021), contain a medley of principles, aims, objectives and actions designed to highlight and address racism. That we are still debating the 'concept' of an anti-racism strategy, however, while Black deaths in custody and the health system continue with depressing frequency should qualify our enthusiasm for grand announcements of this sort. Indeed, liberal tenets of 'equality, tolerance, respect and dignity' are perennially held high as the promise of this place we call Australia but which Aboriginal and Torres Strait Islanders can justifiably claim are nowhere in evidence where they are concerned.

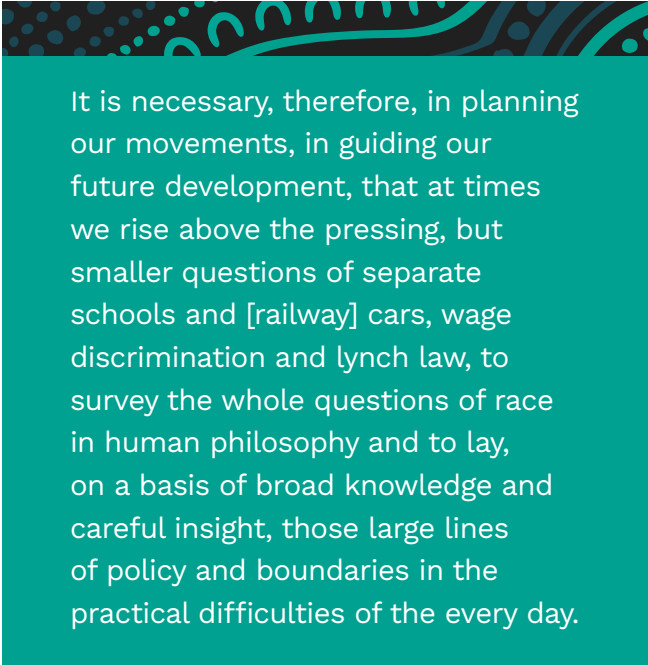
A sovereign or 'sovereign divergent' response (Singh 2020 pp.145–52) eschews a national voice that assumes to speak on behalf of Aboriginal and Torres Strait Islander peoples, and instead takes as the basis for protest and action an articulation of First Nations and First Self. Here is sovereignty as parsed by Mansell:



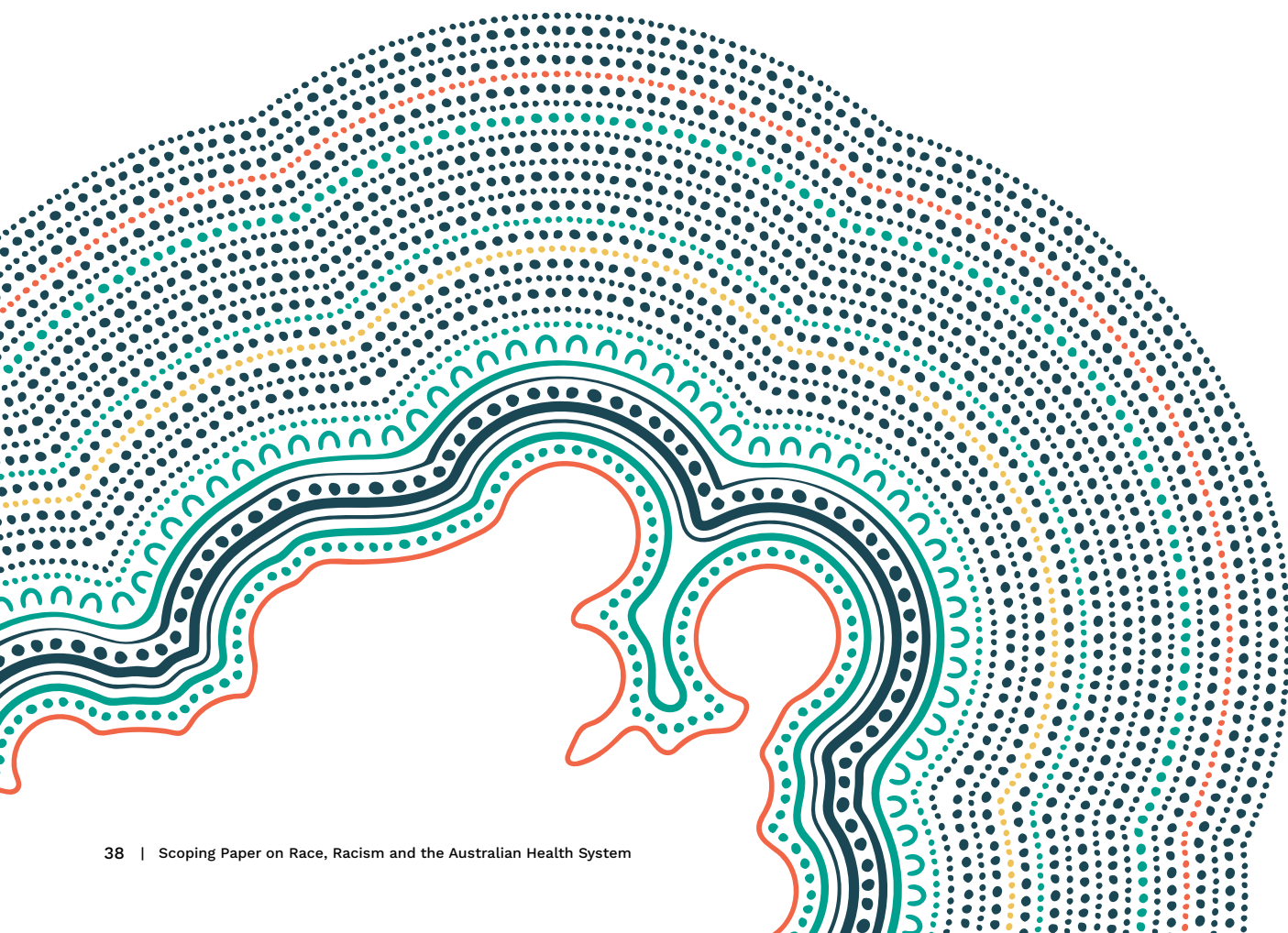
It is to be expected that given dispossession, there will be an oscillation between sovereignty and the state in funnelling anti-racist expression. There will also be a necessary and sophisticated combination of the two as praxis, as determined by whichever aims are being sought and in evidence where family campaigns seek justice for loved ones who have died in custody or care. An exclusive focus on the state, however, such as through political or organisational senior representation, grant funding, or national policy plans, leads to an unavoidable reinscription of colonial race relations. It is also worth bearing in mind that the state can appropriate anti-racism as means to affirm its liberal virtue. It will also curtail the radical promise of anti-racist expression because it is not in its long-term interest to consistently oppose the structural arrangements of race which presently work to deny the corrosive claims of sovereignty. Sovereignty, by contrast, is actively rejected by the state and so a better suited vehicle for more radical aims. Additionally, and as should also be clear by now, sovereignty does not rely on recognition from any official quarter. It simply is.

The work of anti-racism and race criticality continues therefore, and in deciding how to proceed, it is worth reminding ourselves of Stuart Hall's concern to

ground opposition in a sophisticated understanding of present conditions. This requires collective effort, and a guiding appreciation of the role community plays in resisting the predations of racism on a daily basis. In his injunction and to conclude, Hall is joined across the years by one he admired immensely, W.E.B. Du Bois (1897 pp.1–2):



It is necessary, therefore, in planning our movements, in guiding our future development, that at times we rise above the pressing, but smaller questions of separate schools and [railway] cars, wage discrimination and lynch law, to survey the whole questions of race in human philosophy and to lay, on a basis of broad knowledge and careful insight, those large lines of policy and boundaries in the practical difficulties of the every day.

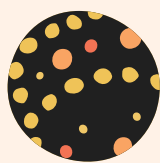


Recommendations

Aboriginal and Torres Strait Islander peoples are dying at the hands of the state in numbers that should shame. And, time is not on our side. In this place, as in so many others where race is part of the social formation, race means death and the continuing disavowal that it matters to the degree claimed by the terrorised is morally unforgivable. Deaths in custody and in the health care system continue and the energy of the 'Black Lives Matter' movement has largely petered out within the wider community, who have long since returned to lives where race is a choice and not a stubborn marker of difference. There remain, however, those still standing, individuals and families at the rallying points of city squares, on stages, outside courts, watchhouses, on the street, in waiting rooms and anywhere else where resistance and protest can be registered, and grief and mourning expressed.

If this paper can serve usefully, we hope to serve these individuals and families whilst also informing the emergence of a race critical Indigenous health research program that can better inform a wider Indigenous health justice agenda. Such an agenda is more than an intellectual one. We find ourselves at a pivotal moment characterised by contradiction: a bold commitment to a health system free of racism in a society that is founded upon it. As such the enthusiasm of the state for an anti-racist agenda is tepid at best; and not because it has yet to understand race, but rather it is wilfully ignorant and indifferent to its effects upon Aboriginal and Torres Strait Islander peoples. The heavy lifting, as ever, will need to be done by those most weakened by race and racism. This scoping paper offers a lever, and in keeping with the original remit of addressing knowledge gaps about the operation of race within the health system and the remedial political strategies needed to follow, we offer some broad initial recommendations in an attempt to bring together a more explicit and cohesive anti-racist agenda that is culturally, intellectually and politically aligned with the organising and activism that has always fallen on under-resourced Indigenous communities.

We recommend:



1. That the National Health and Medical Research Council (NHMRC) consider race and racism as a forthcoming Targeted Call for Research, one that broadens investment beyond epidemiological studies and systematic reviews to more fully explore how race operates in the production of health inequalities;



2. That the NHMRC consider including an assessment criteria for Indigenous health research bids which demonstrates how race will be accounted for;



3. That the composition of NHMRC assessment panels include those with expertise in race critical studies. Such a membership will demonstrate good faith as well as better orientate the NHMRC towards a body of knowledge that has been neglected for far too long;



4. That the Australian Research Council issue a call under the Special Research Initiative scheme for a centre of excellence in race and Indigeneity. We are now beyond research capacity building and have moved to a concern with the most pressing research problematic facing Aboriginal and Torres Strait Islander communities today – that of the operation of race and Indigeneity in all social and economic domains. A commitment in this regard would complement the anticipated investment in race critical research from the NHMRC;



5. That the Indigenous Medical Research Futures Fund institute a capacity building program for Indigenous health researchers that broadens the toolkit to better enable health researchers to attend to race, specifically in addressing Priority Area 4 of the Implementation Plan ‘Address the root causes of inequity’ (Department of Health 2020);



6. That an acknowledgement that any investment in research focused on race and racism must foreground Indigenous intellectual sovereignty;



7. That this discussion paper form the basis for the development of a master-class to upskill health researchers, and to foster urgent uptake of an 'Indigenous centred race critical health agenda' capable of achieving justice in health, enabling a health system free of racism;



8. That the Lowitja Institute be supported to provide leadership in bringing together Indigenous stakeholders so that they may continue to strategize around the intellectual work required to support the legal and political responses to race. In so doing, we broaden the category of Indigenous researcher to include Indigenous academics outside of the health sciences as well as Indigenous artists, activists, and community organisers, so that Indigenous life worlds and the structuring impact of race may be better understood;



9. That the Lowitja Institute be supported to convene a National Indigenous Anti-Racist Health Roundtable in order to forge a more explicit and cohesive Indigenous race critical health research agenda as well as to debate the formation of a values framework to guide research.

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Acronyms

AIHW Australian Institute of Health and Welfare

BLM Black Lives Matter

CRT Critical Race Theory

NATSIHP National Aboriginal and Torres Strait Islander Health Plan

NGO Non-government Organisation

P4JH Partnership for Justice in Health





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