



Racism: a major impediment to optimal Indigenous health and health care in Australia

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Abstract

Objectives: To highlight the scope and ramifications of racism on health and health care of Indigenous Australians, and suggest approaches for minimising racism's adverse health impacts.

Methods: Literature review and conceptual frameworks based on the historical, structural and social determinants of health and health care were used to highlight the scope and ramifications of racism in relation to health, and to Indigenous health care access.

Results: Racism has major adverse impacts on the health of Indigenous Australians, and significantly hinders their access to effective health care. Most of racism's negative effects on Indigenous health may be ameliorated through addressing structural determinants of health inequities, improving community awareness regarding racial prejudice, strengthening political will to address racism, improving cultural competence among health workers, and health service redesign to facilitate optimal access to Indigenous health care.

Conclusions: A feasible, integrated approach for addressing negative health consequences of racism on health and health care access should involve all stakeholders working cooperatively to minimise adverse impacts of its proximal (e.g. stereotypes and prejudice), distal (e.g. imprisonment and education) and contextual (e.g. politico-legal) determinants.

Implications: Sustainable and effective approaches to address racism's impacts on Indigenous health and healthcare access may be achieved by addressing structural determinants of health inequities. Multifaceted anti-racism interventions demand active participation by Indigenous people, governments, a culturally competent health workforce, all Australians, and the international human rights community.

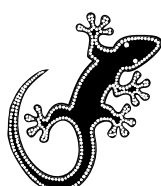
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Introduction

Renewed media interest on the pervasiveness of racism in relation to Indigenous Australians may in great measure be attributed to the 2011 *Challenging racism project report*, which compiled surveys on racism conducted since 2000. The report documented that 27.9% of Australians demonstrate racist attitudes towards Indigenous Australians, based on the proportion of Australians who stated that they would be concerned if a relative were to marry an Indigenous person. The report also revealed that 85.6% of Australians agreed that ‘Something should be done to minimise or fight racism in Australia’[1]. This article examines the concept, as well as health-related ramifications, of racism and suggests how to minimise its adverse health impacts on Indigenous Australians.

Although there is no biological justification of race [2], it is generally assumed to be a political and sociological fact. The spectrum of racism is wide and complex. Be it the 1994 ethnic cleansing of Tutsis by Hutus in Rwanda, hatred and violence against African-Americans by so-called white supremacists in the United States between the 1890s and 1930s, or retraction of equity laws in Malaysia during the prime ministership of Dr. Mahathir Mohammed under the guise that such laws disadvantage ethnic Malays, racism is characterised by dominant groups, exercising social, economic and legal encumbrances against other groups in order to retain or expand societal privileges and rights. In the United States, scholars define racism in relation to two legal theories: Intent Theory, where actions are racist when done with the intent of disadvantaging persons because of their race; and Disparate Impact Theory, where

practices and/or institutions are racist when they systematically result in disadvantaging a subordinate racial group relative to a dominant one [3]. Racism is defined by article 1(1) of the International Convention on the Elimination of All Forms of Racial Discrimination as;

‘Any distinction, exclusion, restriction, or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment, or exercise, on equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural, or any other field of public life.’ [4 p.2]

In this article a behavioural discrimination-based definition of racism is adopted, with racism described as arbitrary power by a population group to enforce prejudice or discrimination based on perceived inferiority in skin colour, voice or other exemplars of difference. The author adopts Wellman’s definition of racism as;

‘The deliberate structuring of privilege by means of an objective, differential and unequal treatment of people, for the purpose of social advantage over scarce resources, resulting in an ideology of supremacy which justifies power of position by placing a negative meaning on perceived or actual biological or cultural differences.’ [5 p.5-6]

While prejudice or discrimination may be emotionally hurtful if known to the intended victim, it is technically not racism unless it is actioned through the agency of power and domination to disadvantage those perceived as inferior [6]. Individual prejudice

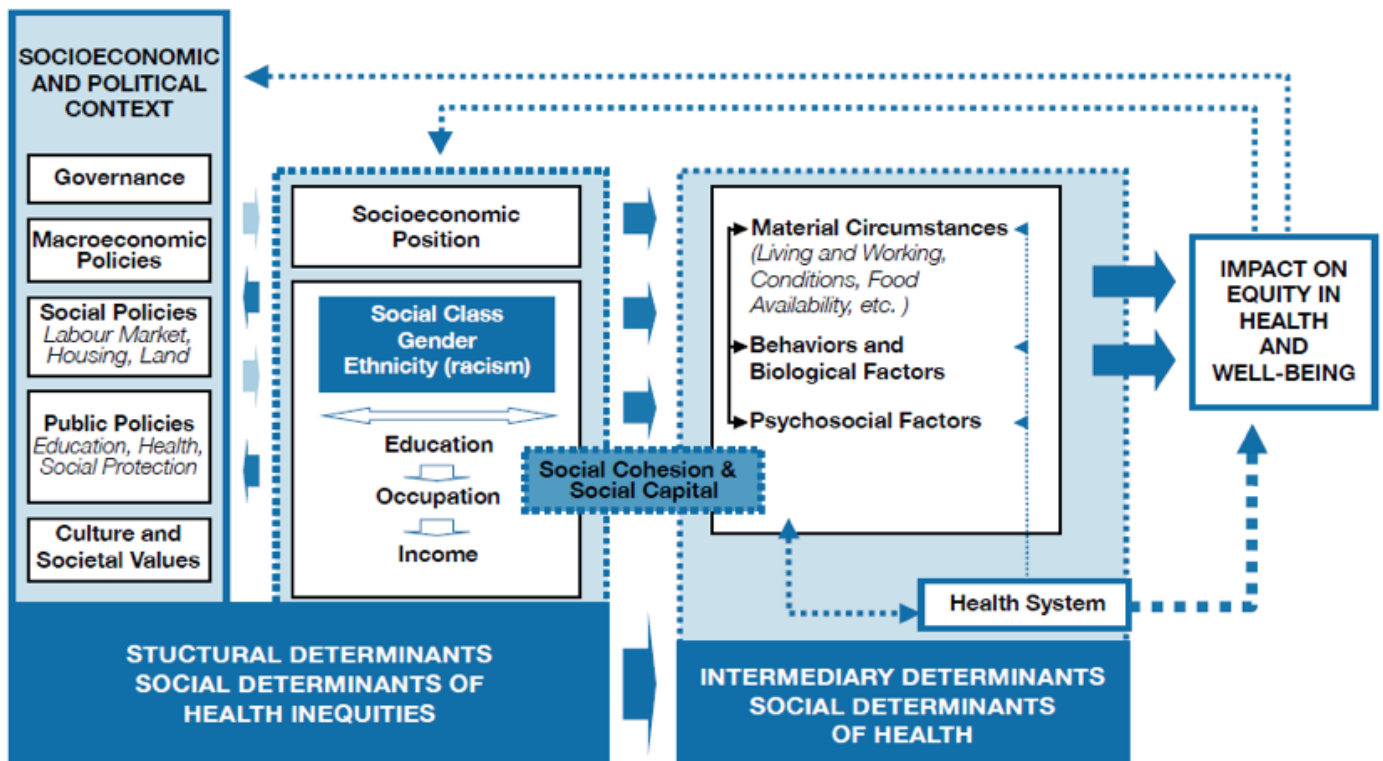


Figure 1: Conceptual framework highlighting racism as a structural determinant of health inequity

has limited racist impact as most individuals have inadequate power to actualise their prejudices. However, when prejudice is backed by government laws and enforced by community attitudes and actions, then such institutionalised racism has strong potential to result in sustained adverse impact of the health, wellbeing and social standing of victims.

Racism is a subset of racialism, as it tends to exist in a dynamic relationship with anti-racism. Racialism is defined as;

'A societal system through which people are divided into "races" with power unevenly distributed (or produced) based on these social classifications. Racialisation is embodied through attitudes, beliefs, behaviours, laws, norms, and practices that either reinforce or counteract power asymmetries.' [7 p.3]

The dynamic relationships between racism and anti-racism is important from an interventionist perspective as most racist practices can be redressed through coordinated anti-racism campaigns in which racially oppressed groups are key players [8].

Although adverse health outcomes are among the most common markers of the consequences of racism [9, 10], the major drivers of racism lie outside of the health sector, and are closely linked with the institutions of military and political power, money and other valuable resources [11]. Thus, racism may be regarded as one of the structural determinants of health inequities, influenced by socio-economic and political context, and in turn influencing material circumstances and behaviours of individuals and groups (Figure 1) [12].

Racism and Indigenous Australians

Although other Australian population groups, such as Muslims [13], have been documented as experiencing racism in Australia, the lived experience of racism is most protracted among Indigenous people, who have been described as *'by far the most "outsider" group in Australian society* [14]. Racist attitudes directed against Indigenous Australians may be viewed as having two dominant waves. The first wave was predominant during the first 170 years following the arrival of the First Fleet, and the second was in the post-referendum era, which led to changes to sections 51 and 127 of Australia's constitution that formally recognised Indigenous people as part of the Commonwealth of Australia. In the pre-referendum era, the 'old' or classic racism – belief in superiority based on white skin colour - was justified by the framing of Indigenous Australians as inferior humans (exemplified by their non-recognition as Australians in the Constitution). Such politically entrenched racialised attitudes justified dispossession of Indigenous Australians from their native homelands. Dispossession from country resulted in denial of land rights, loss of spiritual values, disrupted law, and disconnection from land, community, family and cultural values.

Most of these policies were backed by legal provisions instituted by Australian state governments. For example, in Queensland, racialised laws were enacted which effectively treated Indigenous people like prisoners, with little freedom of choice. They were required to work without payment, and forbidden from undertaking traditional cultural practices [15]. Such racially-driven policies created feelings of powerlessness, hopelessness, psychological stress and related illnesses [16]. These policies contributed to rapid decline in the colonised Indigenous population. By 1850, only 10% of 1788 Indigenous population remained due, in part, to the effects of resource dispossession, psychological distress, limited access to health care, and violence [17].

These racially discriminatory policies and practices were generally accepted as humane by other Australians until after the Second World War, when contradictions in the 1901 Immigration Restriction Act highlighted inequities in racial practices directed against Indigenous Australians. The referendum of 1967, which gave Indigenous people the right to vote and annulled racially discriminatory state laws, was passed by 90.77% of votes cast. Interestingly, a 2007 racism survey revealed that 7.7% of overwhelmingly Anglo-Australians believed that all races are not equal [18]. Thus, 'old racism' perspectives persist in a small (<10%) but significant proportion of Australians in contemporary era.

Attitudes indicating a tendency towards social exclusion based on perceived flaws and incompatibility of other culturally and linguistic groups with Australia's 'mainstream' Anglo-Saxon majority (i.e. 'new racism') were evident in this 2007 Australian survey, which found

that 57% believed that Australia is weakened by different ethnic groups sticking to their old ways [18]. However, researchers such as Gary Johns [19] posit that the high level of intermarriage between Indigenous and non-Indigenous Australians contradicts notions that racism is a major determinant of Indigenous despair. He argued that where contemporary racial prejudice is shown to exist in Australia, it is more likely based on stereotypes of drunkenness and anti-social behaviour, not race. Other researchers disagree. For example, Mellor [20], in a 2002 qualitative study of 34 Koori Indigenous Australians' perception of racism revealed that, in contrast to studies assessing racism trends from the perspectives of potential perpetrators, Indigenous people perceive institutional racism to be chronically pervasive in Australian society, and that 'new racism' impinges on health and wellbeing as adversely as blatant racism.

Apart from the self-reported adverse impacts of racism on Indigenous health, racism may also encumber access to effective health care by Indigenous Australians in mainstream health services. A perception that Australia's healthcare system is institutionally racist – i.e. that racist beliefs or values are built into how social institutions operate, and end up discriminating against Indigenous Australians [21] - remains controversial. Nevertheless, there does seem to be differential operation of accountability standards. The fact that Derbarl Yerrigan, the Aboriginal Medical Service in Perth was penalised severely for exceeding its \$8m annual budget by 10% in order to widen its client base in high need suburbs from 400 to 2100, while several major teaching hospitals suffered relatively mild sanctions for overspending by over \$80 million during the same period, appears racially discriminatory [21]. The 2007 Australian Medical Association Indigenous health report-card documented that sub-optimal access of Indigenous Australians to health care constituted 'institutionalised inequity', and health care access barriers were described as major contributors to poor Indigenous health outcomes [22].

Racism has strong historical links with health and, for victims, is aetiologically important in the causation of illness. Paradies' review of 138 empirical studies testing for correlations between self-reported racism and ill-health found strong associations with racism and adverse mental health outcomes and risky health behaviours [23]. A 2009 meta-analysis of chronic and subtle discrimination on health documented a complex relationship, mediated by variables such as coping style, level of discrimination, stress, and identity complexity. However, when weighted by sample size, the findings concur with Paradies' study that chronic discrimination has an adverse impact on mental and physical health, and may operate through increased stress and increased tendency to exhibit unhealthy behaviours [24]. Racism is thought to impact adversely on health outcomes through pathways like chronic stress, risky health-related behaviours, less use of preventive services, and racialised patient - health worker relationships [25].

A 2009 study of the impact of racism on wellbeing was conducted among 823 Australian high school students aged 12 – 19. The sample comprised 28 Indigenous Australians, of whom only 9 were interviewed. Although the study found that the interviewed Indigenous Australian students appeared to experience less racism compared with refugee and migrant youth, the authors opined that the depth of racist experiences suffered by Indigenous Australians may be greater than those reported by other cohorts [26]. At an ecological level, a cross-sectional study in the United States based on data from 39 states showed that racism, measured in relation to social disrespect, is associated with higher mortality in both blacks and whites, and that a 1% increase in the prevalence of those who believed that blacks lacked innate intellectual abilities was associated with an increase in the age-adjusted black mortality rate of 359.8 per 100,000 [27].

Although not officially acknowledged by Australia's political authorities, high rates of racism are consistently reported by Indigenous Australians. For example, based on 2008 data contained in the 2010 Australian Bureau of Statistics Indigenous Wellbeing report, 27% of Indigenous people experienced discrimination over a 12-month period [28]. Institutional racism against Indigenous Australians continues to be identified in the media, education and welfare system, in the provision of public housing and in the criminal justice systems [29]. In Australia, racism may impact on Indigenous health and wellbeing via the environments identified in Figure 2. This figure shows that racism impairs Indigenous health through multiple pathways, including health care.

Increasingly, racism against Indigenous Australians in the provision of, and access to, health services is becoming apparent [31-34]. Thus racism constitutes a 'double burden' for Indigenous Australians, encumbering their health as well as access to effective and timely health care services.

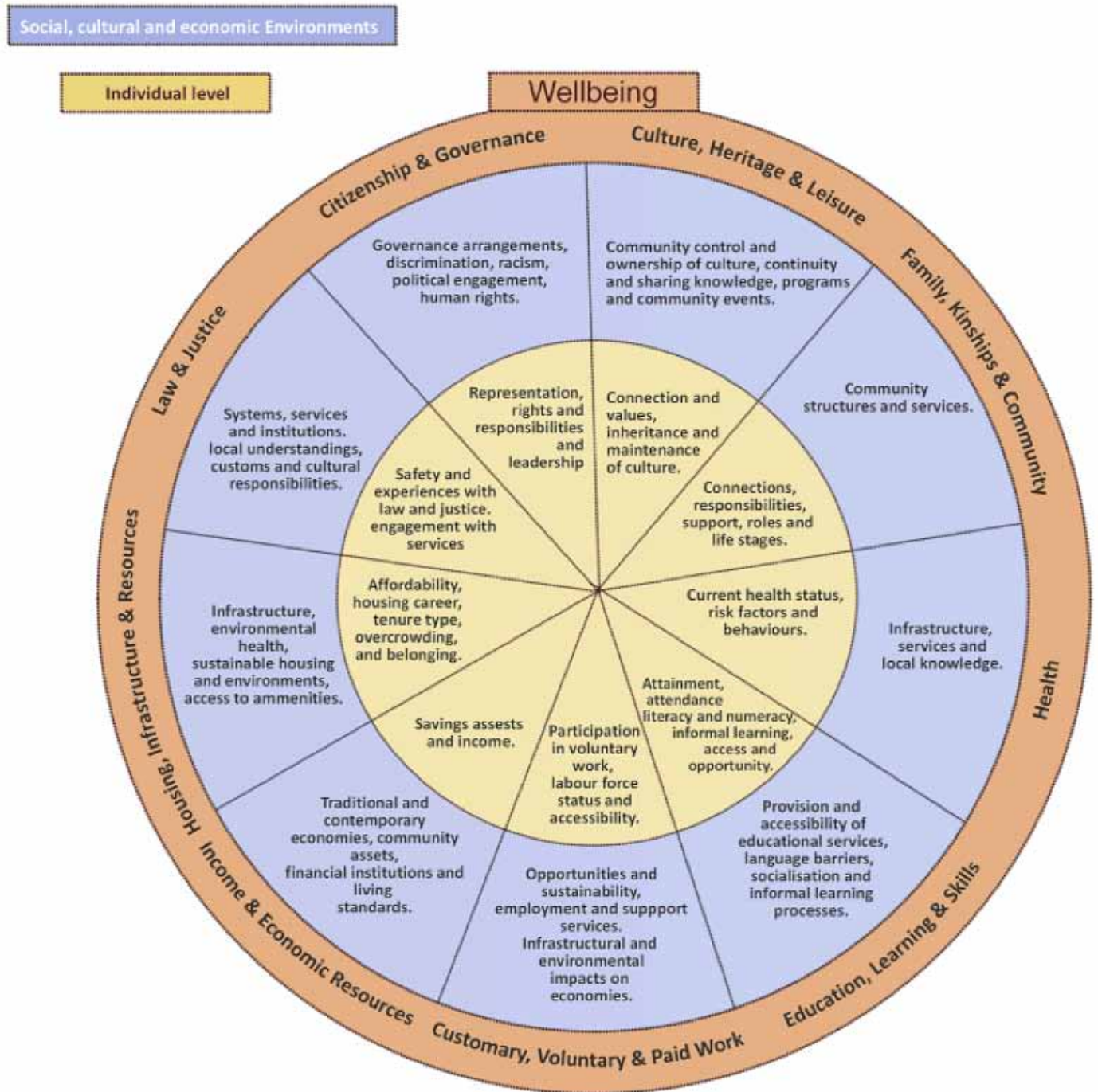


Figure 2: Dimensions of Indigenous well-being, through which racism may operate.
Source: [30]

Addressing determinants of racism against Indigenous Australians

The conceptual framework depicted below highlights the Proximal, Distal and Contextual determinants of racism, together with their impacts on Indigenous health status and outcomes in Australia (Figure 3).

This framework shares common features with Paradies’ four levels of anti-racism intervention in relation to Indigenous Australians: Cognitive, Individual, Interpersonal and Societal [7]. Arguably, it extends Paradies’ framework by providing a broader platform for studying the dynamic relationships between determinants of racism as well as integrated anti-racism intervention mechanisms.

Proximal determinants

Proximal determinants of racism directed against Indigenous Australians relate to factors operating at individual and interpersonal levels. At the individual level, unhealthy (e.g. smoking and alcoholism) and anti-social (e.g. unkempt appearance, swearing, and public nuisance) behaviours by some Indigenous Australians may reinforce negative stereotypes which tend to

evolve into racist attitudes and practices [19]. It is noteworthy, however, that such unhealthy behaviours and anti-social attitudes may be the outcome of racist practices directed towards Indigenous Australians [23, 24]. Interpersonal prejudices which promote racism are best illustrated by stereotypes of Indigenous people as dole bludgers, lazy and alcoholics. Such prejudices operate from teenage years, with some of their non-Indigenous peers perceiving ‘successful’ and ‘Indigenous’ as mutually exclusive terms. Tragically, some young Indigenous teenagers live out such racial stereotypes, with adverse health and wellbeing consequences, in line with Abramson et al’s Leaned Hopelessness Theory [35]. Australian media deliberately or inadvertently propagated negative Indigenous stereotypes over the past century. For example, a 1932 article in the South Australia’s the Advertiser newspaper had the headline *The Aboriginal of Australia; more intelligent than supposed*, echoing the stereotype of the time that Indigenous people were intellectually inferior [36]. Racialised stereotypes of Aboriginal people as ‘backward or ‘intellectually inferior’ are not restricted to early colonialists’ media reports. For example, contemporary depiction of Indigenous individuals’ images on nations’ coins not only represents such individuals, it expresses something about them, their social status, and their ancestry. The metaphorical and numismatic exemplification implicit in the current Australian \$2 coin suggests a racialised and unflattering

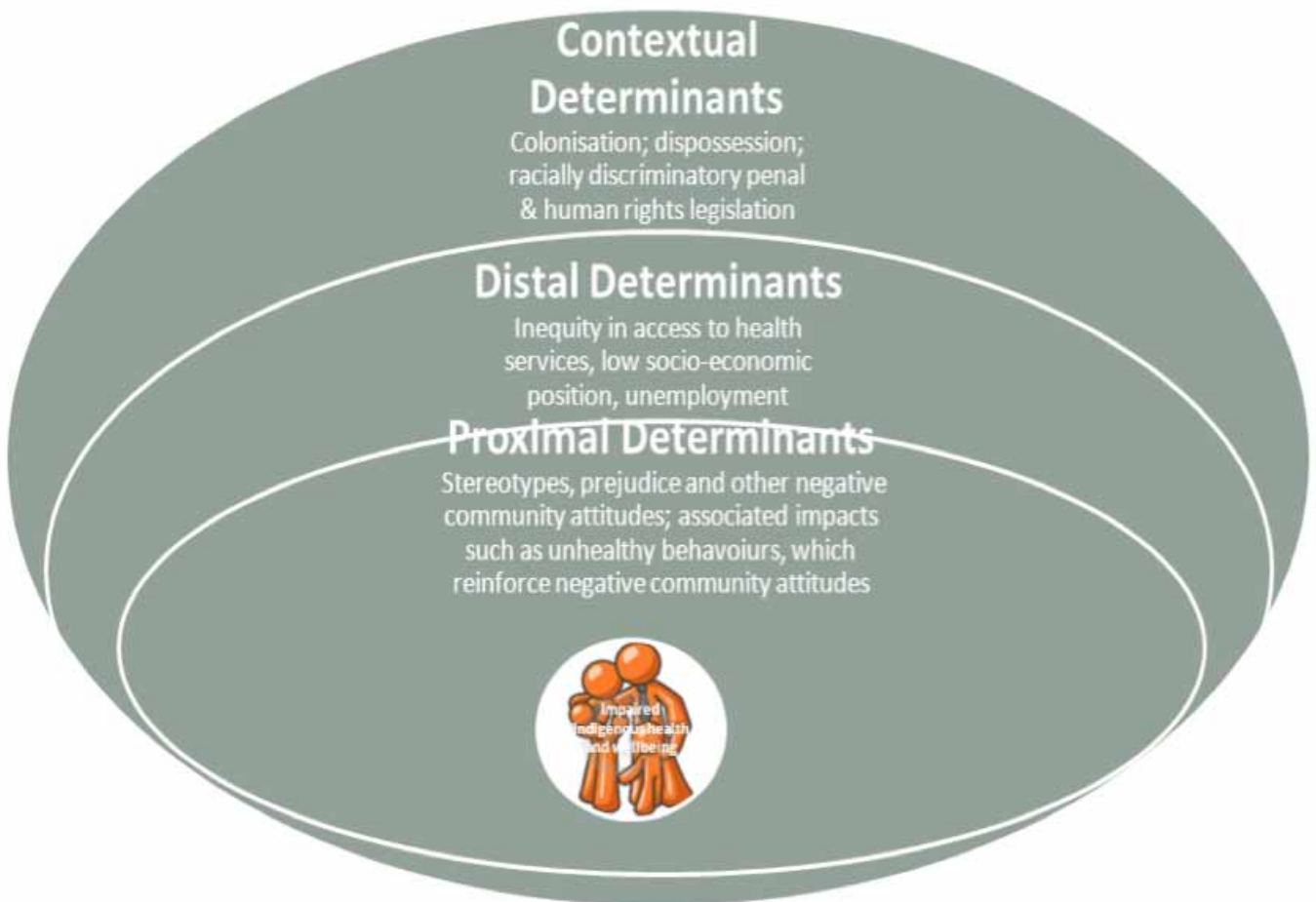


Figure 3: Determinants of racism among Indigenous Australians (Source: author).

national identity of Indigenous Australians, which is deeply rooted in the history of colonisation. Such negative stereotypes have been shown contribute to inferior health experienced by Indigenous Australians [37]. A consequence of these racist attitudes is that it has eroded the trust of Indigenous Australians in the institutions of government, as well as in mainstream healthcare services. Racism has also created a situation in which there is a diminishing self-esteem and self-confidence among Indigenous people in their culture [20].

An appropriate starting point for addressing determinants of racism is enhancing self-efficacy of Indigenous children and youths, so as to enable them to stand up, persevere with their career aspirations, and be successful. Internalisation of positive Indigenous identity as well as educational and career successes provide significant counterweights to being subject to racial stereotypes and discrimination, and is strongly associated with healthier lifestyles. Furthermore, working collaboratively to improve the health status of Indigenous Australians has significant potentials to facilitate their educational outcomes and career success [38].

Indigenous Australians may also play key roles in reducing racist community attitudes, in part by conforming to basic norms of public decency, and by being active community development participants, both politically and socio-economically. While such activities may not necessarily change the attitudes of the minority (< 10%) of Australians who harbour racial ideologies against Indigenous Australians, they may operate mutually to influence positive attitudinal changes among the majority Australian population, as well as among Indigenous Australians towards their non-Indigenous counterparts. Community and opinion leaders, including journalists, have important roles in reducing racism. Evidence-based anti-racism initiatives at the interpersonal and community levels include; providing accurate information on Indigenous groups, behaviours and traditions, organising community meetings where locals are able to freely discuss the drivers of prejudice, and suggest ameliorative strategies, and encouraging individuals to have contact with members of Indigenous groups against whom they have obvious prejudice [1].

Distal determinants

A common feature of distal determinants of racism is legally or institutionally structured inequitable access to social determinants of health, particularly, health care services, education, criminal justice, housing and employment. These determinants are mutually reinforced by the socio-political context – governance, macro-economic policies, social policies, culture and societal values. Prior to the 1967 referendum, overt racism was legally enforced in Australia in most areas of Indigenous life, from movement restrictions to discrimination in military service, sporting events, restrictions in health care access, and employment barriers [15]. Post-1967, all legally structured racial barriers encumbering equity

of access to Indigenous people to health and social services were abolished. While this step reduced racial discrimination directed against Indigenous Australians, it did not eliminate all structural determinants of racism. For example, despite major deficiencies in Indigenous health status and outcomes, populist resentment at programmes to ameliorate Indigenous health disadvantage is increasing, in part based on notions that apparently generous government-funded initiatives focussed on improving the health, cultural security and wellbeing of Indigenous people are counterproductive and doomed to fail [19]. Inequitable delays in access have been documented for Indigenous Australians in relation to hospital emergency services, cancer management and cardiac surgery in major Australian hospitals [32-34]. Partly as a result of these inequities, Indigenous Australians make up 2.5% of the total Australian population but carry 3.6% of the total Australian burden of disease. Between 2001 and 2005, 71% of all mortality among Indigenous Australians occurred prior to age 65 years, compared with 21% of death prior to age 65 years among non-Indigenous Australians [39]. Late diagnosis, limited access to specialist care, and assumptions made by healthcare workers about the merit in providing cancer care for Indigenous people in certain socio-economic circumstances are significantly influenced by structurally embedded racist attitudes and practices.

Nevertheless, most distal determinants of racism against Indigenous Australians lie outside of the health system. For example, in Western Australia, Indigenous people constitute 3.5% of the total population but 42% of the prison population [40]. In the words of Angela Davis;

'Imprisonment has become the response of first resort for far too many of the social problems that burden people who are ensconced in poverty. These problems are often veiled by being conveniently grouped together under the category 'crime' and by the automatic attribution of criminal behaviour to people of colour. Homelessness, unemployment, drug addiction, mental illness, and illiteracy are only a few of the problems that disappear from public view when the human beings contending with them are relegated to cages.' [41 p. 146-147]

Judicial racism is also an issue, with Indigenous people up to three times more likely to be sentenced to prison terms than non-Indigenous people, for similar offences. In his report into Indigenous deaths in custody, Johnston noted that;

'... in certain circumstances Aboriginal people may receive longer sentences for the same offence than non-Aboriginal people.' [42 p. 217]

Imprisonment is a major distal determinant of Indigenous health in Australia. Apart from increased risks of contracting infectious disease, chronic health disorders like diabetes and hypertension are less likely to be well managed in prison settings compared with the general community. Imprisonment creates social exclusion,

the consequences of which extends beyond release from prison, and may increase risks of suicide and drug use following release. A 1995-2003 Australian study of 13,667 released prisoners tracked over two years showed that Indigenous males had significant higher standardised mortality rates (7.9/1000) compared to their non-Indigenous peers (4.8/1000) [43, 44].

Addressing distal determinants of racism is essentially a matter of addressing the social determinants of Indigenous health inequities and inequalities [12]. Fortunately, major improvements are being made in the Australian health sector, with coordinated efforts to reduce structural encumbrances and improve cultural competence of health workers, both during training of frontline health workers and as part of professional development [45, 46]. Non-Indigenous health-related professional associations have important roles to play in addressing distal determinants of racism. The Australian Medical Association's advocacy on behalf of Indigenous people to reduce racialised encumbrances to accessing adequate health care is exemplary [22]. As distal determinants of racism are closely linked to governments' social, employment, health, penal, cultural, education and human rights policies, coordinated anti-racism advocacy, programs and support services are important for addressing racism in Australia. To be effective, particular attention needs to be focussed on vulnerable populations such as Indigenous Australians and first-generation migrants [1, 47]. The use of Critical Race Theory (CRT) may facilitate effective advocacy, program implementation and evaluation of efforts to address distal determinants of racism;

'CRT is a flexible framework that embraces pragmatic trans-disciplinary tenets whose point of departure is not the question "do we live in a racist society", but rather the realization that "we live in a racist society"... A practical CRT framework maintains the potential for antiracists to adopt a critical standpoint that can challenge mainstream agendas and epistemologies and therefore transform them.' [48 p.338]

Contextual determinants

Contextual determinants relate to historical antecedents of racism, as well as regional and global trends, ideologies, treaties and laws which have significant influences on racism in specific nations. The Australian Human Rights and Equal Opportunity Commission determined that most formal reports of racism by Indigenous and non-Indigenous Australians are related to employment. The Commission therefore introduced Race for Business, an information and training package for workplace settings, to;

'assist employers prevent and eliminate racial discrimination and harassment in the workplace. The program emphasises mutual respect in the workplace and recognition of the benefits of diversity to business.' [49 p. 91-92]

In Australia, historical antecedents remain strong contextual determinants of racism against Indigenous Australians. The dispossession of Indigenous people of their communal lands was justified by British colonialists' pastoral capitalism and racism. Agricultural land were required by pastoralists like Melbourne-based John Batman, who expanded his wealth through generous land grants from the Tasmanian government in return for being part of several murderous expeditions against the local Aborigines, such as the 1830 'Black Line' operation. During such operations,

'it was common for parties of the civilised portion of society to scour the bush for, and, on making a find, to slaughter parties of natives.' [50 p. 503]

Apart from the obvious adverse effect of racially-motivated injuries and murders on the health of Indigenous people and communities, the dispossession of land also had serious implications for health. For most Indigenous people, their homelands are closely linked to their identity and spirituality, and perceptions of individual and community health are intertwined with the health of their country. Their relationship with country is reciprocal – country cares for its people and provides resources, and people look after country with appropriate management [51]. In the words of Pat Anderson;

'Our identity as human beings remains tied to our land, to our cultural practices, our systems of authority and social control, our intellectual traditions, our concepts of spirituality, and to our systems of resource ownership and exchange. Destroy this relationship and you damage – sometimes irrevocably – individual human beings and their health.' [52 p.15]

Forced exclusion of Indigenous people from their traditional land impacted on Indigenous health in many ways, including loss of social cohesion, loss of cultural knowledge, and loss of self-esteem. Compounding these losses is the added burden of learning alien legal concepts, food culture, religious and educational practices introduced by colonialists, some of which conflict with Indigenous norms [53]. For example, Indigenous people who were used to hunting for 'bush tucker' in their country find themselves imprisoned for 'stealing sheep' if they hunt for game in their homelands that have been taken over by colonialists. In *Why warriors lie down and die*, Trudgen highlighted how trying to imbibе colonial prescriptions of education and living paradoxically worsened Indigenous health and wellbeing in Arnhem Land [16]. Similar findings have been reported for Indigenous Australians in the Kimberley region of Western Australia [54].

Global and national human rights trends are also important contextual determinants of racism. During the last 63 years since the adoption in 1948 of the Universal Declaration of Human Rights, the international community has made some important advances in the fight against racism, racial discrimination, xenophobia and related intolerance. The first World Conference to Combat Racism and Racial Discrimination was held in Geneva in 1978. The

Declaration and Programme of Action adopted at the fourth World Anti-racism Conference in Durban, South Africa in 2001 strongly rejected any doctrine of racial superiority, along with theories which attempt to determine the existence of so-called distinct human races. Declaration 9 stated;

'racism, racial discrimination, xenophobia and related intolerance may be aggravated by, inter alia, inequitable distribution of wealth, marginalisation and social exclusion.'
[55 p.3]

In the context of racial discrimination in relation to health care, Article 24(1) of the 2007 United Nations Declaration on the Rights of Indigenous People states that;

'Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.'
[56 p. 5-6]

In Australia, international pressure on racism-related issues has influenced national approaches to minimising the effects of racism on Indigenous people. For example, the Australian government's restoration of the *Racial Discrimination Act 1975* (RDA) in the Northern Territory in December 2010 was partly influenced by a United Nations Human Rights report which criticised the 2007 Northern Territory Intervention that set aside the RDA in order to implement changes to welfare provision, law enforcement, land tenure in order to address child sexual abuse and neglect among Indigenous residents. Current initiatives by the Gillard Government to amend Australia's constitution to include recognition of Indigenous people were also due, at least in part, to pressure by the United Nations Human Rights Commission [57].

In his 2008 'Sorry' address to Indigenous Australians, former Prime Minister Kevin Rudd stated;

'We apologise for the laws and policies of successive parliaments and governments that have inflicted profound grief, suffering and loss on these our fellow Australians... We today take this first step by acknowledging the past and laying claim to a future that embraces all Australians... A future where we harness the determination of all Australians, Indigenous and non-Indigenous, to close the gap that lies between us in life expectancy, educational achievement and economic opportunity.' [58 p. 1]

This symbolic act was strengthened by a generously funded National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. The agreement comprises six ambitious targets, related to closing gaps in life expectancy, infant mortality, childhood education, and employment outcomes [59].

Addressing contextual determinants of racism entails governments developing strong political will to actively participate in, and abide by, international anti-racism treaties, conventions and declarations. It also entails governments acknowledging past wrongs against community groups that have suffered racism and prejudice, and taking symbolic and practical steps to redress past injustices through legal, social, economic, cultural and health interventions. The promulgation, and strict enforcement, of national laws prohibiting racial discrimination is an important starting point in addressing contextual determinants of racism.

Conclusion and implications

Racism is a structural determinant of Indigenous health inequity in Australia [12, 29, 60]. An explanatory and intervention framework needs to take account of contextual determinants, such as colonisation and international human rights enforcement, distal determinants, which are essentially the structural and social determinants of health, and proximal determinants, including stereotypes, prejudice, and their adverse self-efficacy and behavioural impacts on Indigenous people. Irrespective of its origins, the health consequences of racism are substantial and have been demonstrated among Indigenous Australians [16, 20, 29, 31, 34, 35].

Fortunately, recent Australian governments have demonstrated strong political will to address racism against Indigenous Australians and other vulnerable population groups in Australia. Positive government anti-racism initiatives have been influenced or complemented by key stakeholders locally and internationally, including Indigenous Australians, non-governmental organisations, anti-racism researchers, policy makers, international anti-racism coalitions and the United Nations Human Rights Commission. In relation to interventions at the proximal determinants level, greater multifaceted efforts to reduce the prevalence of perceived or actual peer and community discrimination against young Indigenous Australians are required in order to optimise the impact of efforts to enhance self-efficacy and career motivation among Indigenous youths [61]. It is also important to assess racism from the perpetrator's, as well as the victim's perspective. To account for discrepancies in research findings from these two groups, and improve validity of racism research, both unconscious and conscious awareness of discrimination should be investigated [20, 62].

Provided it is effectively implemented, the COAG framework [59] will address many core structural determinants of health inequalities. However, it was not designed to address culturally linked structural determinants such as relationship with land and country [51-53]. Reconnecting Indigenous people with their traditional lands is an important strategy for reducing the impact of racism on Indigenous health. Apart from ecological benefits of Indigenous land management, evaluation studies also indicate that such reconnections improve the health of Indigenous people. A 2007 evaluation study of sustainable urban landscapes in northern Australia showed that;

'Aboriginal people actively involved in the Indigenous natural and cultural resource management were demonstrably healthier than those who weren't. In particular they had low levels of the precursors of cardiovascular disease and diabetes. They also felt good about themselves because they were fulfilling cultural responsibilities, eating good traditional food and avoiding the social tensions of town life.' [63 p. iv]

Other studies indicate that, among Indigenous communities who reconnect with country through participation in Indigenous Protected Areas (IPA) projects, 95% report economic participation and development benefits, 85% report that IPA activities improve early school engagement, 74% report that IPA activities have contributed to reduced substance abuse, and 74% report IPA participation results in more functional families by reinforcing family and community structures, and restoring relationships [64].

At the contextual level, advocacy by national stakeholders is important to address racially-sensitive policies such as the Northern Territory Emergency Response. The 2010 UN report on the Northern Territory Intervention recommended, in part, that Australia's federal government should:

'Amend the Australian Constitution to include the recognition of Aboriginal and Torres Strait Islanders as First Nations Peoples; reset the relationship with Aboriginal people based on genuine consultation, engagement and partnership and that Government actions affecting the Aboriginal communities respect Australia's human rights obligations and conform with the Racial Discrimination Act; reform and remedy the discriminatory impact that the Northern Territory Emergency Response has had on affected communities, including restrictions on Aboriginal rights to land, property, social security, adequate standards of living, cultural development and work; increase access to justice for Indigenous peoples, including through increased funding for Aboriginal legal aid and interpretative services.' [65 p.2]

Most of the recent Federal Government anti-racism initiatives related to Indigenous Australians may be attributed to the advocacy inherent in this UN report.

Finally, since culturally inappropriate health services provision contribute to persistent health inequalities, cultural education is an important strategy for reducing the adverse impact of racism on the health of Indigenous Australians. Cultural education in the Indigenous Australian context entails cultural competence training, which provides knowledge and skills beyond mere awareness to competence in working effectively and harmoniously with Indigenous Australians. Developing and implementing policies on cultural competence training in the health sector is an important strategic approach [66]. A culturally competent workforce will encourage health seeking behaviour and promote treatment adherence among Indigenous people. Health workers who engage in racist practices should be disciplined. Undergraduate and postgraduate health workers require in-service and continuing training in culturally respectful health care with education programs that are evaluated for long-term improvements to practice. Despite major expansion in cultural education programs in Australia over the past two decades, the evidence base for their effectiveness is poor, and this knowledge gap requires urgent attention [67]. A Cultural Safety model of facilitating cultural competence, which

focus more on improving the application of knowledge in social, political, cultural and historical processes that influence health and health care, than on cataloguing diverse culture-specific beliefs of over 200 Indigenous groups in Australia, is a promising framework for Indigenous cultural education [68].

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