

Institutional racism in Australian healthcare: a plea for decency

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Fairness and compassion are the bases for improving Aboriginal health

THERE IS NO DISPUTE THAT ABORIGINAL HEALTH in Australia is both poor and very much worse than that of non-Aboriginal people, and their life expectancy at birth is about 21 years less for men and 19 years less for women. Among Aboriginal and Torres Strait Islander males, 6.8% die in infancy, compared with 1% for the rest of the population. For females the figures are 6.7% and 0.8%. A large array of diseases are much more prevalent among Aborigines.¹

This is not news. The question is how to improve this situation. The argument presented in this article rests on two core and related ideas:

- that our health services are “institutionally racist”; and
- that such racism stems from Australia being, or at least having become, an uncaring society.

The way forward that we propose is recognising and addressing institutional racism. This would provide a framework for improving Aboriginal health. We believe, however, that acceptance of the need to address such racism can only come about through building a more compassionate and decent society.

To suggest that healthcare in Australia is institutionally racist may be confronting for some, but we argue not only that it is institutionally racist, but, more importantly, that such racism represents one of the greatest barriers to improving the health of Aboriginal and Torres Strait Islander people. We will also indicate what might be done to overcome this institutional racism and improve Aboriginal health.

Defining institutional racism

Institutional racism “refers to the ways in which racist beliefs or values have been built into the operations of social institutions in such a way as to discriminate against, control and oppress various minority groups”.² It has been claimed that “Institutional racism is embedded in Australian institutions”.³ Often, institutional racism is covert or even unrecognised by the agents involved in it.

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Institutional racism in Australian healthcare — some examples

- **Funding inequity:** Overall funding of Aboriginal healthcare is not commensurate with extra need.⁸
- **Different performance criteria for black and white:** For example, in Perth, Derbarl Yerrigan Aboriginal Medical Service funding was cut when an “overspend” arose because of success in attracting clients; at the same time the teaching hospitals’ overspend was 120 times as great as that at Derbarl Yerrigan. The teaching hospitals were given an extra \$100 million to cover their overspend.⁹
- **“Body part” funding:** For instance, separate streams of money for conditions such as diabetes and heart disease for a health service which is intended to be holistic — 26 funding streams (and hence 26 separate accounts and 26 demands for accountability) for the Danila Dilba Aboriginal Medical Service in Darwin.
- **Differences in treatment regimens:** Aboriginal people in Western Australia born in the 1940s received low-cost nursing care; in contrast, a white cohort of the same age received higher-cost technological care.¹⁰
- **Inequitable Medicare Primary Health Care (Medicare Benefits Schedule plus Pharmaceutical Benefits Scheme):** In Katjungka (a remote Aboriginal community), \$80 per head per year; in Double Bay (an affluent Sydney suburb), \$900 per head per year.¹¹
- **Cultural barriers to Aboriginal use of healthcare services:** Inadequate funding to reduce these barriers (such as language barrier and lack of recognition of different constructs of health) for Aboriginal people.

In recent years, interest in both the concept and practice of institutional racism has increased. In the United Kingdom, it was sparked by the Stephen Lawrence Inquiry,⁴ published in 1999. This examined the events which followed the completely unprovoked murder in 1993 of Stephen Lawrence, a young black man, which was “unequivocally motivated by racism”. It found that the investigation was marred by a combination of professional incompetence, institutional racism and a failure of leadership by senior officers. It claimed that “officers approached the murder of a black man less energetically than if the victim had been white and the murderers black”.

In the context of racial and ethnic disparities, Camara Jones,⁵ an Assistant Professor at Harvard University School of Public Health, has called for “a growing national conversation on racism”, one key aspect of which is “institutionalized racism”. This she sees as being “often evident as inaction in the face of need”. An increasing focus on institutional racism in Aotearoa (New Zealand) was prompted by a visit there by Camara Jones in 1999.⁶

In Australia, institutional racism has been an almost constant feature of our history, from the British designation of the continent as *terra nullius*, through the 1897 Conven-

tion on Federation (where the question of whether Aboriginal people should be counted as “people” in the national census was covered in just 195 words⁷), to the stolen generations and the failure of the federal government to issue an apology. Examples of institutional racism are shown in the Box.

Clash of cultures

We believe that any healthcare system is a social institution built on the cultural stance of the population it serves. It follows that cultural values should provide the value base for health services.

Between Aboriginal and non-Aboriginal Australians, there is not only a difference in culture, but a clash of cultures. We think some white people are at least dimly aware of this. However, the extent of their understanding of the difference between a culture based on individualism, where the individual ranks above the community in importance, and a communitarian culture, in which each individual is less important than the whole, is limited.

One of us, S H,⁷ a Gungulu man, has written: “Aboriginal Peoples have built a communitarian solidarity that includes an awareness and affirmation of the [cultural] difference [of Aboriginal people]. Such communitarian solidarity is a form of civic friendship between peoples that is distinguishable from other forms of friendship because it unites people who are members of the same particularistic cultural community — persons who share a common worldview and use the same primary moral vocabulary.” Yet that value base is inadequately recognised in the planning of healthcare services in this country.

Where societies or social entities have a greater awareness of and concern for mutuality, reciprocity and sharing, trust in institutions will be fostered and racism will diminish. Many Australians have embraced the individualism of neoliberalism. Uniting as a community around little other than the successes of its sporting teams, today’s white Australia lacks these “communitarian” traits.

While communitarianism need not always be a force for good (the Nazi vision of the “master race” is a case in point), it can be and has been a beneficial force in Aboriginal culture. Here it is best seen in terms of what the distinguished public servant Coombs¹² describes as “the Aboriginal ethic of accountability to others”. This, he writes, “is required by their commitment that autonomy, at a personal and group level, will be exercised so as to ensure that what is done contributes to the care and nurture of others with whom they are related; so that personal behaviour remains socially grounded”.

In current health policy there is little attempt to recognise the differences in culture between black and white. The holism of Aboriginal health involves not just a “wholeness”, but a series of mutual obligations. Aboriginal Medical Services attempt to provide culturally “secure” services (ie, services based on Aboriginal preferences where differences in culture do not create additional barriers to use). Their poor funding levels, however, severely restrict them in this.

Mainstream services make almost no effort to understand or provide culturally secure services. To deliver such services might increase primary healthcare costs for Aboriginal people by more than 50%.^{9,13} This is because, for example, questioning with respect to history has to be indirect, and preceded by time spent in building trust and confidence between the doctor and patient. This process, to be done well, can be time consuming. Also, advocacy on behalf of the client with other agencies, such as those providing housing, is often expected by Aboriginal clients as part of a GP’s role.

The prospects for creating a cohesive Australian community, advancing social capital, furthering equity and reducing racism are not bright. For example, the Human Rights and Equal Opportunities Commission conducted a series of consultations across Australia which showed racism to be widespread and institutionally based, especially with respect to Aboriginal people.¹⁴ We believe that the current Australian federal government puts at risk our social capital in its pursuit of divisive policies. This applies not only to Aboriginal people, but also to other minority groups, defined racially or otherwise. For example, extending upfront fees for universities gives the affluent greater access compared with the poor; and ignoring the principle of universality (which did not rate a mention in the Prime Minister’s media release as one of his three pillars of Medicare¹⁵) on Medicareplus creates yet more of a two-tier healthcare system. The government’s policies on immigration have been severely criticised by many, including Father Frank Brennan, the Jesuit priest and lawyer, who concludes his book on the subject with an appeal to re-create social capital in Australia: “Many of us would like to return collectively to being a warm-hearted, decent international citizen.”¹⁶

We believe that Aboriginal people have lost their trust in the institutions of government, including healthcare services. Lack of respect by white Australians for Aboriginal values, the discounting of these values by those who have sought, patronisingly and paternalistically, to “do good” to Aboriginal people (according to a “good” defined by white fellas), leads to further erosion of trust. The lack of trust by Aboriginal people in white people and white institutions is obvious. More tellingly, we believe there is a lack of trust by Aboriginal people in themselves as a people — a lack of confidence in their culture. It is this last, a legacy of colonisation and its aftermath, that has wreaked the greatest havoc of all.

We also believe that there is a lack of political will and of leadership to deal with inequalities generally in Australian healthcare. The most glaring example in recent times lies in the government’s schemes to promote private health insurance. The cost of increasing spending on primary healthcare for Aboriginal people to a level which would take into account such considerations as greater health problems, cultural-access barriers and equity (ie, increasing it to five times the per-capita level for non-Aboriginal people¹⁷) might be measured by the benefit forgone if the government were to halve the rebate (from 30% to 15%) for private health insurance.¹⁸

Progressing from institutional racism

Currently, cultural differences and ignorance create racism, and indifference nurtures it. Cultural differences must be celebrated, rather than denigrated. Former Prime Minister Paul Keating's Redfern Speech on reconciliation pointed the way forward: "I think what we need to do is open our hearts a bit. All of us. Perhaps when we recognise what we have in common we will see the things which must be done . . . If we open one door others will follow."¹⁹

That was 12 years ago. Today, the converse is true. As we have closed one door, others have followed. So many doors on social justice are closing in this society. We closed the door on a Norwegian freighter carrying abandoned refugees. We close the door on children in detention centres, on poor youngsters trying to get a university place. We close the door on opportunities for Aboriginal people and on the richness of an ancient culture which is potentially there for all Australians to learn from and take pride in.

What scope is there for building compassion? Not much, it might seem, in this neoliberal society and this globalising world. Yet, as the social commentator Richard Titmuss remarked 30 years ago about the UK National Health Service, altruism and compassionate acts are infectious not only to other people, but to other events and circumstances.²⁰ Compassion is *good* for us.

What to do?

Firstly, white Australia must learn to understand Aboriginal culture, particularly with respect to its fundamental philosophy of "communitarian solidarity". Only then can social institutions, such as healthcare services for Aboriginal people, be built on a genuine understanding followed by accommodation of the hopes and aspirations of Aboriginal people. More directly, only then can Aboriginal people have the chance to have health services delivered to them that are, *by right*, as accessible (in the broadest sense) as they are to white Australians.

Secondly, those white people who were described (above) as patronising and paternalistic would cease to be so when, in their "doing good", good was defined by Aboriginal preferences.

Thirdly, Aboriginal communitarian preferences must drive Aboriginal health services, their funding and their performance indicators. Unless the governance of Aboriginal organisations is based on Aboriginal cultural values, these services will not function effectively or efficiently.

Fourthly, public compassion must be built into the Australian social fabric. The "fair go", if it ever existed, has gone, but Australia needs a leadership that will articulate that fair go. The philosopher Martha Nussbaum argues against "impoverished models of humanity" with "numbers and dots taking the place of women and men".²¹ She continues: "...when one's deliberation fails to endow human beings with their full and complex humanity, it becomes very much easier to contemplate doing terrible things towards them... if you really vividly experience a concrete human life, imagine what it is like to live that life,

and at the same time permit yourself the full range of emotional responses to that concrete life, you will... be unable to do certain things to that person. Vividness leads to tenderness, imagination to compassion."²¹

Finally, our call is for a more compassionate society. Attitudes to asylum seekers, to Aboriginal people, to people who are in any way disadvantaged, are linked. Social attitudes need to be more compassionate to all who are disadvantaged, and not just to Aboriginal people.

Conclusion

Aboriginal people merit so much more from white Australia. First and foremost, they deserve white Australia's trust — trust that Aboriginal people know better than white Australians what is good for Aboriginal people. They deserve (and not just in their music and dancing) recognition of their culture. Two things are necessary — first, Australian society needs to listen and hear the calls of the disadvantaged (and there are so many in Australia today, especially Aboriginal people); then, those who have compassionate voices need to use them. Many people working in healthcare and in universities have social consciences and believe in social justice. They need not only to give voice to the voiceless, but to give themselves voice as decent, white Australians.

In this Australia — this divided, divisive, racist, socially unjust society that we have built — we now need institutions and policies that will unbuild it. We need to acknowledge that the "fair go" is struggling to survive, if not already dead. Fairness and compassion need to be once again the guiding principles of our leaders and our democracy. Only then can we build a society where decency can become the fundamental in addressing Aboriginal health.

There will be no sudden breakthrough; there is no magic pill. Decency, however, is a good place to start.

Competing interests

None identified.

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