The impact of racism on indigenous health in Australia and Aotearoa: towards a research agenda

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The ideas and opinions presented in this discussion paper are the authors' own and may not reflect those of the Cooperative Research Centre for Aboriginal Health.

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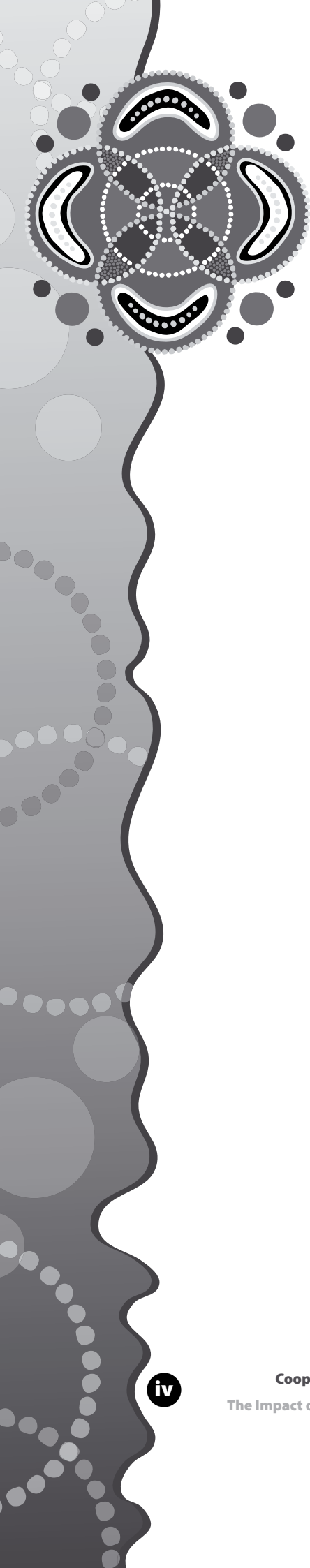
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Glossary

DRUID	Darwin Region Urban Indigenous Diabetes
Elite racism	Racism that is perpetrated by influential figures in the public domain (i.e. political, media, educational, scholarly or corporate)
Internalised racism	Acceptance of attitudes, beliefs or ideologies among members of stigmatised ethnic/racial groups about the inferiority of one's own ethnic/racial group
Interpersonal racism	Interactions between people that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups
Inter-racial racism	Racism that is perpetrated against a member of an ethnic/racial group by a member of a different ethnic/racial group
Intra-racial racism	Racism that is perpetrated against a member of an ethnic/racial group by a member of the same ethnic/racial group
Macro-stressors	Large-scale stressors of a general nature (e.g. economic recessions) that are known as race-related macro-stressors when affecting ethnic/racial communities specifically (e.g. racial riots)
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
Systemic racism	Requirements, conditions, practices, policies or processes that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups (also known as institutional racism)
WAACHS	Western Australian Aboriginal Child Health Survey

Executive Summary

It is well established that Indigenous Australians[1] and Māori have higher levels of ill health and mortality than non-Indigenous people. It is also clear that the disadvantage suffered by Indigenous peoples[2] is associated with both historical and contemporary racism, colonisation and oppression. Both an 'adequate state of health' and 'freedom from racism' are rights enshrined in legislation in Australia and Aotearoa (New Zealand).[3] Although several recent national and international reports have shown a link between racism and public health, there is little research on this topic in Australia or Aotearoa.

In response to this paucity of research, the 'Racism and Indigenous Health' symposium was held at The University of Melbourne on 27 November 2007. This event brought together 35 key researchers and policy-makers from Australia and Aotearoa in the area of racism and Indigenous health to discuss recent findings in this field and to set an agenda for future research. The symposium endorsed a cohesive research agenda to advance our understanding of, and our ability to combat, racism as a threat to Indigenous health in Australia and Aotearoa. Five key research questions were identified from the symposium:

- What is the prevalence and experience of racism across the life course for Indigenous peoples?

- What impact does racism have on Indigenous health across the life course?

- How can we appropriately assess systemic racism against Indigenous peoples?

- What are the best ways to address systemic racism against Indigenous peoples?

- How can an understanding of the ways in which societal systems produce advantage and positive health outcomes for White Australians and Pākehā New Zealanders help improve Indigenous health?

These key questions focus on systemic racism, stressing the importance of further research on the prevalence of racism, its impact on Indigenous health and approaches to eliminating it from society. The symposium also highlighted the need to explore the benefits of racial socialisation (i.e. learning about the nature and ubiquity of racism in society) and to find effective ways to combat interpersonal racism against Indigenous peoples. Improvements in health system performance were supported as an approach to addressing systemic racism in health care, and the symposium emphasised the need to systematically estimate the cost of racism to society in Australia and Aotearoa.

This discussion paper highlights the vital importance of sound research in endeavours to combat racism as a threat to Indigenous health in Australia and Aotearoa. We hope that this paper will act as an impetus to policy and decision-makers at the national, regional and local levels to engage in efforts to combat racism against Indigenous peoples as a public health intervention.

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[1] 'Indigenous Australians' refers to Australian Aboriginal and/or Torres Strait Islander people.

[2] In this paper, the term 'Indigenous peoples' refers to both Indigenous Australians and Māori New Zealanders.

[3] Aotearoa is the most widely accepted Māori name for New Zealand and is used in this paper as such.

Introduction

The right to a 'standard of living adequate for … health and wellbeing' was established as a basic human right in Article 25.1 of the 1948 Universal Declaration of Human Rights. A right to health is also enshrined in Article 12.1 of the International Covenant on Economic, Social and Cultural Rights 1966, which has been ratified by both Australia and Aotearoa.

Freedom from racism and racial discrimination is also a fundamental human right. In Australia, Section 9 of the *Racial Discrimination Act 1975* was the first piece of federal legislation that, based on the United Nations Convention on the Elimination of All Forms of Racial Discrimination, made it unlawful to commit a racist act that impinges upon a human right. Similarly, in Aotearoa the *Human Rights Act 1993* makes it unlawful to discriminate on the basis of race/ethnicity in key areas of public life.

It is well established that both Indigenous Australians and Māori have a state of health and wellbeing far below other groups in their respective nations. The estimated half a million Indigenous Australians comprise 2.4 per cent of the Australian population and are the most disadvantaged group in Australian society. They suffer from high rates of unemployment and incarceration, low income, substandard housing, and a high burden of ill health and mortality, including a life expectancy that is seventeen years less than other Australians. Indigenous Australians are three times more likely to be admitted to hospital than other Australians and suffer high rates of risk factors such as smoking, substance misuse, exposure to violence, lack of exercise and obesity (ABS & AIHW 2005).

In 2006 a little over half a million Māori comprised 14.6 per cent of the Aotearoa population. Major inequalities exist between Māori and non-Māori across a range of social, economic and health indicators. These include inequalities in education, income, housing and employment, with Māori experiencing disproportionate socioeconomic disadvantage. In health Māori have a life expectancy that is approximately eight years lower than non-Māori and have inequalities in nearly all major health status indicators. For example, Māori are more than twice as likely to have diabetes and more than seven times as likely to die from diabetes than non-Māori. Māori are nearly twice as likely to die from cancer as non-Māori, and more than twice as likely to die from cardiovascular and respiratory disease. Māori are also more likely to have a disability (Robson & Harris 2007).

The disadvantage experienced by Indigenous peoples in Australia and Aotearoa is associated with both historical and contemporary racism, colonisation and oppression. Racism against Indigenous Australians continues to be evidenced among non-Indigenous people by misconceptions that portray Indigenous peoples as being welfare dependent, more likely to drink alcohol and as getting special 'government handouts' (Pedersen *et al*. 2006). The extent of contemporary racism in Australia is also borne out by representative survey research (Dunn *et al*. 2003; ABS 2004, 2006; Zubrick *et al*. 2005; Forrest, Dunn & Pe-Pua 2007; Larson *et al*. 2007). Similar research shows that racism against Māori is an enduring feature of Aotearoan society (MacDonald 1986; Knight 1991; Wetherell & Potter 1992; McCreanor 1997; Hackwell & Howell 2002; Howell & Hackwell 2003; Harris *et al*. 2006a; Harris *et al*. 2006b).

A number of recent seminal reports have recognised racism as a threat to public health in both Australia and Aotearoa. The *NHMRC Road Map* (RAWG 2002:12) recognised the need to understand racism as a cause of Indigenous ill health, while the Australian satellite conference of the World Conference Against Racism in 2001 noted the 'health ramifications', including the 'physical effects', of racism (Nakata 2001).

The recent report *More than Tolerance: Embracing Diversity for Health* (VicHealth 2007) focused specifically on the heath effects of racism for migrant and refugee communities in Victoria. In Aotearoa the 2002 Māori Health Strategy and the *Reducing Inequalities in Health* report both recognise the need to tackle institutional racism against Māori (Ministry of Health 2002a, 2002b), while the importance of racism as a health issue has also been recognised in several countries around the world (Smedley, Stith & Nelson 2002; Karlsen 2007; Ombudsman Against Ethnic Discrimination 2007).

The investigation of racism as a cause of ill health is an emerging field of scholarship. A recent review of the worldwide public health literature revealed a strong association between direct personal experiences of racism and ill health among a number of minority groups in developed countries (Paradies 2006a). This association remained after adjustment for a range of confounders and occurred in longitudinal, as well as cross-sectional, studies, suggesting that racism precedes ill health rather than vice versa. The most consistent finding in this body of research is the association between racism and mental health conditions such as psychological distress, depression and anxiety. Racism also appears to be consistently associated with health risk behaviours such as smoking, alcohol and substance misuse (Paradies 2006a).

Given the scope of the problem, relatively little research on the links between racism and Indigenous ill health exist in Australia and Aotearoa, with less than a dozen studies that have examined racism as a contributor to the poor health of Indigenous peoples (Cunningham 2002; Cass et al. 2004; Coory & Walsh 2005; Zubrick et al. 2005; ABS 2006; Harris et al. 2006a, 2006b; Paradies 2006b; Gallaher et al. 2007; Hall et al. 2007; Larson et al. 2007).

In response to this identified paucity of research on racism as a contributor to Indigenous ill health, the 'Racism and Indigenous Health' symposium was convened by Dr Yin Paradies (Menzies School of Health Research and The University of Melbourne) and Professor Ian Anderson (The University of Melbourne). This symposium was sponsored by the Cooperative Research Centre for Aboriginal Health.

The symposium brought together thirty-five key researchers and policy-makers with interest in the area of racism and Indigenous health in Australia and Aotearoa to discuss recent findings in this field and to set an agenda for future research. Professor David Williams from Harvard University, a leading figure in the study of racism and health worldwide, also attended the symposium. About three-quarters of participants were researchers from a range of disciplines including psychology, public health, sociology, media and policy studies. The remainder worked in policy and research roles in a range of state and national government departments and non-government organisations. About one-third of those who attended were Indigenous researchers from Australia and Aotearoa (see Appendix A for a list of symposium participants).

The principal aim of the symposium was to develop key research questions that could further our understanding of racism as a cause of Indigenous ill health in Australia and Aotearoa (see Appendix B for symposium program).

Keynote presentations were given on the following topics:

- the current knowledge of the links between racism and Indigenous health in Australia and Aotearoa;

- theoretical and methodological challenges in the study of racism and Indigenous health; and

- approaches to combating racism against Indigenous peoples.

The symposium endorsed a cohesive research agenda to advance our understanding of, and our ability to combat, racism as a threat to Indigenous health in Australia and Aotearoa. The twenty-five research questions (including five key research questions) that constitute this agenda are detailed under five themes:

- concepts in the study of racism and Indigenous health;

- the extent of racism against Indigenous peoples;

- the impact of racism on Indigenous health;

- approaches to studying racism and Indigenous health; and

- combating racism against Indigenous peoples.

Theme 1: Concepts in the Study of Racism and Indigenous Health

Racism is an organised system based on an ideology of inferiority that labels some ethnic/racial groups as inferior to others and differentially allocates desirable societal resources to the superior ethnic/racial groups (Bonilla-Silva 1997). Racism can be broadly defined as avoidable and unfair actions that further disadvantage the disadvantaged or further advantage the advantaged. Racism can be expressed through stereotypes (racist beliefs), prejudice (racist emotions) or discrimination (racist behaviours and practices) (Paradies 2006c).

Racism is one manifestation of the broader phenomenon of oppression, which also includes, for example, sexism, ageism and classism. Oppression is intrinsically linked to the concept of privilege (Paradies 2006c). As such, in addition to disadvantaging Indigenous peoples, racism also results in white Australians and Pākehā New Zealanders being privileged and accruing unfair opportunities.

Racism can occur at three conceptual levels that are interrelated and frequently overlap in practice (Berman & Paradies, under review).

- *Internalised racism:* Acceptance of attitudes, beliefs or ideologies by members of stigmatised ethnic/racial groups about the inferiority of one's own ethnic/racial group (e.g. an Indigenous person believing that Indigenous people are naturally less intelligent than non-Indigenous people).

- *Interpersonal racism:* Interactions between people that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups (e.g. experiencing racial abuse).

- *Systemic racism:* Requirements, conditions, practices, policies or processes that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups (e.g. Indigenous people experiencing inequitable outcomes in the criminal justice system). This type of racism is also referred to as institutional racism.

Symposium participants readily acknowledged the importance of each of these levels of racism, but noted that systemic racism is the level of racism that fundamentally underpins racial/ethnic inequalities in health. Systemic racism is the most pervasive form of racism across a range of life domains such as education, employment and housing. These life domains have, in turn, been found to strongly influence health and wellbeing (Marmot & Wilkinson 1999). It is important to note that systemic racism can persist in institutional structures and policies in the absence of prejudice at the individual level and that it is a fundamental cause of both internalised and interpersonal racism.

Racism that is perpetrated by influential figures in the public domain is known as 'elite racism'. Such racism in the political, media, educational, scholarly or corporate domains is particularly damaging in that it fuels racist attitudes among the general public (Van Dijk 1993). Few studies have examined elite racism in Australia and Aotearoa (Spoonley & Hirsch 1990; Wetherell & Potter 1992; McCreanor 1993; McGregor & Comrie 1995; Augoustinos, Lecouteur & Soyland 2002; Rankine & McCreanor 2004; Moewaka Barnes *et al*. 2005; Tuffin 2008), and further research is required to understand how elite racism leads to everyday racism.

The symposium also noted the value of racism field experiments in Australia and Aotearoa, which could involve, for example, sending an Indigenous and non-Indigenous person to seek goods or services or to apply for employment, housing or admission to various institutions or venues (Blank, Dabady & Citro 2004). Except for their race, these two auditors/testers would have equivalent characteristics such that any differences in their

treatment, opportunities or outcomes can be attributed to racist treatment on the part of the providers. To date, the few studies in this area have been conducted in Aotearoa and have focused only on the private rental market. These studies have found that Māori clients received inferior services and were offered accommodation of a poorer quality (FAIR 1980; MacDonald 1986; Knight 1991).

Learning about the nature and ubiquity of racism in society is known as 'racial socialisation' and has three main components: (i) learning to identify racism; (ii) learning appropriate responses to racism; and (iii) understanding that the experience of racism may be fraught with feelings of rejection, confusion and doubt (Paradies 2005). Although research on this topic has been conducted in the United States (Hughes *et al*. 2006), the nature, extent and effectiveness of racial socialisation has received very little attention in Australia and Aotearoa (see Carter 1994; Dudgeon, Oxenham & Grogan 1997).

The concept of *intra*-racial racism caused some debate among symposium participants. Intra-racial racism has been defined as racism that is perpetrated against a member of an ethnic/racial group by a member of the same ethnic/racial group. This is contrasted with the more usual understanding of racism as a situation wherein the perpetrator and target are from different ethnic/racial group (known as *inter*-racial racism). A number of participants argued that intra-racial racism was a lived reality for many Indigenous people whose opportunities are curtailed due to discrimination perpetrated by other Indigenous people on the basis of skin colour and racial identity (Paradies 2006d). Others considered such actions to be intra-racial discrimination but did not classify them as distinct from internalised racism, but rather a manifestation of it. There was debate over the value and meaning of this concept, and concern that it had the potential to reinforce 'victim-blaming' discourses that characterise racism as an Indigenous 'problem' rather than recognising it as a consequence of systemic racism within non-Indigenous society.

The potential of collaborative research involving both Indigenous peoples and other minority ethnic/racial minority groups was discussed at the symposium. Bearing in mind the unique position and needs of Indigenous peoples as the original custodians of the land, it may be possible and beneficial to conduct research on the health effects of racism that involves both Indigenous peoples and other minority ethnic/racial minority groups who suffer from racism. Similarly, it may be appropriate to include both Indigenous and other minority ethnic/racial groups as beneficiaries of a specific anti-racist intervention. Moreover, there may be synergies with research on other forms of oppression (e.g. sexism) and health that could inform research on racism and Indigenous health.

Symposium participants also discussed the importance of further research on the concept of 'whiteness'. This concept is now receiving attention as an approach to understanding how the benefits of racism for dominant groups such as white Australians and Pākehā New Zealanders lead to positive health outcomes for these groups (Krieger, Williams & Zierler 1999; Gregory 2002; Martin-McDonald & McCarthy 2008; Borell *et al*. in press).

Key research question

- How can an understanding of the ways in which societal systems produce advantage and positive health outcomes for white Australians and Pākehā New Zealanders help improve Indigenous health?

Further research questions

- What role should experiments have in research on racism and Indigenous health?

- What impact does racial socialisation (i.e. learning about the nature and ubiquity of racism in society) have on the experience of racism among Indigenous peoples?

- What role should intra-racial and internalised racism have in research on Indigenous health?

- What is the extent of racism among influential figures in the public domain ('elite' racism) and how does it translate into racist behaviour among individuals?

- Is it possible and appropriate to combine research on racism and anti-racism affecting Indigenous peoples with such research affecting other ethnic/racial minority groups?

Theme 2: The Extent of Racism against Indigenous Peoples

The small body of research on racism against Indigenous peoples in Australia and Aotearoa conveys a mixed but alarming picture of its extent and nature. Most of this research has focused on the prevalence of self-reported interpersonal racism, with some studies of systemic racism and virtually no studies examining the extent of internalised racism. Recent research has also examined reactions and responses to the racism experienced by Indigenous peoples, as well as racist attitudes against Indigenous peoples.

In Australia studies of racism that have used multiple item measures have found a prevalence of self-reported racism among Indigenous participants ranging from 58–79 per cent (Forrest, Dunn & Pe-Pua 2007; Gallaher *et al.* 2007; Paradies & Cunningham, under review). Each of these studies has only included a relatively small number of respondents (one hundred to three hundred) and has been conducted in capital cities (Gallaher *et al.* 2007; Paradies & Cunningham, under review) and nationally (Forrest, Dunn & Pe-Pua 2007).

In contrast, a prevalence of 16–40 per cent has been found in research utilising single-item measures of self-reported racism. About 16 per cent of the 5757 Indigenous adults in the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) who were asked about their experiences of racism reported that, in the past twelve months, they felt they had been treated badly because they were Aboriginal/Torres Strait Islander (Paradies 2007b). Of the 9400 Indigenous respondents in the 2002–03 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 18 per cent reported experiencing discrimination as a personal stressor in the past twelve months (ABS 2004). Similarly, 22 per cent of the 1073 children aged between twelve and seventeen years in the 2001–02 Western Australian Aboriginal Child Health Survey (WAACHS) reported experiencing racism (defined as being treated badly or refused service due to being Aboriginal) in the past six months (Zubrick *et al.* 2005).

A 2001 survey found that about 30 per cent of Indigenous peoples reported discrimination due to ethnic origin (Dunn *et al.* 2003), and a 2003 survey found that 40 per cent of Aboriginal respondents reported being physically or emotionally upset as a result of treatment based on their race (Larson *et al.* 2007). In Aotearoa data from the national 2002–03 New Zealand Health Survey show that 34 per cent of Māori had experienced racism in their lifetime (as measured using a limited number of situations), while 15 per cent had experienced racism in the twelve months prior to the survey (Harris *et al.* 2006a, 2006b).

Systemic racism is more difficult to establish and is often assessed via indirect methods. Nonetheless, a range of studies highlight the widespread nature of such racism in domains such as national politics (Augoustinos, Tuffin & Rapley 1999), media (Cunneen 2001), education (Sonn, Bishop & Humphries 2000) and the welfare system (Sanders 1999), as well as in the provision of public housing (Equal Opportunity Commission of Western Australia 2004) and in the legal/criminal justice systems (Blagg *et al.* 2005). For example, evidence from Victoria indicates that when apprehended by police, Indigenous youth are two to three times more likely to be arrested and charged with an offence than non-Indigenous youth (Department of Justice 2005; Indigenous Issues Unit 2006).

Research in Aotearoa has demonstrated that, compared to non-Māori, Māori have higher rates of police scrutiny, arrest and conviction and receive harsher sentencing for same offences (Fergusson, Swain-Campbell & Horwood 2003a; Fergusson, Swain-Campbell & Horwood 2003b). Racism against Māori has also been demonstrated in private rental markets (MacDonald 1986; Knight 1991) and is evident in the welfare system (Hackwell & Howell 2002; Howell & Hackwell 2003). Research on systemic racism against Indigenous people in the health care sector has been the most common to date. As such, racism has a direct impact on Indigenous health and is detailed in theme three below.

Virtually no research on the prevalence or nature of internalised racism among Indigenous peoples in Australia or Aotearoa has been conducted to date. Findings from the Darwin Region Urban Indigenous Diabetes (DRUID) study found that 30 per cent of participants had high levels of internalised racism (characterised by a denial of Indigenous disadvantage and endorsement of assimilationist beliefs) (Paradies 2006b). A doctoral thesis on the health effects of internalised racism for Indigenous Australians is due to be completed in 2008 and will shed further light on this topic (Gallaher unpub.).

The prevalence of reactions and responses to interpersonal racism was examined in the DRUID study and the NATSIHS. Findings from the NATSIHS are presented in Tables 1 and 2. These data show that Indigenous Australians have a mix of reactions and responses to interpersonal racism. Anger was, by far, the most frequent reaction to racism, with two-thirds of respondents reporting this reaction. Less than one-tenth of respondents tried to change the way they were or the things that they did in response to experiences of interpersonal racism. Clearly, more research is required to understand the role that reactions and responses have in the pathways between racism and ill health.

Table 1: Reactions to racism among 915 Indigenous adults in the NATSIHS

Reactions to racism	%
Anger	67
Feeling sorry for ther perpetrator	31
Sadness	28
Shame or worry	17
Physical reaction (e.g. pounding heart, headache)	12

Source: NATSIHS (Paradies, unpublished data)

Table 2: Responses to racism among 915 Indigenous adults in the NATSIHS

Responses to racism	%
Talk to family/friends about it	38
Try to avoid the person/situation	33
Try to do something about the perpetrator(s)	30
Just forget about it	28
Keep it to yourself	18
Try to change the way you are/things that you do	9

Source: NATSIHS (Paradies, unpublished data)

The work of the Racism Project (a joint venture of the University of New South Wales and Macquarie University) provides the only current representative data on racist attitudes against Indigenous peoples in Australia. Some 5000 respondents in the 2001 Racism Survey (conducted in New South Wales and Queensland) and 4000 respondents in the 2006 Victorian Racism Survey were asked, 'Would you be concerned if a close relative were to marry an Indigenous person?': 28 per cent of respondents in New South Wales/Queensland and 25 per cent in Victoria expressed concern at such a prospect (Dunn *et al*. 2003; Forrest, Dunn & Pe-Pua 2007).

Some studies in Australia have found that Indigenous peoples of higher socioeconomic position, those who lived in urban areas, those who were members of the Stolen Generation, or those who identified with a tribal group and recognised a traditional country were more likely to report experiencing racism (Paradies 2006d, 2007a), while another study found no association between demographic or socioeconomic factors and self-reported racism (Larson *et al*. 2007). In contrast, findings from the national 2002–03 New Zealand Health Survey indicate that Māori of lower socioeconomic position reported higher levels of racism (Harris *et al*. 2006a, 2006b).

The small body of research into the extent of various levels of racism (including reactions/responses to interpersonal racism) suggests that further research on the prevalence and nature of racism for different groups in various areas of Australia and Aotearoa is required.

Key research question

- What is the prevalence and experience of racism across the life course for Indigenous peoples?

Further research questions

- What are the commonalities and differences in the prevalence and experience of systemic, interpersonal and internalised racism for Aboriginal Australians, Torres Strait Islanders and Māori across various geographic regions?

- What is the relationship between socioeconomic position and self-reported interpersonal racism among Indigenous peoples?

- What is the relationship between racial/ethnic identity and self-reported interpersonal racism among Indigenous peoples?

Theme 3: The Impact of Racism on Indigenous Health

Health among human populations is a multifaceted and complex phenomenon, and this is no less so for Indigenous peoples. For Indigenous peoples, unlike white Australians and Pākehā New Zealanders, racism is a fundamental driver of health. Pathways from racism to ill-health may include:
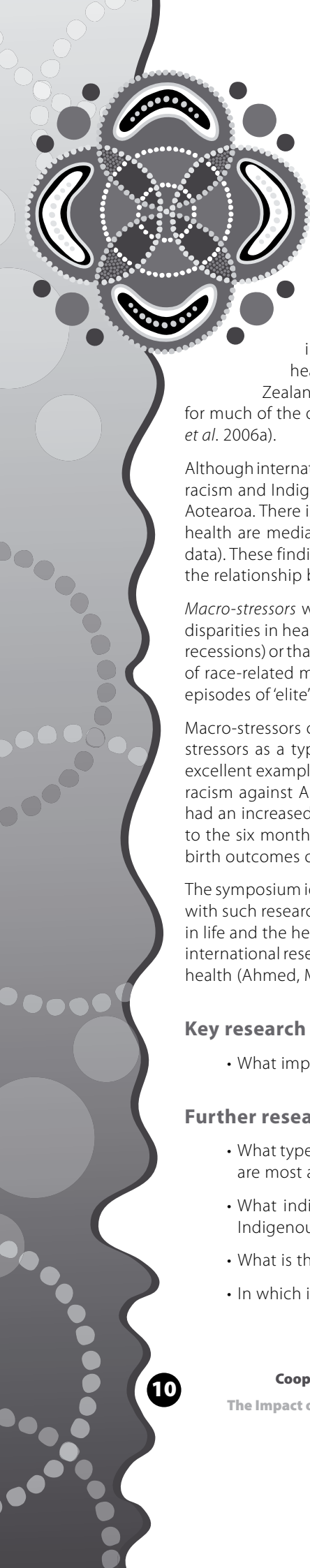
- reduced and unequal access to the societal resources required for health (e.g. employment, education, housing, medical care, social support);

- increased exposure to risk factors associated with ill health (e.g. differential marketing of dangerous goods, exposure to toxic substances (Krieger 1999));

- direct impacts of racism on health via racially motivated physical assault;

- stress and negative emotion reactions that contribute to mental ill health, as well as adversely affecting the immune, endocrine and cardiovascular systems; and

- negative responses to racism, such as smoking, alcohol and other drug use.

As detailed in theme two above, there is strong evidence that systemic racism exists in a number of life domains, resulting in reduced opportunities to access the societal resources required for health. However, we are not aware of any research that has attempted to quantify the health effects of systemic racism. As noted above, it is in health care itself that the small amount of research on systemic racism and health has largely occurred. The symposium noted the need for research to fill this gap in our knowledge and, in particular, to determine in which institutional settings racism has the most impact on Indigenous health.

In Australia it has been found that, compared to non-Indigenous patients with the same medical needs, Indigenous patients were about one-third less likely to receive appropriate medical care across all conditions (Cunningham 2002), as well as for particular diseases such as lung cancer (Hall *et al*. 2007) and coronary procedures (Coory & Walsh 2005). Indigenous Australians are three times less likely to receive kidney transplants than other Australians with the same level of need (Cass *et al*. 2004). Similar research in Aotearoa shows that, given the same level of need, Māori are less likely than non-Māori to receive cardiac interventions (Westbrooke, Baxter & Hogan 2001) and obstetric interventions (Harris *et al*. 2007) and have higher rates of adverse events in hospital (Davis *et al*. 2006).

Interestingly, such findings are not matched by self-reported experiences of racism in the health care settings. Respondents in the NATSIHS were asked about treatment when seeking health care in the past twelve months compared to non-Indigenous peoples. Only 4 per cent indicated that they felt they were treated worse than non-Indigenous peoples, 90 per cent reported being treated the same and 6 per cent reported being treated better than non-Indigenous peoples (Paradies 2007a). Such findings highlight the covert nature of systemic racism and the difficulty individuals have in identifying such racism in institutional settings.

Other research has focused on the effects of interpersonal racism on Indigenous health. There is good evidence that self-reported racism is associated with a range of adverse health conditions. After accounting for the effects of a range of other contributing factors, racism was significantly associated with poor self-assessed health status, psychological distress, diabetes, smoking and substance use in the NATSIHS (Paradies 2007a) and with depression, poor self-assessed health status and poor mental health in the DRUID study (Paradies 2006b). Preliminary findings from the Indigenous Urban Location and Health project show that racism in service provision and from neighbours and health staff is correlated with poor general health status (Gallaher *et al*. 2007), while a study in a rural Western Australian town demonstrated that racism was associated with reduced general physical and mental health after accounting for age, gender, employment and education (Larson *et al*. 2007). Racism was also associated with increased smoking, marijuana use and alcohol consumption in the WAACHS after accounting for the effects of age and gender (Zubrick *et al*. 2005).

Data from the national 2002–03 New Zealand Health Survey demonstrate that experiences of racism for Māori are significantly associated with poor self-assessed health status and poor mental and physical health, as well as with smoking and cardiovascular disease after accounting for the effects of age, gender and socioeconomic status (Harris *et al.* 2006a, 2006b). Across these studies in Australia and Aotearoa, Indigenous people who experienced racism were 1.5 to 2.5 times more likely to have one or more of the adverse health outcomes detailed above.

Racism accounts for a significant burden of Indigenous ill health. Analysis of the DRUID study indicated that racism explained one-third of the prevalence of depression and poor self-assessed health status among Indigenous Australians (Paradies 2006b). Data from the national 2002–03 New Zealand Health Survey showed that measures of racism, in combination with deprivation, accounted for much of the disparity in the health outcomes assessed between Māori and Pākehā New Zealanders (Harris *et al.* 2006a).

Although international research has identified a range of factors that may be implicated in the relationship between racism and Indigenous health (Paradies 2006a), there has been very little research on this topic in Australia or Aotearoa. There is some evidence from the DRUID study that the effects of interpersonal racism on Indigenous health are mediated by acute and chronic stress and a 'lack of control' over one's life (Paradies, unpublished data). These findings highlight the particular need to understand the role played by acute and chronic stress in the relationship between racism and ill health (Paradies 2006a; Ahmed, Mohammed & Williams 2007).

Macro-stressors were also discussed at the symposium as a potentially important contributor to ethnic/racial disparities in health. Macro-stressors are large-scale stressors that can be of a general nature (such as economic recessions) or that can affect particular ethnic/racial communities (Williams, Neighbors & Jackson 2003). Examples of race-related macro-stressors include highly public events such as the 2005 Palm Island 'riots' in Australia or episodes of 'elite' racism against Māori reported in the national media (Nairn *et al.* 2006).

Macro-stressors can lead to experiences of vicarious racism, which are then associated with ill health. Macro-stressors as a type of systemic racism have been the subject of very little research worldwide. However, an excellent example of such research is a paper by Lauderdale (2006), which documented the effects of increased racism against Arab-Americans following the September 11 terrorist attacks in 2001. Arab-American women had an increased risk of low-birth weight and pre-term birth in the six months after September 11 compared to the six months before September 11. Women of other ethnic/racial groups in California had no change in birth outcomes over this period (Lauderdale 2006).

The symposium identified the need for research on race-related macro-stressors in Australia and Aotearoa. Along with such research, the symposium highlighted the need to better understand the effects of racist events early in life and the health implications of cumulative racist experiences over the life course. Such a call is echoed in international research, which has highlighted the need to attend to the detrimental effects of racism on children's health (Ahmed, Mohammed & Williams 2007; Ombudsman Against Ethnic Discrimination 2007).

Key research question

- What impact does racism have on Indigenous health across the life course?

Further research questions

- What types of racism have the most impact on Indigenous health and what aspects of Indigenous health are most affected by racism?

- What individual, community and place-based factors mediate the relationship between racism and Indigenous ill health?

- What is the contribution of race-related macro-stressors to Indigenous ill health?

- In which institutional sectors does racism have the most impact on Indigenous health?

# Theme 4: Approaches to Studying Racism and Indigenous Health

The study of racism and Indigenous health is particularly challenging because of the difficulties in measuring racism itself. Because racism can be subtle, unintentional, unwitting and even unconscious, it is rarely possible to definitively attribute a particular event to racism. A subjective experience of racism may, in fact, be caused by other forms of oppression (e.g. sexism), while an individual may erroneously attribute an objectively racist experience to another form of oppression or to his/her own limitations. Moreover, internalised racism and systemic racism can be invisible to those affected. Systemic racism in health care, as discussed above, may be an example of 'invisible racism'.

Above and beyond this complexity, each level of racism has its own particular measurement challenges. Internalised racism is, by its nature, unlikely to be recognised by those who suffer from it. As such, its measurement necessarily involves questions that implicitly assess racist beliefs and negative attitudes towards one's own ethnic/racial group. In the United States, one measure of internalised racism has been associated with health outcomes such as obesity, diabetes, high blood pressure, high levels of alcohol consumption and stress (Taylor & Jackson 1990a, 1990b; Tull *et al*. 1999, 2003, 2005, 2007; Tull & Chambers 2001; Butler *et al*. 2002; Chambers *et al*. 2004). To our knowledge, internalised racism has never been examined as a cause of Indigenous ill-health in Aotearoa and has been examined in only two studies in Australia (Gallaher unpub.; Paradies 2006b). As such, its relationship to Indigenous health remains unclear.

Interpersonal racism is perhaps the most straightforward level of racism to measure. Although it is difficult to comprehensively assess all the possible manifestations of interpersonal racism, its measurement via self-reporting ensures that Indigenous people themselves are given the chance to report their experiences as they perceive them. However, such an approach raises questions about what factors may distort the reporting of racism. Although a number of personality traits have been found to affect self-reports in general, there is little evidence of this in relation to racism. Research has demonstrated that the relationship between self-reported racism and health is not accounted for by factors such as neuroticism and hostility (Huebner, Nemeroff & Davis 2005), cynicism (Broudy *et al*. 2007; Richman *et al*. 2007), social desirability (Verkuyten 1998; Gee *et al*. 2007; Chae *et al*. in press) or impression management (Clark 2004a). At present, it is not known to what extent individuals become accustomed to experiences of racism (Clark, 2004b) or how this may impact on health. It is also not clear, at present, how to capture the health effects of reactions and responses to interpersonal racism.

Other questions that remain about the measurement of interpersonal racism include whether single-item measures can accurately assess the prevalence of racism or if multi-item approaches are necessary (as discussed above under theme two); what is the best timeframe over which to measure interpersonal racism (e.g. one, six or twelve months); and what terminology should be used, including whether racism should be measured explicitly as a form of stress (Paradies 2006a).

Systemic racism can be either explicit or implicit. Most explicit systemic racism is historical and includes a raft of legislation that has existed in Australia and Aotearoa for the purpose of controlling the lives of Indigenous peoples (see Chesterman & Galligan 1998). As detailed under theme two above, contemporary forms of systemic racism are almost exclusively implicit in form. Systemic racism is measured using audit-based tools that seek to compare indicators (process or outcome-based) across ethnic/racial groups using indirect methods. Such audit approaches establish avoidable and unfair outcomes that result from institutional or organisational requirements, conditions, practices, policies or processes.[4] As discussed under theme one above, experimental approaches are also useful in establishing the existence of systemic racism. To enable the identification of systemic racism,
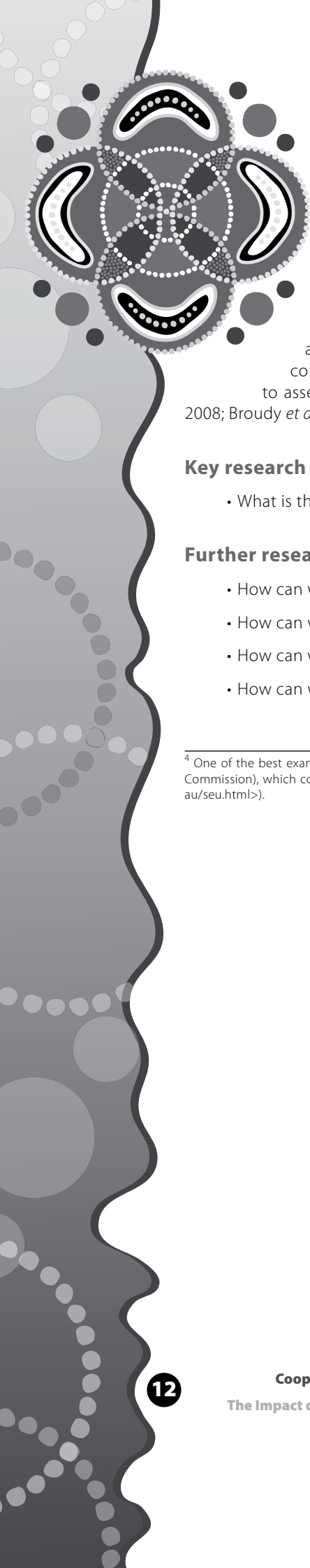
it is vital to have complete, accurate and timely data on health and social outcomes for Indigenous peoples. The symposium noted that further work is required to improve the quality of such data in both Australia and Aotearoa.

In studies where both racism and health are measured at one point in time, there is a danger that an individual's health status may influence the perception and reporting of racism. This is especially the case where pre-existing mental health problems may affect the way an individual perceives his/her social reality. For this reason, symposium participants highlighted the importance of studying the effects of racism over several years (i.e. longitudinally). In addition to repeated survey approaches, the symposium highlighted a number of methods that could be utilised in such longitudinal research. In particular, recent studies using diary approaches to assess experiences of racism should be explored in Australia and Aotearoa (see Brondolo *et al*. 2008; Broudy *et al*. 2007).

Key research question

- What is the best way to measure systemic racism against Indigenous peoples?

Further research questions

- How can we appropriately assess internalised racism affecting Indigenous peoples?

- How can we appropriately assess interpersonal racism experienced by Indigenous peoples?

- How can we appropriately assess Indigenous peoples' reactions and responses to racism?

- How can we best study racism longitudinally across the life course?

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[4] One of the best examples of this approach is the Western Australian Substantive Equality Unit (part of the Western Australian Equal Opportunity Commission), which conducts anti-racism audits within public sector departments in Western Australia (see <http://www.equalopportunity.wa.gov.au/seu.html>).

Theme 5: Combating Racism against Indigenous Peoples

Despite the evidence presented above on both the prevalence of racism and its detrimental effects on Indigenous health, there is very little intervention research in either Australia or Aotearoa aimed at reducing racism or its adverse affects. A recent review of this topic in Australia canvassed institutional and legal policy options for anti-racism interventions in relation to education and child-rearing, public service, law enforcement and media, as well as monitoring racism and promoting anti-racism in civil society (Paradies 2005). The findings of this review, together with three other key reviews in this area, are summarised in Table 3 (VicHealth 2007).
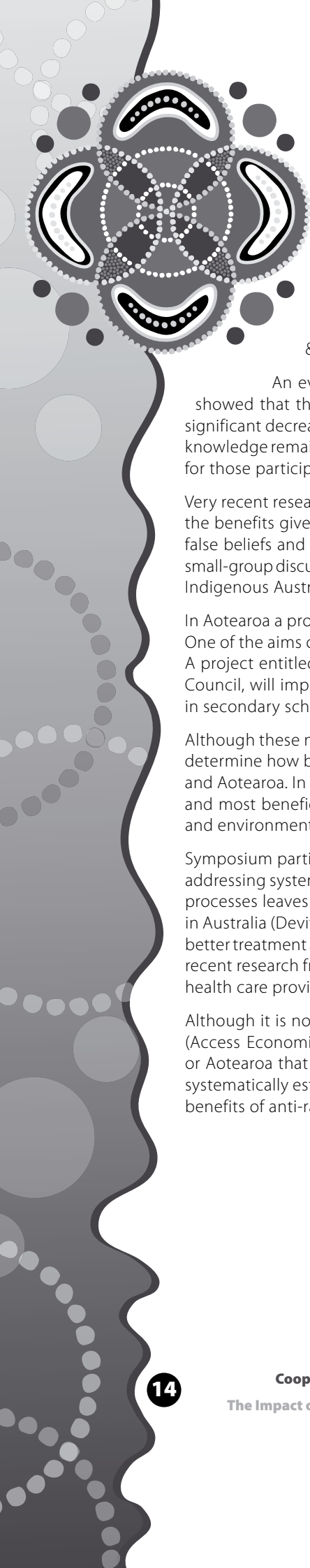
Table 3: Key anti-racism strategies

Strategy	Actions
Direct participation programs	Initiatives to promote learning about other cultures and to address false beliefs and stereotypes
	Anti-discrimination/pro-diversity community and school-based education programs
	Deliberative polls[1]
	Programs increasing contact and cooperation among groups between whom there is social distance[2]
Communications and social marketing	Anti-racial discrimination/pro-diversity training for journalists
	Media policies and procedures, guidelines and ethical codes designed to promote fair reporting on issues relating to ethno-cultural communities
	Inclusion of anti-discrimination messages in entertainment media
	Resources to raise awareness of and address discrimination/promote cultural diversity
	Whole-of-population and geographically targeted communications campaigns[3]
Community development	Cultivating local leaders to take a stand in support of cultural diversity/against discrimination
	Cultivating leadership within cultural communities to serve as advocates for their community
	Initiatives to build cross-cultural networks and cohesion within communities
Workforce and organisational development	Anti-discrimination/diversity management training
	Policies and protocols to address discriminatory behaviour/promote diversity at the organisational level
	Strategies to address institutional discrimination
Advocacy	Campaigns to promote national leadership in support of cultural diversity/against discrimination
	Activities to promote positive changes in policy and programs at the organisational and societal levels
Policy and legislative reform	Laws and policies to generate social norms against discrimination and in support of diversity (for example, racial vilification legislation, anti-discrimination legislation)
	Social policy platforms to address institutional and systemic discrimination
Research and monitoring	Use of research findings to raise awareness of the problem of discrimination and its impacts or to promote the benefits of diversity

Source: VicHealth (2007). Table compiled from information in Council for Aboriginal Reconciliation (nd); Donovan & Vlais 2006; Pedersen, Walker & Wise 2005; and Paradies 2005.

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[1] While their format varies, deliberative polls generally involve engaging a group in hearing about and discussing an issue, with participants being polled before and after this deliberation.

[2] Measures to increase contact between cultural groups are effective in reducing discrimination providing that certain conditions are met.

[3] Practice and rigorous evaluation in this area are sparse and findings are mixed.

The few specific anti-racism research projects involving Indigenous peoples that have been evaluated and published are detailed below.

A two-week television campaign funded by the Western Australian Equal Opportunity Commission focused on 'Aboriginal employment week' in Bunbury, Western Australia. This intervention aimed to reduce negative stereotypes about Indigenous Australians in relation to employment. Among residents of Bunbury, the intervention resulted in significant changes in beliefs about the proportion of Indigenous people in paid employment and the proportion of Indigenous people remaining in jobs for an extended period of time (Donovan & Leivers 1993).

An evaluation of an in-house anti-racist education program in a large public sector organisation showed that the program resulted in significant increases in knowledge about Indigenous Australians and significant decreases in prejudice and negative stereotyping towards Indigenous Australians. While increases in knowledge remained after three months, the decrease in prejudice against Indigenous Australians only remained for those participants who initially had high levels of prejudice (Hill & Augoustinos 2001).

Very recent research shows that engaging tertiary students in a class that sought to combat false beliefs about the benefits given to Indigenous Australians and their level of alcoholism resulted in significant reductions in false beliefs and prejudice towards Indigenous Australians (Barlow, Louis & Pedersen 2007). Similarly, focused small-group discussion between non-Indigenous Australian tertiary students resulted in reduced prejudice against Indigenous Australians and an increased commitment to combat such prejudice (Blink & McGarty 2007).

In Aotearoa a project entitled *Media, Health and Wellbeing* was recently funded by the Health Research Council. One of the aims of this project, which commenced in 2008, is to improve media coverage of Māori in Aotearoa. A project entitled *Bubalamai Bawa Gumada*, which has also been recently funded by the Australian Research Council, will implement a classroom-based intervention to address stereotyping against Indigenous students in secondary schools.

Although these newly funded initiatives are welcome, it is clear that much more applied research is required to determine how best to combat both interpersonal and systemic racism against Indigenous people in Australia and Aotearoa. In particular, it will be important to establish the forms of systemic racism that will be the easiest and most beneficial to address, and to develop proven interventions to foster sustainable anti-racist cultures and environments.

Symposium participants strongly supported improvements in health system performance as one approach to addressing systemic racism in the health sector. Enhancing and tightening health system practices, policies and processes leaves less leeway for systemic or interpersonal bias to influence clinical decision-making. Research in Australia (Devitt *et al*. in press) and Aotearoa (Penney, Moewaka Barnes & McCreanor 2006) has demonstrated better treatment and outcomes for Indigenous patients via improvements in service provider practices. Moreover, recent research from the United States describes a range of effective approaches to reducing racial bias among health care providers that should be explored in Australia and Aotearoa (Burgess *et al*. 2007).

Although it is now relatively common to measure the cost to society of phenomena such as arthritis, obesity (Access Economics 2005, 2006) or ageing (Productivity Commission 2005), there are no studies in Australia or Aotearoa that have systemically estimated the costs of racism to society. The symposium supports calls to systematically estimate the cost of racism to society in Australia and Aotearoa and, concomitantly, the potential benefits of anti-racism policy and practice (Paradies 2005; VicHealth 2007).

Key research question

  • What are the best approaches to addressing systemic racism against Indigenous peoples?

Further research questions

  • How can we combat interpersonal racism against Indigenous peoples?

  • What racist elements of institutions/systems are most amenable to change and how should the fostering of anti-racist cultures and environments be measured?

  • How can we improve health system performance as a way of combating systemic racism against Indigenous peoples in health care?

  • What are the costs of racism and the savings from anti-racism policy and practice?

Conclusion

This discussion paper has presented a cohesive research agenda to advance our understanding of, and our ability to combat, racism as a threat to Indigenous health in Australia and Aotearoa. The twenty-five key research questions that constitute this agenda call for research on the best approach to measuring systemic, interpersonal and internalised racism and determining their effect on Indigenous health. The five key research questions identified in this report are:

- What is the prevalence and experience of racism across the life course for Indigenous peoples?

- What impact does racism have on Indigenous health across the life course?

- How can we appropriately assess systemic racism against Indigenous peoples?

- What are the best approaches to addressing systemic racism against Indigenous peoples?

- How can an understanding of the ways in which societal systems produce advantage and positive health outcomes for white Australians and Pākehā New Zealanders help improve Indigenous health?

These key questions focus on systemic racism, stressing the importance of further research on the prevalence of racism, its impact on Indigenous health and approaches to eliminating it from society.

This paper has also highlighted the need to explore the benefits of 'racial socialisation' (i.e. learning about the nature and ubiquity of racism in society) and to find effective ways to combat both interpersonal and systemic racism against Indigenous peoples. Improvements in health system performance are required to address systemic racism in health care, and there is a need to systematically estimate the cost of racism to society in Australia and Aotearoa.

This discussion paper highlights the vital importance of sound research in endeavours to combat racism as a threat to Indigenous health in Australia and Aotearoa. We hope that this paper will act as an impetus to policy and decision-makers at the national, regional and local levels to engage in efforts to combat racism against Indigenous peoples as a public health intervention.

About the Authors

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Dr Yin Paradies is an Aboriginal-Anglo-Asian Australian who has lived most of his life in Darwin and now resides in Melbourne. He is a postdoctoral research fellow on the Capacity-building in Indigenous Policy Relevant Health Research (CIPHER) program of the National Health and Medical Research Council and has worked in Indigenous health research since 1995. Yin holds qualifications in mathematics and computing, medical statistics, public health and social epidemiology. His research focuses on issues of race and racism in relation to health and broader social policy, particularly as applied to Indigenous Australians. His work has included topics as diverse as the epidemiological study of racism, social theories of racism, discourses of race in public health, approaches to Indigenous identity, and anti-racism policy and practice. Yin has teaching experience at the postgraduate level in epidemiology, biostatistics, demography and critical race theory.

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Professor Ian Anderson is the foundation Chair in Indigenous Health at The University of Melbourne. His family are Palawa Trouwunna: Plaimairrerenner and Trawlwoolway clans. Professor Anderson is currently the Deputy Head of the School of Population Health and the Director of the Centre for Health and Society and the Onemda VicHealth Koori Health Unit. He has been a full-time research academic since 1998 when he established the *Onemda* VicHealth Koori Health Unit with external funding from the Victorian Health Promotion Foundation and the Commonwealth Department of Health and Ageing. He completed a medical degree at The University of Melbourne in 1989 and has a PhD in sociology and anthropology from La Trobe University. He is also currently the Research Director for the Cooperative Research Centre for Aboriginal Health. Ian has a long-standing interest in issues of identity, representation, Aboriginal health policy and art practice.

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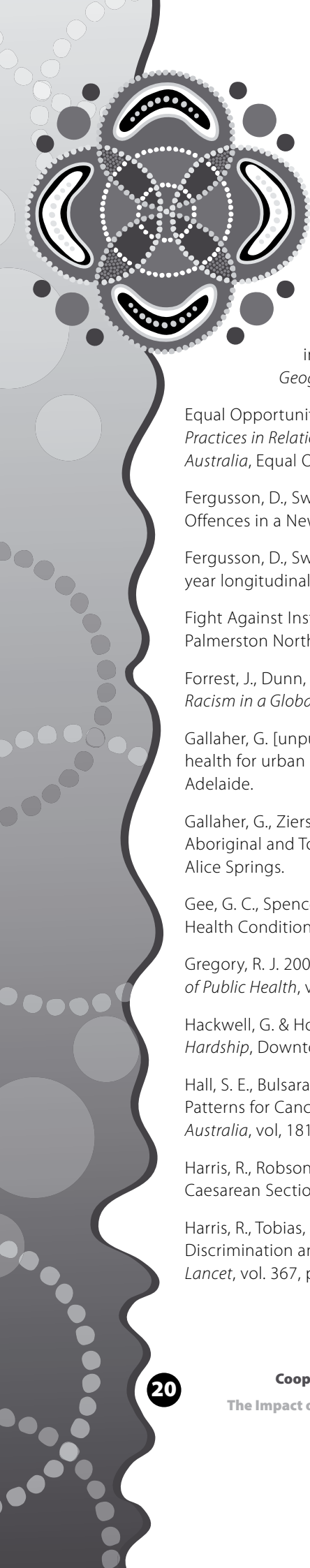
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Appendix A: Symposium Participants

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Foundation for Young Australians

Professor Ian Anderson
Onemda VicHealth Koori Health Unit, School of Population Health, The University of Melbourne

Ms Fiona Barlow
University of Queensland

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Ms Juli Coffin
Combined Universities Centre for Rural Health

Ms Donna Cormack
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Professor Joan Cunningham
Menzies School of Health Research

Mr Simon Finlayson
La Trobe University

Dr Marion Frere
The McCaughey Centre, The University of Melbourne

Mr Gilbert Gallaher
Department of Public Health, Flinders University of South Australia

Dr Marisa Gilles
Combined Universities Centre for Rural Health

Ms Sandy Hall
Mental Health Foundation of New Zealand

Mr Todd Harper
VicHealth

Dr Ricci Harris
Wellington School of Medicine and Health Sciences, Otago University
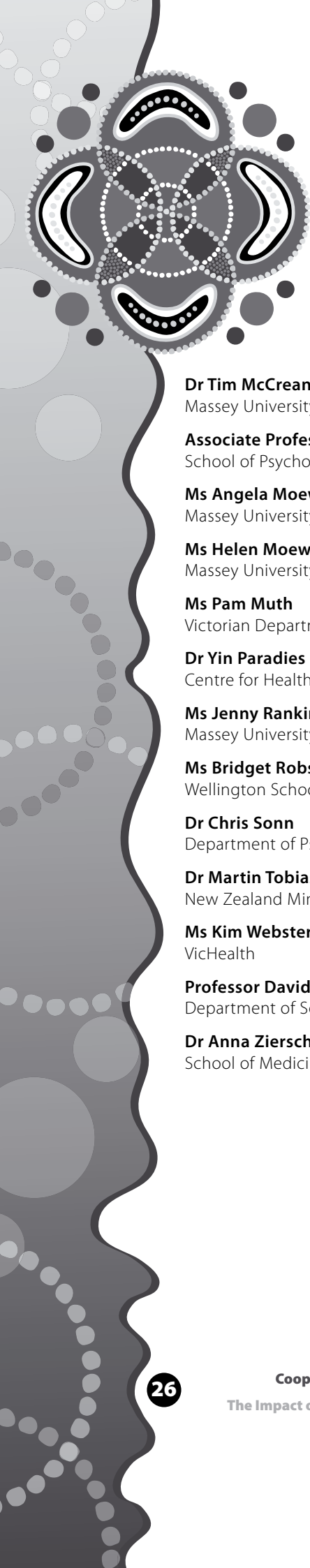
Associate Professor Nick Haslam
School of Behavioural Science, The University of Melbourne

Mr Chris Holland
Human Rights and Equal Opportunities Commission

Ms Cathy Hollander
Equal Opportunity Commission of Western Australia

Dr Margaret Kelaher
Centre for Health Policy, Programs and Economics, The University of Melbourne

Dr Emma Kowal
School of Social and Environmental Enquiry, The University of Melbourne

Ms Tanya Koolmatrie
Murdoch Children's Research Institute

Associate Professor Ann Larson
Combined Universities Centre for Rural Health

Dr Tim McCreanor
Massey University

Associate Professor David Mellor
School of Psychology, Deakin University

Ms Angela Moewaka-Barnes
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Ms Helen Moewaka-Barnes
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Ms Pam Muth
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Ms Jenny Rankine
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Dr Chris Sonn
Department of Psychology, Victoria University

Dr Martin Tobias
New Zealand Ministry of Health

Ms Kim Webster
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Professor David Williams
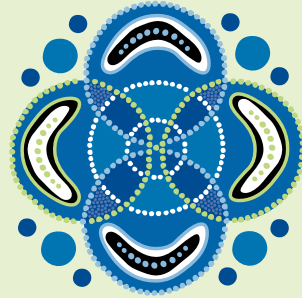Department of Society, Human Development and Health, Harvard University

Dr Anna Ziersch
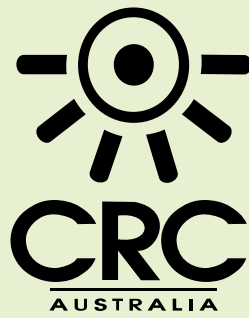School of Medicine, Flinders University of South Australia

Appendix B: Symposium Program

8:30 – 8:35 am	Welcome to symposium (Professor Ian Anderson)
8:35 – 8:40 am	Symposium overview (Dr Emma Kowal)
8:40 – 9:15 am	Brief introductions (all delegates)
9:15 – 9:30 am	An overview of existing research on racism and the health of Indigenous Australians (Dr Yin Paradies)
9:30 – 9:45 am	An overview of existing research on racism and Māori health (Dr Ricci Harris)
9:45 – 10:00 am	Open discussion
10:00 – 10:30 am	Morning tea
10:30 – 10:45 am	Theoretical challenges in researching racism & Indigenous health (Professor David Williams)
10:45 – 11:30 am	Facilitated discussion
11:30 – 11:45 am	Methodological issues in researching racism and Indigenous health (Dr Yin Paradies)
11:45 – 12:30 pm	Facilitated discussion
12:30 – 1:30 pm	Lunch
1:30 – 1:45 pm	The Public Sector Anti-Racism and Equality Program (Ms Cathy Hollander)
1:45– 2:00 pm	Media, health and wellbeing in Aotearoa (Ms Jenny Rankine & Ms Angela Moewaka-Barnes)
2:00– 2:45 pm	Facilitated discussion
2:45– 3:15 pm	Afternoon tea
3:15 – 3:30 pm	More than tolerance: Embracing diversity for health (Ms Kim Webster)
3:30 – 5:00 pm	Setting the research agenda for the study of racism and Indigenous health