Policy Document

Racial Discrimination and Cultural Diversity (2024)

Executive Summary

Culture encompasses the values, ideas, and behaviours, shared within a distinct collective of individuals. Certainly, Australia is a multicultural country, with the Australian Bureau of Statistics reporting the nation's broad language and ethnic diversity. Regardless of such documented diversity, Culturally and Linguistically Diverse Australians, Aboriginal and Torres Strait Islander peoples are faced with significant challenges, particularly in access to healthcare services.

Racism is the process of inequity, indignity and injustice of certain race groups via policies, systems, attitudes, and actions. It can be categorised into three groups: Institutionalised, which exists within society, limiting access to goods, opportunities and services, Personally-mediated racism, which is characterised by prejudice and discrimination, presenting as disrespect, dehumanisation and other similar processes, and internalised racism, which unfortunately involves individuals of certain race to accept racial messages and stereotypes made against them [1,2]. Such racism still exists within Australian society, regardless of its cultural diversity and multiculturalism. Particularly, Amnesty and the ScanIon Foundation Research Institute obtained worrying numbers proving and establishing the existence of racism in Australia. A glaring value is 63% of respondents to the Amnesty International Human Rights Barometer suggesting many ethnic and cultural groups do not fit into Australia's way of life [7,8].

Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse Populations

For Indigenous Australians and Torres Strait Islanders racism is an omnipresent barrier. It contributes to the stark health disparities between Indigenous Australians and non-Indigenous Australians. Unfortunately, such racism has translated as barriers at both institutional and individualised levels for Indigenous Australians and Culturally and Linguistically Diverse populations when accessing health services. This has meant that Indigenous peoples have experienced significant social, mental, emotional and physical impacts, such as worsening of health conditions and taking up maladaptive and risky behaviours. These statistics underscore Australia's profound multiculturalism and diversity. Nevertheless, despite these demographic

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realities, racism not only exists but also represents a growing problem within Australian society [1]. In 1975, Australia implemented the Racial Discrimination Act, which aims to protect the community from discrimination, particularly racial hatred, in different aspects of life. This marks a pivotal moment in the nation's legal landscape by outlawing discrimination on a national scale [2]. This Act represented Australia's inaugural federal legislation solidifying its dedication to the UN Convention on the Elimination of All Forms of Racial Discrimination [3]. Subsequently, in 1995, the law was broadened to encompass public acts of racial hatred, further fortifying its scope and impact [2]. Despite the strength of this legislation, regrettably, many Australians still endure prejudice and discrimination based on their appearance or ethnicity [2]. Individuals from Culturally and Linguistically Diverse backgrounds, spanning first and subsequent generations, play integral roles in Australia's economy as consumers, employees, and professionals.[2] Their diverse perspectives and contributions not only enhance competition and productivity but also foster innovation and inclusivity [2].

AMSA calls upon the Australian state and federal governments as well as the Australian Institute of Health and Welfare and any other relevant bodies to advocate for cultural diversity in healthcare and update anti-racial discrimination policies guided by the input of affected parties and audited data collection. Additionally, AMSA calls for relevant stakeholders to promote diverse leadership, implement initiatives addressing racism and establish anonymous third party protocols for the reporting of discrimination within schools and universities.

Academic Settings

Medical schools play an integral role in ensuring diverse admissions and thus, eventual diverse hiring, provision of mentoring opportunities and networking with underrepresented faculty members, via ensuring culturally appropriate curriculum design. The experiences students go through at medical school underpin their future interactions with minorities, at both a clinical level, as well as a personal level. With the power to change mindsets by reform at a structural and individual level, the importance of medical schools in addressing racial discrimination and enhancing cultural diversity cannot be understated.

AMSA calls upon schools, universities and other relevant bodies to address racism in the educational system, develop curricula promoting empathy and respect for diverse cultures and backgrounds, and implement anonymous and third-party reporting protocols for racism incidents.

Healthcare Settings

In the context of hospitals and health services, institutional racism manifested in the form of discrimination and bias remains a systemic problem that can have profound effects on the experiences of both patients and healthcare professionals. Cultural safety in healthcare goes beyond cultural awareness by creating an environment where patients feel safe, respected, and empowered to express their needs and concerns without fear of judgement or discrimination. Improving staff interactions and working conditions is essential for promoting a positive and inclusive healthcare environment. Discrimination and microaggressions directed at healthcare professionals based on their ethnicity, culture, race, or religion can have detrimental effects on their well-being and job satisfaction, ultimately impacting patient care. The flipside can also occur, where patients and their loved ones are on the receiving end of discrimination, which can have detrimental effects on their overall care. Addressing racism and cultural discrimination requires proactive implementation of measures that ensure patients require equitable access to high quality care. Hence, by prioritising safe, sensitive, and holistic patient care and creating a supportive, inclusive and conducive work environment free of racism and cultural discrimination, health institutes can better foster trust, promote diversity and enhance overall delivery of patient care.

AMSA calls upon hospitals, health service, medical workplaces, and specialty training colleges to increase cultural training and awareness among staff and ensure culturally safe spaces and implement reporting protocols for racial discrimination and ensure diverse representation in executive positions.

Policy Points

AMSA calls upon:

1. The Australian Government to:
    a. Appoint a Royal Commission into cultural diversity within healthcare settings;
    b. Continue to update the national stance against racial discrimination;
    c. Develop policies to:
        i. Ensure zero-tolerance for racial discrimination;
        ii. Recognise and acknowledge responsibility for past and present discriminatory government policies, so as to inform future collaborative policies;
        iii. Ensure that these policies are developed with the input of implicated parties and their lived experiences;
        iv. Ensure regular review and auditing of implemented policies to determine efficacy and relevancy;
    d. Implement culturally diverse representation in roles of leadership and governance, including but not limited to:
        i. The implementation [replace "implementation" with "exploration"] of quotas and targets;
        ii. Addressing structural barriers through research and consultancy;
        iii. Targeted programs for early career upskilling and support for diverse peoples;
        iv. Mandated data collection and reporting of cultural diversity within institutions and organisations;
    e. Implement initiatives in schools and universities that:
        i. Recognise the prevalence and seriousness of racism within the education system;
        ii. Develop a curriculum that promotes empathy, understanding, and respect for individuals from different racial and cultural backgrounds;
        iii. Educate and train teachers and learning staff to be able to identify and appropriately act upon racism;
        iv. Create national structures to hold all schools/unis accountable to having appropriate policies and guidelines regarding racial discrimination;
2. State and Territory Governments to:
    a. Allocate adequate funding to health services for:
        i. Increased training and availability of qualified medical interpreters;

ii. The provision of health promotion materials in different languages;
    1. Proof checked for accuracy to ensure precise translation
iii. Cultural training in hospitals which are regularly reviewed and audited to ensure efficacy and relevancy;
iv. The establishment of Culturally and Linguistically Diverse and Aboriginal and/or Torres Strait Islander advisory groups for evaluation and monitoring of hospital policy, infrastructure and action

b. Ensure that the governing bodies prioritise diversity and cultural representation within hospitals and health services;
c. Implementation of anonymous and third party reporting services in partnership with Culturally and Linguistically Diverse and Aboriginal and/or Torres Strait Islander communities to escalate racial discrimination;

3. Australian Institute of Health and Welfare to:
    a. Collect complete and high-quality data on cultural diversity within healthcare, particularly with regard to professional cohorts and attitudes towards workforce inclusivity;
    b. Expand the current cultural safety monitoring framework to include all culture and population groups;
    c. Collect data and develop strategies specifically on racism and its manifestations in healthcare spaces and in Australia, including but not limited to racism towards:
        i. Aboriginal and/or Torres Strait Islander health professionals;
        ii. Culturally and Linguistically Diverse health professionals;
        iii. International medical students;
        iv. International medical graduates;
    d. Consider the intersectional variations in data collected for experiences of racism and discrimination;
4. The Australian Medical Council to:
    a. Explore the implementation of quotas and targets for primary medical educators, pre-vocational training providers, and specialty training colleges to achieve culturally diverse representation in positions of leadership, including but not limited to:
        i. Board members;
        ii. Senior management;
    b. Continue to require that assessable material on anti-marginalisation, anti- racism and the provision of culturally safe care be included in the medical curriculum:

i. Regularly audit assessable material to ensure that assessment is efficacious, fair and relevant;

5. Specialty Training Colleges to:
    a. Implement transparent, anonymous and third party reporting protocols and support services in regard to racial discrimination from both patients and colleagues;
    b. Actively and regularly conduct cultural training, including implicit bias and habits of racism for trainees and Supervisors;
    c. Explore implementation of quotas and targets to achieve culturally diverse representation, in positions of leadership, including but not limited to:
        i. Board committees;
        ii. Senior management;
    d. Explore implementation of targets to achieve culturally diverse representation, including but not limited to:
        i. Trainees;
        ii. Supervisors;
    e. Collect, publish and implement open-access data about existing levels of cultural diversity;
6. Hospitals and medical workplaces to:
    a. Acknowledge the existence of racial discrimination in the workplace for students, health professionals and patients;
    b. Ensure that anonymous and third party escalation pathways and reporting protocols for workplace related racial discrimination, bullying, or harassment are available and accessible for all, including:
        i. Perpetrators of racist or discriminatory behaviours are held accountable;
        ii. Perpetrators are prevented from enacting further racist behaviours through disciplinary action, cultural training and follow up;
        iii. Provide ongoing support to individuals who have experienced, witnessed (bystanders) or reported racial discrimination, including access to confidential supportive services;
    c. Increase funding allocation to conduct audited cultural training for health professionals and staff;
    d. Develop and implement cultural awareness, humility and safety strategies including the provision of bystander training for healthcare professionals;
    e. Increase the availability of health promotion materials, which are:
        i. In different languages;
        ii. Representative of diverse groups;

f. Increase the availability and accessibility of medical interpreters;
g. Explore implementation of quotas and targets to achieve culturally diverse representation in positions of leadership, including but not limited to:
    i. Senior management;
    ii. Board members;
    iii. Regularly audit quotas and targets to ensure that they are efficacious, fair and relevant;
h. Explore implementation of targets to achieve culturally diverse representation in positions held by hospital employees;
i. Ensure culturally diverse groups have access to:
    i. Flexible visitor numbers and arrangements whenever possible;
    ii. Flexible mealtimes;
    iii. Flexibility in dietary options available;
    iv. Ability to choose demographic of healthcare provider (i.e. gender) as per cultural or religious requirements
    v. Culturally safe physical spaces, including but not limited to:
        1. Rooms for worship;
        2. Rooms for cultural practices;
        3. Waiting rooms;
        4. Examination rooms;

7. Australian universities and their medical schools to:
    a. Ensure that anonymous third party escalation pathways and reporting protocols for university related racial discrimination, bullying, or harassment are available and accessible for all, including:
        i. Perpetrators of racist or discriminatory behaviours are held accountable;
        ii. Perpetrators are prevented from enacting further racist behaviours through disciplinary action, cultural training and follow up;
        iii. Provide ongoing support to individuals who have experienced, witnessed or reported racial discrimination, including access to confidential supportive services;
    b. Provide bystander training for the identification and response to witnessed racism;
    c. Actively foster a culturally safe physical and virtual environment for all students and staff, such as:
        i. Providing adequate training on cultural safety;

ii. Promoting cultural humility through the use of reflective practices;

d. Update curricula design in medical schools that:
    i. Integrate assessable, intersectional anti-marginalisation, anti-racism and cultural safety content into the current medical curricula;
    ii. Ensures that materials concerning culturally diverse groups are taught with an intersectional approach;
    iii. Ensures better integration of diverse patient representation throughout the curriculum and in assessments;
    iv. Ensures Indigenous health content is created with collaboration from Aboriginal and/or Torres Strait Islander peoples and global First Nations peoples, and if feasible taught by Indigenous health experts;
    v. Establishes appropriate training for educators to deliver such materials in a culturally safe manner;
    vi. Establishes Culturally and Linguistically Diverse and Aboriginal and/or Torres Strait Islander staff/student advisory bodies and community partnerships to assist in curricula design, evaluation and ongoing monitoring;
    vii. Acknowledge that curricula design can only be implemented effectively if taught by trained faculty;
e. Implement training and upskilling programs for faculty in regards to anti-marginalisation and anti-racism material;
f. Explore implementation of targets to achieve culturally diverse representation in positions of leadership, including but not limited to:
    i. Board members;
    ii. Senior management;
g. Explore implementation of targets to achieve culturally diverse representation, including but not limited to:
    i. Staff;
    ii. Councils;
    iii. Committees;
h. Support Culturally and Linguistically Diverse and Aboriginal and/or Torres Strait Islander individuals considering commencing and currently engaged in tertiary studies by:
    i. Establishing longitudinal mentoring;
    ii. By introducing funding and prioritising support and mentorship for Aboriginal and Torres Strait Islander doctors/ medical students, that is provided by Aboriginal and Torres Strait Islander doctors;

iii. Introducing programs at both high school and tertiary education levels to inform students about the opportunities and resources available to them;
iv. Encouraging culturally diverse representation in positions of leadership;
v. Outreach groups and access schemes to support completion of medical studies;
vi. Improving availability of scholarships and special access schemes;
vii. Evaluating and working to improve graduation rates of Aboriginal and/or Torres Strait Islander students;

8. The AMSA Council, Executive and Board to:
    a. Develop and distribute formal documentation for reporting processes concerning racial discrimination;
    b. Explore implementation of targets to achieve culturally diverse representation in positions of leadership;
    c. Remove racial blinding from applications in order to appoint Culturally and Linguistically Diverse and Aboriginal and/or Torres Strait Islander peoples to roles directly concerning these groups;
    d. Collect data and develop strategies specifically to promote Culturally and Linguistically Diverse and Aboriginal and/or Torres Strait Islander representation in positions of Leadership;
    e. Continue fostering partnerships and collaborations with medical associations representing Culturally and Linguistically Diverse and Aboriginal and/or Torres Strait Islander populations;
9. Medical Societies to:
    a. Collaborate with medical faculties to develop and publish racial discrimination reporting pathways for both victims and bystanders;
    b. Commit resources to the advocacy of issues that affect Culturally and Linguistically Diverse and Aboriginal and/or Torres Strait Islander peoples;
    c. Implement targets to achieve culturally diverse representation in student committees and ensure that:
        i. Culturally and Linguistically Diverse and Aboriginal and/or Torres Strait Islander students are prioritised for positions that specifically relate to representation and advocacy for these aforementioned backgrounds;
        ii. Participation of underrepresented student communities in committee positions is encouraged;
    d. Create and promote events that celebrate and inform students on cultural diversity;

e. Elect Culturally and Linguistically Diverse and Aboriginal and Torres Strait Islander representatives in executive positions in medical societies;

10. Health professionals to:
    a. Commit to anti-racist and culturally safe practice in the workplace, including but not limited to:
        i. Taking appropriate bystander action by reporting and challenging witnessed racist behaviour;
        ii. Providing appropriate interpreter and cultural support services where appropriate;
        iii. Actively fostering a culturally safe environment for patients, patients' families and colleagues;
        iv. Actively using reflective practices to identify potential unconscious biases and ways to better cultural responsiveness;
        v. Engaging in cultural training, and implementing this in everyday practice;
    b. Seek appropriate support and treatment where their physical wellbeing, mental wellbeing and/or work performance is negatively impacted by all forms of racism;
11. Medical students to:
    a. Recognise and report acts of racism in their personal and professional lives, including taking meaningful bystander action;
    b. Seek appropriate support and treatment where their physical wellbeing, mental wellbeing and/or work performance is negatively impacted by any form of racism;
    c. Acknowledge and educate themselves on the impacts of racial discrimination in the:
        i. Medical student body;
        ii. Healthcare workforce;
        iii. Patient population;
        iv. General public;
    d. Recognise, reflect and learn from potential unconscious and implicit biases;
    e. Actively engage in teaching on anti-racism and cultural safety concerning Culturally and Linguistically Diverse, Aboriginal and/or Torres Strait Islander, and global First Nations Communities;
    f. Acknowledge and educate themselves on the importance of cultural diversity in healthcare and institutions;

g. Educate themselves on the cultural diversity of patients and their experiences, and how this has affected their ability to access healthcare
h. Actively engage with opportunities to experience and learn from other cultures and traditions.

Background

Acknowledgement

We would like to begin by acknowledging and extending our respect to the multitude of cultures, ethnicities and races present in our globalised world. As part of our policy, we have chosen to utilise the specific terms Aboriginal and/ or Torres Strait Islander, Global First Nations peoples, Refugee and Asylum Seeker Communities, and Culturally and Linguistically Diverse communities, when discussing racism and cultural diversity. While we acknowledge that these terms categorise populations and over simplify far more complex intersectional dynamics, by no means is our intention to homogenise the diversity and culture represented through these groups. But, rather talk about victims of racism and cultural diversity as a collective group to recognise the systematic nature of these lived experiences and how they transcend borders, groups and times.

In helping inform our policy and its direction, we consulted AMSA Global Health as our policy team is not, and cannot be, fully representative of the entire Australian demographic of medical students. We extend our sincere thanks and appreciation for all feedback we received and have endeavoured to incorporate these into the policy.

We would also like to address that this policy addresses both racial discrimination and cultural diversity and how they overlap, but simultaneously recognises that they both remain distinct issues. We implore readers to understand that the performance of diversity can operate to uphold racist systems through attempts to subsume cultures into white norm or nominalisation which establishes the idea of the 'other.' While we implore for the diversification of institutions, work places, structures and spaces, we appreciate that this alone won't act as a panacea to racism. Rather we appreciate diversification as a contributor to meaningful systemic change.

We would like to disclaim that this policy makes reference to racist practices and cultural insensitivity that may cause distress for some readers, particularly when discussing colonial violence and atrocities faced by Aboriginal and Torres Strait Islander peoples. We have provided the details of some culturally safe support services to contact if you are experiencing distress and encourage that you do seek help.

Beyond Blue: 1300 22 4636

Lifeline: 13 11 14

Social and Emotional Wellbeing Services for Aboriginal and Torres Strait Islander Australians: http://www.sewbmh.org.au/location/list

Definitions: For a full list of definitions, please refer to Appendix 1 at the bottom of the document.

This policy has been written on behalf of the Australian Medical Students' Association (AMSA) and all medical students in Australia with the intention to take a stand against racism and promote cultural diversity within institutions and medicine as a whole. As the peak representative body for a diverse group of 18,000 medical students across Australia across 22 medical schools in Australia, AMSA acknowledges and commits to addressing issues of recognising diversity, racism and discrimination within medicine.

We would like to acknowledge the presence of diversity, racism and discrimination in Australian society and that they transcend governance, hospitals, healthcare spaces and medical schools. While these domains have been analysed separately in our policy, we appreciate their interconnectedness and the importance of treating them as such.

Cultural Diversity

Culture is a concept with not one definition. However, it is broadly understood as the behaviours, values and ideas, either explicit or implicit, that are shared within a distinct collective. Effectively, it allows such collectives to coherently communicate, collaborate and understand one another. In saying this, culture can include ancestry, religious affiliation, a person's language, country of birth etc [4].

Undeniably, Australia is a multicultural country. In 2021, 27.6% of the population (7 million Australians) were born overseas. This is an increase from 2016, with 26.3% of the population born overseas. Particularly, the top 5 countries of birth were: England, India, China, New Zealand and the Philippines, with England and India experiencing a drop and increase respectively. Additionally, other than English, the most common languages spoken in Australia are Mandarin, Arabic, Vietnamese, Cantonese and Punjabi, with 5.8 million Australians using a language other than English at home [5].

However, despite such explicit data describing Australia's diversity, Culturally and Linguistically Diverse communities face extensive barriers in accessing healthcare services. These barriers include language barriers, difficulty navigating the healthcare system, and low health literacy. As such, Culturally and Linguistically

Diverse communities usually tend to have poorer health outcomes and an increased risk of poor quality healthcare [4]. For example, the Australian Institute of Health and Welfare reported Australians with low English proficiency have a higher prevalence of chronic conditions. In addition to this, the Australian Institute of Health and Welfare also recognised the lack of consistent collection of data regarding Culturally and Linguistically Diverse people. This makes it much more difficult to understand the struggles of Culturally and Linguistically Diverse people in accessing healthcare [4].

Discrimination and Racism

Despite Australia's rich cultural diversity, racism riddles Australia's social fabric, acting as a key social determinant contributing to significant health disparities in Culturally and Linguistically Diverse, Aboriginal and Torres Strait Islanders. Racism is a process characterised by inequity, indignity and injustice. Via policies, systems, attitudes and actions, persons of a certain race are oppressed, with their rights often limited, and may experience abuse, harassment and the like due to race [6].

Racism broadly exists in **three categories:** institutionalised, internalised and personally-mediated. (1) I**nstitutionalised racism** structurally exists within society, controlling the access to services, opportunities, and goods according to race. At times, this can materialise within laws and practice. In reality, this may include poor access to medical facilities, employment and appropriate housing. (2) Personally-mediated racism, intentional or unintentional, presents as prejudice and discrimination. This materialises as disrespect (poor service) and suspicion towards a person of a certain race (shop vigilance), and dehumanisation. For example, following the massacre in Christchurch, the Australian Human Rights Commission found that 80% of Muslim Australians experienced personally-mediated racism, such as negative comments in public [7]. Lastly, (3) internalised racism, involves individuals of a certain race accepting the racial messages against them - thus "internalisation". This can involve a person limiting their own self-determination, their humanity, and self-expression. It typically involves accepting "whiteness", helplessness, hopelessness, and self-devaluation by rejecting culture and ancestral background [8].

Racial Discrimination in Australia

Across history to modern times, racism is still omnipresent, placing Culturally and Linguistically Diverse peoples, Aboriginal and Torres Strait Islanders vulnerable to discriminatory experiences that have a range of implications. Particularly, Scanlon Foundation Research Institute found that between July 2020-202, 60% of participants in the Mapping Social Cohesion Report found they consider racism to be a "fairly big problem" or a "very big problem" in Australia [9]. According to the Amnesty International Human Rights Barometer Report 2021, 63% of respondents believed that certain cultural and ethnic groups didn't fit into the "Australian" way of life. Furthermore, 55% and 51% of respondents signified that Aboriginal and Torres Strait Islanders and refugees required protection from racism the most respectively, followed by 45% for ethnic minorities and 44% for immigrants. Worryingly, such values indicate that racism is still very grounded within our society [10]. A significant majority of 84%, advocate for freedom from discrimination, with 78% supporting freedom of religion and culture [11]. Despite 64% viewing Australia as a successful multicultural society, 47% acknowledge racism as a prevalent issue, while 26% deny its existence altogether. Reports indicate widespread experiences of racism, with one-third encountering it in workplaces or educational settings, and over two-thirds of non-Anglo-Saxon students facing it in schools [11]. An ABC survey underscores the severity, revealing that 76% of non-European-background individuals endure racial discrimination [11]. The 2015-2016 Challenging Racism survey highlights a strong consensus, with 77% recognizing racism as a pertinent issue and 76% committing to personal action [11]. Within this context, 34.8% have encountered racism in public spaces, 32.8% in workplaces, and another 32.8% within educational institutions [11].

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples made up 3.8% of Australia's total population from 30 June 2021. This has steadily increased across two decades, with a 0.5% increase from 2016. Albeit pushes and government initiatives, such the Close the Gap created to address the prominent health disparities between Aboriginal and non-Aboriginal individuals, these disparities continue to exist ever so. The most glaring disparity is probably the stark difference in life expectancy, with Aboriginal males likely to live 8.8 years less than non-Aboriginal male counterparts, and Aboriginal females expecting to live 8.1 years less than female non-Aboriginal individuals [13,14]. Undeniably, racism and its associated health implications has a significant role to play in this and other major disparities experienced by Aboriginal and Torres Strait Islander peoples.

Racism against Aboriginal and Torres Strait Islanders has existed since Australia's colonial history, perpetuating our modern society. From the discriminatory interactions between European colonists and Aboriginals, forcible separation of families, to the many exclusionary policies and legislations, Aboriginal and Torres Strait Islanders bring with them a history of horrid racism and still experience this, preventing the ability to engage as equal citizens with the rest of society [15]. Particularly, the effects of this historical racism ripples into the current generation of Aboriginal and Torres Strait Islanders, with the 2010 *Australian Reconciliation Barometer* suggesting 91% of Aboriginals believe that race-based policies continue to affect their communities today.

For Aboriginal and Torres Strait Islanders, racism exists at all levels previously explored [16]. Specifically, institutional racism and personally-mediated racism is a common indicator of health disparities, as suggested by a Closing the Gap report [17]. It attributed 47% of the health gap between Aboriginal and non-Aboriginal individuals is due to institutional racism, personally-mediated racism and intergenerational trauma [14]. The Challenging Racism National Survey particularly painted the vastness of racism within healthcare, with 52.6% Aboriginal and Torres Strait Islanders experiencing personally-mediated racism compared to 24.7% of non-Aboriginal Australians [18, 19]. In regard to institutionalised racism, this can be harder to detect due to indirect methods of measurement, but it is still very present within Australia's social structure, particularly healthcare, whereby Australia's health system is built upon the Western model of medicine that doesn't facilitate Aboriginal understanding of health, wellbeing and medicine [19].

As an additional note, another form of racism highlighted by the National Congress of Australia's First Peoples (2012) is racial vilification, not outlined previously. This is, based on the victim's colour, national or ethnic origin, and race, the perpetuator does something which will intimidate, humiliate or insult the victim [16]. For Aboriginal and Torres Strait Islanders, this has included racist graffiti in public spaces, and images and comments on publications, such as magazines, which are racially offensive [16].

From inability to access healthcare due to racism to the personal and communal health consequences and gaps that follow, Aboriginal and Torres Strait Islanders are stuck in a perpetual cycle of generational racism that still remains unresolved. However, it is worth mentioning that the Australian Government has provided $75 million in funding towards the National Anti-Racism Strategy, which is set to complete by June 2026, and will focus on addressing racism in Australia. The effectiveness of which remains to be studied [20].

Cultural and Linguistically Diverse Communities

As per the Department of the Prime Minister and Cabinet (PM&C) Culturally and Linguistically Diverse network, 'Culturally and Linguistically Diverse,' people are those that identify with cultural backgrounds, cultural/ ethnic identities, languages, countries of birth, heritage/ ancestry and national origin outside of predominant Anglo- Australian culture/ heritage [21].

In 2020, the UN estimated that there were 280.6 million international migrants worldwide, constituting 3.6% of the global population [22]. According to this survey, Australia ranked 9th globally in terms of the significant number of migrants it hosts [5]. Since 1947, the number of overseas-born Australians has steadily increased, especially following the post-war migration program [5]. Migration efforts continued throughout the latter half of the 20th century, primarily aimed at population growth and economic development. Post-2006, Australia witnessed a sharp rise in the proportion of people born overseas due to changes in its immigration policy, which aimed at increasing the intake of skilled workers [5]. As of 2022, 7.7 million people, comprising 29.5% of the Australian population, were born overseas, with an annual growth of 155,000 people born overseas recorded that year [22]. These statistics underscore Australia's profound multiculturalism and diversity. Nevertheless, despite these diverse demographics, racism not only exists but also represents a growing problem within Australian society.

While the terms 'ethnicity' and 'ethnic' lack a universally accepted definition, the Australian Bureau of Statistics (ABS) has adopted a multidimensional approach to examine ethnicity within Australia [5]. Drawing from the Borrie report of 1984 on the 'Measurement of Ethnicity in the Australian Census of Population and Housing,' ethnicity is understood as encompassing shared identity or similarity among a group of people, grounded in various distinguishing factors [5, 23]. These include but are not limited to historical heritage, cultural traditions, common geographic origins, shared language, literature, religion, minority status, and racial visibility [5].

In 1975, Australia implemented the Racial Discrimination Act, marking a pivotal moment in the nation's legal landscape by outlawing discrimination on a national scale [24]. This Act represented Australia's inaugural federal legislation solidifying its dedication to the UN Convention on the Elimination of All Forms of Racial Discrimination [24]. Subsequently, in 1995, the law was broadened to encompass public acts of racial hatred, further fortifying its scope and impact [24]. Despite the strength of this legislation, regrettably, many Australians still endure prejudice and discrimination based on their appearance or ethnicity, due to the systemic nature of racism in society [24].

Migrants heavily contribute to the Australian economy, contributing an estimated fiscal benefit of over $10 billion dollars in their first ten years of settlement [25]. Recent research conducted by the Migration Council Australia and Independent Economics highlights compelling trends for Australia's future population, projecting it to reach 38 million by 2050. The study also reveals that migration contributes significantly to Australia's GDP, amounting to $1.625 billion [26]. Furthermore, it anticipates a 15.7% increase in workforce participation and a 5.9% rise in GDP per capita growth attributable to migration [26]. Individuals from Culturally and Linguistically Diverse backgrounds, spanning first and subsequent generations, play integral roles in Australia's economy as consumers, employees, and professionals [26]. Their diverse perspectives and contributions not only enhance competition and productivity but also foster innovation and inclusivity [26].

Refugee and Asylum Seeker Communities

Australia is a signatory to the United Nations Convention Relating to the Status of Refugees (1951) and the Protocol (1967) and hence accepts refugees from a range of countries every year [27]. Asylum seekers and humanitarian refugees worldwide represent a vulnerable subset of the Culturally and Linguistically Diverse population, and unfortunately, they continue to face persistent political discrimination [28]. This issue is thoroughly examined in the AMSA policy for Refugee and Asylum Seeker Health (2023).

The 1967 UN Convention relating to the status of Refugees defines refugees as individuals who, due to a well-founded fear of persecution based on race, religion, nationality, membership in a particular social group, or political opinion, are outside their country of nationality and unable or unwilling to seek protection or return to their country of origin [29]. In contrast, asylum seekers are those who are seeking refugee status and whose applications are still pending [30]. While there is limited empirical evidence of prejudice specifically targeting refugees and asylum seekers based on racial differences, it is crucial to acknowledge that by implementing an intersectional approach, asylum seekers and refugees face various forms of discrimination compounded by their interconnected social identities, including race, migration status, religion, gender, and political beliefs.

Racism in Australian Schools

It is imperative to recognize that systemic issues such as racism and cultural prejudices are deeply entrenched within societal structures. Delving into the manifestations of racism within educational institutions and scrutinising the approaches taken to address and confront it provide invaluable insights into its enduring presence and evolution over time.

The Speak Out Against Racism (SOAR) project, funded through an Australian Research Council Linkage grant, represents a significant endeavour as the first large-scale, population-representative study examining experiences and attitudes toward racism, racial bullying, and bystander responses among Australian students in government schools across New South Wales (NSW) and Victoria [29]. Findings indicate that approximately one third of students reported experiences of racial discrimination by peers (31%) and society (21%), with just over one tenth (12%) reporting such incidents involving teachers [29]. Comparative analysis shows that students from non-European backgrounds were twice as likely as their European counterparts to experience discrimination [29]. Additionally, more than half (60%) of the participants reported witnessing peer-to-peer racial discrimination, particularly among students from South Asian (74%) and African (68%) backgrounds [29]. Religious discrimination was reported more frequently by students born overseas or with at least one parent born overseas. Student responses to racial bullying varied, with many assuming bystander roles, and a small percentage actively engaging in bullying behaviours [29]. Despite these challenges, students reported low levels of loneliness and high levels of social connectedness [29]. A substantial majority (63%) of students expressed confidence in their teachers' ability to address racism [29]. There was notable concern amongst teachers and staff regarding racial discrimination in school settings with 19% identifying it as a serious problem [29]. Furthermore, almost one-quarter (21%) of staff participants highlighted inadequate policies, practices, and processes to address race-based discrimination in their schools [29].

These statistics highlight the need to address systemic racism through a perspective that acknowledges the experiences and challenges faced from marginalised groups. Such can be obtained from the implementation of the following:

1. School based programs educating students on racism and cultural diversity.
2. Training programs for teachers as to how to address racism.
3. Introduction of third party and anonymous reporting platforms to facilitate escalation of racism and cultural discrimination.

Healthcare and Hospitals

Institutional racism within hospitals and healthcare systems

At its core, institutional racism is the structural discriminatory bias inbuilt into society - it is the "differential access to goods, services and opportunities of society by race." Even today, (Indeed - take away), institutional racism is prevalent in the Australian healthcare setting (even today - take away). This racism stems from the British regime at the colonisation of Australia, seen throughout history in the idea of *terra nullius* and the stolen generation, among many other things [30]. How institutionalised racism presents today is quite different to in the past, yet still carries the same negative consequences if not addressed adequately [30]. For example, the health of Aboriginal Australians is worse overall statistically compared to non-Aboriginal Australians [30, 31]. The life expectancy for Aboriginal people is 8.8 years lower for males, and 8.1 years lower for females [14]. Aboriginal people are more likely to have certain conditions, for example: they have 2 times the suicide rate, are 1.2 times more likely to report having a respiratory or cardiovascular disease and are 3.3 times more likely to have diabetes [32].

In terms of institutional racism relating to Culturally and Linguistically Diverse patients, a 2012 study was conducted with immigrants to Australia who had varying levels of English proficiency and educational backgrounds to investigate not only the perceptions of Culturally and Linguistically Diverse patients but also health professionals involved in their care [33]. From the patients' perspectives, some of the main challenges highlighted were difficulty in navigating to health services, and primarily the availability of services that would cater to their language and cultural barriers, compounded by the restricted access to bulk-billing services given the low socioeconomic status of a significant proportion of the Culturally and Linguistically Diverse community [3].

Institutionalised racism can impact the health outcomes of Aboriginal and Torres Strait Islander peoples and limit the growth of the Aboriginal health workforce [35]. It can also manifest between medical professionals, medical students, and allied health professionals. This will be expanded more upon later in the paper. Since institutionalised racism can impact the quality of health care provided to patients, it is an important topic to address, and can be done so through several strategies [30]. This includes diverse racial representation on government boards, implementing policies that address racism, the recruitment of culturally safe workers, and transparency in finance management [35]. Introduction to change cultural thinking and address culturally appropriate care can be construed into action for the improvement of culturally safe care [34].

Cultural responsiveness in health care

Cultural responsiveness refers to "being open to new ideas that may conflict with the ideas, beliefs and values of your own culture and being able to see these differences as equal [36]." This encompasses continual learning about diverse cultures, frequent self-examination, and thorough reflection in order to improve health outcomes for patients [36]. Health workers, therefore, need to consider these points during communication in clinical practice: cultural linguistics, religion, and sexual and racial characteristics of culturally diverse patients [37].

In Australia, cultural responsiveness may look like language, interpreting and translating services, accommodation of food preferences and restrictions, respect of differences in culture (such as respect for modesty and availability to same-gender health professionals), and including religious and spiritual care for palliative and end-of-life care [36]. However, a review noted that there has been inconsistent execution of culturally responsive communication in Australian health care services [37]. There is limited use of such communication and a lack of awareness for the need of cultural responsiveness [37]. Furthermore, according to a large Australian based review, many healthcare professionals feel that there is insufficient training regarding culturally responsive communication and practice, and thus feel unsupported in this region of clinical service [37].

Cultural safety in healthcare

Cultural safety acknowledges and addresses power differentials between the patient and healthcare professional [38]. Cultural safety is different from cultural competence, which is when health workers are tasked to educate themselves on a diverse range of cultures, which may include their beliefs, skills, and attitudes [38]. This is not sufficient as it does not address growth nor practicality in real-life settings [38]. Cultural safety takes it one step further [38]. It asks health professionals to examine themselves and thoroughly reflect on how their own attitudes, beliefs, and assumptions about other cultures can impact the service they provide [38].

The proportion of Aboriginal patients that leave against medical advice is more than 5 times that of non-Aboriginal patients [39]. The Australian Institute of Health and Welfare state that "differences in rates of Indigenous and non-Aboriginal patients who choose to leave prior to commencing or completing treatment are frequently used as indirect measures of cultural safety [39]." Cultural safety is therefore important in the improvement and maintenance of a high standard of patient care [40].

A study conducted in the United States in 1999 revealed that race and sex were key determinants in a physician deciding to refer a patient for cardiac catheterisation, with African American women being referred the least [41]. This highlights the association between the cultural backgrounds of healthcare staff and the presence of health disparities. Thus, hiring healthcare workers who represent the general makeup of the communities enables healthcare facilities to provide culturally competent care [42]. Additionally, by allowing for increased minority representation in leadership roles, minorities are able to offer varied, valuable perspectives and make decisions that can benefit the delivery of care [42, 43]. Additionally, healthcare practitioners who identify as minorities have also been found to be more likely to provide medical care to vulnerable populations [44]. However, even with the known benefits of diverse hiring, disparities in the distribution of the number of minorities in the healthcare industry remain, particularly in managerial and clinical positions [45].

Action to improve culturally safe care includes starting training in medical school, with the goal to foster culturally safe care in future generations of healthcare workers [40]. This can include strategies such as exposing medical students to learning in rural settings, or in Aboriginal health centres, collaboration with culturally diverse groups, including Aboriginal health content in learning, and increasing cultural awareness and reflections in learning [40]. Another undertaking includes supporting current healthcare workers to improve cultural safety in their clinical practice [46]. In fact, the Australian Medical Association (AMA) recommends that doctors undergo cultural safety training [46]. Such training is available to doctors through the Australian Indigenous Doctors' Associations (AIDA), who provide workshop opportunities covering cultural safety [47]. The Royal Australian College of General Practitioners (RACGP) also provides such training courses [48].

Culturally and Linguistically Diverse patients may have less opportunities to access healthcare services and preventative measures, such as cervical screening, due to barriers such as lack of knowledge, misunderstandings, differences in beliefs and cultural taboos [49]. Therefore, when working with Culturally and Linguistically Diverse patients, it is important to consider aspects of their culture, such as race, religion, gender, and ethnicity so that culturally sensitive care can be provided [49]. Many factors make up a Culturally and Linguistically Diverse patient's background, and may include migration, settlement, and socio-economic status [49]. They need to be taken into account in clinical practice to promote cultural safety and inclusivity [49].

Like all other facets of society, Australia's healthcare system must continue to evolve within the racial discrimination and cultural diversity sphere in order to

effectively deliver services to its multicultural residents [50]. On the surface, impacts of racism can be clearly identified, including inequity in access to resources required for health, education and housing, inequitable exposure to risk factors for poor health, and engagement in unhealthy activities [51]. However, even when accessing such services, both patients and health professionals from Aboriginal and Torres Strait Islander as well as Culturally and Linguistically Diverse backgrounds alike undergo systemic discrimination.

Staff Interactions and Working Conditions

Despite efforts to combat racism within the healthcare system via training in cultural responsiveness and cultural safety, interpersonal racism directed not only towards Indigenous and Culturally and Linguistically Diverse patients but also healthcare workers are still pervasive today. According to a 2019/2020 report from AHPRA, only 0.01% of healthcare practitioners identify as Aboriginal or Torres Strait Islander peoples, demonstrating the severe lack of Indigenous voice in the healthcare sphere [52]. This statement is supported by 2020 statistics supplied by the Australian Indigenous Doctor Association, in which "Indigenous doctors are 5.5 times more likely to report bullying as a major source of stress, 10 times more likely to experience racism, and 27% of Indigenous health students reported being very stressed by racism [53]." Not only does this impact the healthcare worker themselves in terms of mental, physical and psychological health, but also extends to their treatment of patients regarding quality of care [53]. As such, cultural safety in healthcare must not only include patients but also extend to the healthcare practitioner, allowing them to be empowered to work in Australia's healthcare system, creating a more diverse, accepting and equal environment.

Interactions between patients and medical staff

Perhaps the most obvious form of racial discrimination in the healthcare system exists between patients and healthcare professionals. Whilst patients already experience institutional racism integrated into our health system, racism from healthcare workers further adds to the burden they must face, therefore providing another barrier to accessing health care [51].

In a report from the Australian Institute of Health and Welfare (AIHW), statistics sourced from the Australian Reconciliation Barometer showed that the proportion of Indigenous Australians reporting racial discrimination by healthcare practitioners in the last 12 months had increased since 2014 (11% in 2014% to 20% in 2022) [54]. Not only does this show that 1 in 5 patients identifying as an Indigenous person experience direct racism, but this figure has only grown in past years, further discouraging Indigenous and Culturally and Linguistically Diverse patients from accessing health services [54]. For instance, in 2018-2019, 32% of Indigenous

patients who did not access health services when they needed to did so due to cultural reasons, including language barriers, discrimination and cultural appropriateness [54]. Whilst the percentage of Indigenous patients experiencing racism may have grown due to the increased racism subjected towards these patients, it is prudent to note this may have occurred as a result of increased reporting mechanisms and a shift in the stance towards cultural safety.

Unfortunately, with such grounded racism within our healthcare system, Aboriginal and Torres Strait Islanders continue to experience significant gaps in health compared to their non-Aboriginal counterparts. With poor access to and treatment in healthcare services, such as higher rates of discharge, and lower access to procedures, the mental, social, emotional and physical impacts on Aboriginal and Torres Strait Islanders is prominent [14]. Such widespread racism to Aboriginal peoples and communities, Aboriginal and Torres Strait Islanders are more likely to not access healthcare services until their illness worsens, as a result of mistrust, cultural insensitivity and fear of the mainstream healthcare system. Following this, significant health consequences arise, such as psychological distress, suicide, self-harm, and maladaptive and risky behaviours (e.g. smoking, and binge drinking) [13,14].

Referencing the earlier 2012 study conducted with Culturally and Linguistically Diverse patients, participants were generally positive about their experience with patient-provider interactions, yet all parties reported that linguistic and cultural differences had a noticeable detrimental impact on the provision of care and highlighted a lack of professionalism of healthcare providers [33]. Language was highlighted as the main barrier to adequate healthcare, with a Sudanese patient reporting that “some [doctors] are not friendly and are very rude especially when you cannot communicate properly due to language barrier of an African [33].” The effects of impeded communication are clearly seen, with a 2021 report by AIHW exposing that 33% of migrants with low English proficiency had one or more long term health conditions, compared with 23% of migrants with high English proficiency [55]. As a result of facing discrimination, participants felt discriminated against by their providers, and felt undermined, disrespected and intimidated [33]. Therefore, due to obstacles faced by patients including language barriers, perceptions of discrimination are prevalent amongst the Culturally and Linguistically Diverse community, having serious repercussions [33]. Providing a culturally safe and responsive environment is necessary for patients to have the best outcomes and adherence to medical advice [33].

While the 2020 version of 'Good medical practice: a code of conduct for doctors in Australia' delineates the professional expectations of doctors at an individual level including relevant anti-racism practices, it does not clearly account for unconscious and implicit racism which enables racial discrimination to continually infiltrate the healthcare system [56]. Therefore, to ensure that even unintentional acts of racism or unconscious bias are recognised and eradicated, an updated and clearer set of guidelines including necessary cultural safety training must be provided.

Anti-marginalisation and anti-racism

With institutionalised racism in Australian healthcare affecting the health outcomes for vulnerable communities, it is essential to explore anti-racism efforts [57]. These efforts begin with naming racism, and addressing how racism and social determinants of health may intersect to result in health disparities [58]. To be anti-racist is to advocate for racial equality, and actively call out policies, and organisational practices and structures that contribute to the perpetuation of racism [59]. This can be done via many different approaches from individual transformation and organisation change to racial equity policies [60].

For anti-racism strategies to have a sustained impact, it is essential to use a multi-level approach [61]. Interventions have to be utilised at systemic, organisational, individual levels at the same time for a prolonged period of time [62, 63]. However, it was noted that strategies aimed at individuals should only be implemented after organisational ones, as individual behaviours were often influenced by organisational culture [62, 63]. There is also a need for racial equity policies, to hire, retain and promote minorities. Collaborations with government healthcare organisations, regulatory health institutions as well as non-profit organisations will enable hospitals to build on legislation and incorporate anti-racism guidelines into their own practices [61]. This also includes collaborations across disciplines - with critical theorists, sociologists etc. to allow for more education on racism and how to address and heal centuries of systemic and institutionalised racism [61].

Addressing racism in hospitals and health services

As there has been a relatively recent shift to highlighting the importance of cultural safety and responsiveness, audits, indicators and tools are necessary to be able to assess development and engagement with these targets. One such tool was developed by Adrian and Henrietta Marrie in 2014 called the 'Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services' for the purpose of "encouraging transparency and accountability in the implementation of public health policies intended to close the gap in Indigenous health disparities" by measuring 5 criteria and classifying the level of institutional racism [64]. These 5 key indicators include: participation in organisation

leadership/governance, policy implementation, service delivery, recruitment and employment, and financial accountability and reporting [64]. The following examples refer to changes implemented in WA hospitals in steps towards building cultural competency [35].

The first criteria, inclusion in governance refers to several criteria: legal visibility, Aboriginal and Torres Strait Islander representation at board level, and inclusion in hospital executive management structure [64]. Indigenous representation in governance structures, especially at executive and board level, must be directly involved in making decisions and implementing health service laws to address any instances of institutionalised racism [35]. For example, the WA Department of Health is a joint partner of the WA Aboriginal Partnership Forum along with the Aboriginal Health Council of WA (AHCWA). Furthermore, the Aboriginal Health Policy Directorate has representatives in the Aboriginal Health Executive Forum and provides support in oversight and leadership in the Indigenous health domain [35]. These newly established boards allow for Indigenous peoples to have an opportunity in being representative in high level health governance structures in WA [35].

Secondly, policy implementation is key in making steps to tackling institutional racism, and directly addressing initiatives or action plans [64]. Various policies with targets such as the Closing the Gap report in Indigenous Health Outcomes and public reporting and accountability in annual reports provide key information with specific recommendations, and therefore need to be used as the baseline in rolling out new guidelines [64]. In WA, implementation guides are being drafted to provide the scope for health service providers to be able to operationalise the framework effectively, such as the Implementation Guide for the WA Aboriginal Health and Wellbeing Framework 2015-2030, which are being developed with key input from local Aboriginal communities and Aboriginal leaders [35].

Moreover, service delivery refers to developing local Aboriginal health plans and ensuring cultural safety amongst healthcare professionals through reporting from health system performance indicators such as discharge against medical advice, Indigenous peoples in the workforce, and competent governance [64]. In 2015, the WA Health Aboriginal Cultural Learning Package (ACLP) comprising online cultural learning tools and resources was made available to WA healthcare workers, providing them with education on cultural safety and responsiveness in regard to Indigenous patients [35].

Additionally, recruitment and employment aims to highlight the development of the Aboriginal health workforces, focussing on recruitment, retention, training, development and participation in the workforce [64]. Staff who identify as

Indigenous are key for providing culturally safe care, target setting and ensuring an accurate reflection of the local patient demographic [64]. The WA Health Aboriginal Workforce Strategy 2014-2024 aimed to develop a growing Aboriginal health workforce across all roles including clinical, non-clinical and leadership roles [35]. It was based upon the WA Health Aboriginal Workforce policy, mandating six Aboriginal recruitment and development initiatives, and highlighting the importance of policy development [35].

Finally, financial accountability covers Commonwealth and regional funding contributions, allowing for transparency in budget allocations from the federal government in working towards Aboriginal health priority initiatives, conducted through frequent and regular audits [64]. In 2014, 2 reviews were conducted on WA Health: a review by WA Health's Chief Procurement officer and *A Promising Future: WA Aboriginal Health Programs* (the Holman Review) spotlighting practices, processes, policies and requirements involved in the funding procurement arrangements for Aboriginal health programs [35].

As such, through assessing healthcare delivery through the Matrix's 5 principles, a thorough review of institutional racism and steps to overcoming this is essential in ensuring a more effective and culturally safe health care system [35]. A federal plan is being implemented Australia-wide through the development of the *National Aboriginal and Torres Strait Islander Health Plan 2021-2031* [65]. Whilst this is currently only applicable to the Indigenous sphere, a similar plan adapting the same principles and structure should be created to tackle the similar racism experienced by Culturally and Linguistically Diverse patients and healthcare staff, to ensure cultural safety for all.

Medical Schools

Curricula Design

Medical school training forms the foundation of our learning and thus informs our future practice. As such, it is critical that anti-racist teaching is made a priority by key stakeholders in medical education, such as the Australian Medical Council. Rather than considering medicine as a politically neutral space as it traditionally has been viewed, we are shifting towards an awareness that healthcare exists within a socio-political context [66].

We can appreciate this shift by acknowledging the cultural competency training often included in medical school curricula, which seek to improve cultural safety in healthcare. However, valid criticism has arisen about the limitations of cultural safety training. Indeed, while it can develop awareness, it does not adequately teach

the structural roots of race inequality nor provide upskilling about how to recognise and address these inequalities [67]. Anti-racist curriculum is more complex than only cultural safety and should be expanded to include teaching on the historical basis of structural racism, unconscious bias and strategies to address these inequalities proactively as healthcare professionals [68]. Rather than treating race as a risk factor based solely on genetics, curricula should also explore how race becomes a risk factor due to an inherently racist society. For example, gaps in medical school education can lead to lower quality of care for Aboriginal and/or Torres Strait Islander, global First Nations and Culturally and Linguistically Diverse people. This is exemplified by a recent American study into the incorporation of different skin tones into medical textbooks, which found that 93.3% of images depict light skin tone, 6.7% depict medium skin tone, and no images depict dark skin tone [69].

Importantly, we must acknowledge that curricula design can only be implemented effectively if taught by trained faculty. Many educators feel unprepared to discuss these topics and need to be upskilled themselves before engaging with student learners. In addition to this, representation should be a priority and teaching should come from culturally diverse individuals, with instructive input from lived experience of Aboriginal and/or Torres Strait Islander, global First Nations and Culturally and Linguistically Diverse people [68, 70].

Medical students

Australian medical schools are composed of students from a diverse range of backgrounds. Despite this however, Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse medical students often experience racism and discrimination during the course of their studies. This may occur in the setting of patient interaction, supervisor training or even in the course of discussion with other colleagues. In turn, this can cause major stress for these students and negatively impact their learning, confidence and wellbeing [71, 72].

Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse medical students deserve to feel safe and respected. It is the responsibility of medical schools to facilitate this using a multi-prong approach. Firstly, curricula should include anti-racist training. A qualitative study conducted in the UK revealed that students believed including this would be a positive step towards change [71]. Secondly, faculty should be trained to step in, support and debrief with diverse medical students if they witness a microaggression in clinical practice. Finally, anonymous reporting systems to report discrimination should be actively advertised and be made easily accessible by medical schools. Due to the hierarchical nature of medicine, many students and even staff are understandably uncomfortable

reporting supervisors and it should be made a priority by medical schools to dismantle this pervasive attitude [72].

Finally, medical students should be encouraged to direct their own learning about anti-racism, anti-marginalisation and cultural safety. Curricula should include appropriate teaching and resources, but it should be stressed that students also have the responsibility of being active learners.

Medical school societies

Medical school societies are uniquely poised for a role in advocacy. Indeed, as intermediaries between medical students and governing bodies, medical societies are integral in championing cultural diversity. Often, medical students are able to recognise the gaps in their own learning and create solutions. For example, a Canadian student-led initiative implemented and advocated for an anti-racist framework to be integrated into the curriculum [67]. Involving Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse students in these societies is key to advocacy. Indeed, medical school societies should ensure they are representative by adopting targets in the selection process. Some Australian medical schools even have dedicated executive positions for Aboriginal and/or Torres Strait Islander representatives [73]. Moreover, advocacy around anti-racism and discrimination should be a continuous focus rather than once-off, with feedback forms made available to other medical students not directly involved in the society.

Intersectionality

An intersectional approach to curricula must be adopted, as this lens recognises that different social determinants of health – race, gender, sexuality and more – intertwine to obstruct health equity and social justice. One type of marginalisation cannot be neatly separated from another, and rather, the whole picture needs to be considered [74]. A pertinent example is sexual and reproductive health (SRH), where the intersection of gender and race has made it more difficult for specifically Aboriginal and/or Torres Strait Islander, global First Nations and Culturally and Linguistically Diverse women, non-binary and trans people in accessing SRH [75, 76]. Medical students should be encouraged to think critically here about the different barriers both gender and race put up in this example and how this impedes access to safe and quality healthcare.

Another example of the importance of intersectionality in healthcare that the curricula can draw attention to is the stereotyping within medical education itself. Indeed, bias is seeded within the medical curriculum through the many stereotypes taught about conditions such as sickle cell disease being more prevalent in African-

American patients or that younger and overweight women with a headache often have idiopathic intracranial hypertension [77]. Examination questions often start with demographics. While it can be important to learn these associations, it can also be extremely reductive and dangerous. For example, if the stem of a HIV question always specifies that the patient is a gay male, it can reiterate harmful ideas that this disease is only prevalent in the LGBTQIASB+ community and teach students to overlook this differential in people of different sexualities [77].

Diverse Hiring

Diverse hiring is absolutely integral in medicine, where providing the best care to patients is only possible by representation of the different sociocultural backgrounds in the tapestry of society [78]. Possible barriers include issues such as implicit bias, biases in standardised testing, as well as a lack of meaningful mentorship [79]. Firstly, individuals are often unaware of the implicit racial biases and negative associations they hold that may hinder recruitment of applicants of different cultural backgrounds [80]. Additionally, standardised testing for entry into medical schools and residency has also resulted in growing disparities in the number of racial minorities who receive a place, with a study in the US showing that black students regularly scored lower than their white counterparts [81]. These disparities come about due to an interplay of complex factors, such as socioeconomic status, the "acting white" hypothesis, where racialised peer pressure leads to the underachievement of black students, as well as additional pressure and anxiety that arises due to hostile and discriminatory environments [82, 83]. Particularly for Aboriginal and Torres Strait Islander individuals, the paucity of minorities in senior consultant and research positions results in Aboriginal and Torres Strait Islander medical students being unable to find and connect with a mentor who truly understands their struggles of being discriminated against in the healthcare space, and eventually hindering their career advancement [84]. This continues perpetuating the cycle of minorities being underrepresented in the healthcare industry.

This reflects an urgent need for more diverse hiring strategies to be incorporated into healthcare fields and overcome these barriers. This starts with support programs in high school that develop students' interests in the healthcare fields, and university programs that provide support to students of colour, especially at the professional schooling level, which includes medicine, dentistry and nursing, helping to retain and recruit these students in healthcare [85].

International Students/Graduates

In 2021, data collected by the Australian Government found that out of a total of 18, 157 students enrolled in medical programs, 15.7% of them were international medical students [86]. Considered Australia's largest services export, international students contributed approximately $40 billion to the economy prior to the pandemic [87]. Therefore, the Australian government highly values its international students, along with the other social and diplomatic contributions they make to Australian society [87]. However, this is not reflected in the treatment international students receive. A study exploring the key factors affecting an international student's mental health in Australia found that both covert and overt linguistic racism, where one's linguistic rights are denied in institutional and non-institutional settings, was most critical [88].

International medical graduates also face similar issues of mistreatment, with common experiences being that of inadequate recognition professionally, a lack of autonomy over their own future, favouring of local graduates, covert biases, racially insensitive verbal insults and harsher sanctions for mistakes [89]. As a result of these experiences, a study conducted in 2022 found that international medical graduates faced lower levels of satisfaction with their lives compared to their domestic counterparts, especially in areas such as community integration and job autonomy [80]. The abundance of literature on this issue has led to the proposal of various solutions classified as below [89].

1. Sharing of experiences, which includes mentoring and networking;
2. Assistance at workplace, such as services dedicated to support international medical graduates;
3. Structural review and change, including investigations into structural inequities and removing structural barriers that international medical graduates face;
4. Workplace harmony via diversity and anti-discrimination training.

Academia

Racism is incredibly pervasive in academia, with people of colour being denied opportunities and sponsorships, resulting in minorities in academia not being given the awards and recognition that they deserve [90]. Minorities who have been pioneers in various specialties of medicine have been attempted to have been erased from history, and have been denied grants and publications [91]. To combat this issue, *Teaching and Learning in Medicine (TLM)*, an international, peer-reviewed forum, created an editorial internship for racial minorities to apply for in 2021, due to the power editors can hold as gatekeepers of academic literature, leading to the diversification of the TLM editorial team [92]. While a valiant effort, analysis of the internship revealed that it did not manage to foster a culture of antiracism, as senior

editorial mentors viewed the racism that their mentees experienced as separate from their editorial process. This highlights a need for more antiracism initiatives within organisations, and the upheaval of structures that have institutionalised racism.

Additionally, research in general is focused predominantly on white populations, which may result in issues with efficacies of treatment in patients of different ethnicities, with treatments such as cryolipolysis generating different results between Caucasian and Asian populations [93]. This is especially prominent in dermatological research, where skin of colour has different structural and functional properties that give rise various conditions such as hyperpigmentation, hypopigmentation and keloids [94]. Therefore, it is necessary for medical students to be aware of this when analysing research articles and searching for appropriate treatments for their patients in the future. Furthermore, when participating in research, they must be cognizant of the need for an ethnically diverse population.

A study on faculty experiences in academic medicine also found that faculty from underrepresented minorities often found it difficult to communicate with and integrate into the department as well as their Caucasian counterparts, and described it as a "foreign culture" that was not open to having minorities [95]. This led to feelings of isolation, and of inferiority, due to stereotypes placed upon them by their colleagues [95]. Their hiring has also felt tokenistic, with these minorities having the burden of having to represent their entire race placed upon them by institutional leaders who are not genuine in their efforts to include minorities [95]. This often leads to underrepresented minorities leaving academic medicine - a great disservice to those who have the ability to thrive in the area, but were not given the right environment or circumstances to do so.

Mentoring and Outreach Programs

Mentoring programs are widely available across medical schools, and they help develop the clinical skills of medical students, and generate more interest in undersubscribed specialties [96]. Mentoring also plays a role in the personal development and professionalism of the medical student through socialisation and networking opportunities [96].

Medical students from underrepresented minorities often do not get the opportunity to access the benefits of mentoring, as they do not have access to targeted mentoring programs that address the unique obstacles that they face [97]. This is, unfortunately, a result of a lack of diverse hiring amongst faculty, or admissions into medical school that do not reflect the diversity of the general population, leading to reduced mentoring opportunities [97].

The Link and Grow Mentoring Program under Australian National University (ANU) has identified the need for culturally diverse students to be paired with mentors from similar backgrounds [98]. The program is six months long, and is targeted specifically at women from culturally diverse backgrounds to be able to network and share their experiences navigating the healthcare industry [98]. However, there is a fee of $2200, which may seem insurmountable for students of lower socioeconomic statuses. Thus, while a good first step, there is a need to evaluate current programs and improve sponsorships and funding efforts to make it more sustainable.

Improving Cultural Diversity in the Workplace

Culturally Diverse Leadership

Latest census data reveals that Australia boasts a very culturally diverse population. However, there exists a notable underrepresentation of individuals from Culturally and Linguistically Diverse backgrounds in senior leadership and organisational positions [99]. The 'Leading for Change' report investigated leadership representation across various sectors including federal and state government, ministerial positions, and university executive roles. The findings revealed that 95% of Australian senior leaders come from European backgrounds, despite this group representing only 24% of the broader Australian demographic [100]. NSW Workforce government sector data elucidated that in 2022, 14.0% of employees identified as belonging to racial, ethnic or ethno-religious 'minority' groups and 18.3% identified that English was not their first language [101]. One in five Australians are born in non-English speaking countries, while only 14.7% of staff that make up the Australian Public Service (APS) are born in non-English speaking countries [102]. However, the problem becomes acute at the senior executive level with only 7% of senior executives in the APS identifying as being from a non-English speaking background [102]. When this is critically explored, it indicates that lack of diversity in the public sector means that certain parts of Australian society are not being represented and hence are implicitly being given less consideration in national policy debate and implementation [102]. It is however imperative to appreciate that being from a non- English speaking background does not indicate less proficient English language abilities, but rather simply provides a statistical measure of cultural diversity as it is commonly used in censuses [102].

Women from culturally diverse backgrounds are under-represented in the workforce compared with men from culturally diverse backgrounds. This disparity exists across both the workforce as a whole and at senior executive levels [101]. Diversity

in leadership is instrumental in shaping workplace culture and fostering an organisational environment that values diversity.

Research indicates that cultural diversity in managerial roles enhances organisational decision-making and performance. A comprehensive study conducted by McKinsey and Company found that ethnically diverse executive teams were 33% more likely to surpass competitors in terms of profitability. Intellectual and linguistic skills of Culturally and Linguistically Diverse individuals are invaluable in making up for gaps in the public sector [99]. Workplaces that foster inclusion and a sense of affiliation provide better employee satisfaction and staff retention. Many employees from Culturally and Linguistically Diverse backgrounds express the feeling of being 'othered,' in workplace scenarios which can also manifest as a spectrum of different actions from microaggressions to overt discrimination. Furthermore, the lack of safe pathways to raise concerns and complaints makes these incidents perpetual [101]. Conversely, there is also mention of the 'tokenization,' of staff who associate with being Culturally and Linguistically Diverse, and feeling pressured to speak up against issues surrounding cultural diversity [101]. Enhanced Culturally and Linguistically Diverse leadership can also act as a form of staff retention, where diverse leadership removes stigmatised barriers for individuals with underrepresented backgrounds [99].

Lack of diversity at senior executive levels can act as a barrier for employees hoping to progress their careers in the government sector, as they cannot see themselves and their career pathways reflected which can lead to the sense of a 'glass- cultural ceiling' [103]. Companies with limited ethnic diversity were more prone to underperforming compared to their more diverse counterparts. Thus, promoting cultural diversity in leadership positions not only reflects the broader societal makeup but also contributes to improved organisational outcomes [104].

The Public Service Commission (PSC) have proposed a framework for increasing cultural diversity in the New South Wales (NSW) government sector senior executive [101]:

1. Representation and pathways to the senior executive level
2. Opportunities to develop inclusivity across the employee lifecycle:
    a. Response to sector consultation feedback relating to structural bias across lifestyle;
    b. Inclusive recruitment;
    c. More supportive pathways for reporting racism and making complaints;
3. Building support structures for Culturally and Linguistically Diverse employees across sector.

4. Building frameworks for workplace culture safety and belonging.

Targets, quotas and data collection

In order to achieve cultural diversity and representation in workplaces, institutions and organisations, quotas and target systems are often adopted. A target is a voluntary goal that may be customised by organisations to achieve specific aims, whilst quotas are mandated by an external body to allow for enforcement and accountability [105]. Targets allow for individual organisations to take ownership of their diversity goals. In studies on target implementation to increase diversity of workplaces, the 'ownership' of organisational goals greatly improves the likelihood of achieving them [106]. Whilst critics often call for softer measures such as training, mentoring and networking to increase cultural diversity, research shows that quotas are the single most effective method in increasing diversity, and subsequently enhances all other methods of improving diversity in the workplace [107].

There is substantial discussion surrounding the use of quota systems compromising meritocracy in selection systems [108]. There is also debate that systemic barriers stemming from racism already act as barriers that prevent these individuals from achieving the same qualifications and positions that they have demonstrated merit for [109]. Barriers to recruitment and job progression include inaccessibility to the application process, hiring bias, discrimination and lack of representation on recruitment panels [101]. It is also important to acknowledge that overseas qualifications are not always recognised in recruitment and experience gained overseas is not always valued compared to local experience in Australia [101]. This merit debate when referring to quotas has also been proposed as misguided due to there not being an even playing field in the first place and suggests a 'merit paradox' with research suggesting that focusing on merit may paradoxically lead to more biassed outcomes and further discrimination [109, 110]. This paradox could potentially stem from unconscious selection bias such as perceiving certain ethnicities to have higher competence than others [111]. It is important to appreciate that ethnic bias is a critical barrier against equity and diversity, and ethnicity can be easily identified as part of the curriculum vitae screening process [111]. Hence, fundamentally, the application of quota based employment systems may actually increase meritocracy and overall competency of employees when greater diversity and representation is achieved [108, 112].

Thus, well implemented target aims create an inclusive organisation culture where everyone's perspectives and contributions are valued. Australia's foundational principles rest upon the bedrock of egalitarian ideals, which envisions a nation with equal opportunities irrespective of culture, religion and ethnicity. However, the lamentable dearth of diversity within Australia's public service stands as a stark contradiction to these cherished values of egalitarianism. Fortunately, the

implementation of diversity targets emerges as a proven method to redress this imbalance and propel us towards a more inclusive and equitable future 102].

It is essential to acknowledge that 'Tokenism,' may still be present when implementing targets and quotas and caution must be exercised to avoid further discrimination 113]. Studies postulate that diversity becomes normalised and tokenism is eliminated when a representation threshold of 15% is reached [100]. It is pertinent that organisations consider 'ethnic zoning' in the context of workplace hierarchy when applying quotas to ensure that they do not mirror dominant societal cultures and reaffirm cultural stereotypes by having overrepresentation of particular cultures in upper management or leadership roles [113]. Opponents of diversity initiatives contend that they may foster tokenistic promotions, breeding resentment and undermining workplace inclusivity. While these concerns hold validity, the distinction between diversity targets and quotas is pivotal. Unlike quotas, which mandate representation, targets offer measurable objectives, directing organisational efforts towards dismantling systemic barriers that perpetuate a non-meritocratic environment [102].

While ensuring targets and quotas for adequate representation are achieved, data collection and analysis of cultural diversity of groups is advised, organisations within the Australian health services and systems are not currently obligated to report internal cultural diversity [100]. While at a federal level, Australian Human Rights commission has led an inquiry into strengthening multiculturalism and eliminating racial discrimination with a recommendation to suggesting that the government collect comprehensive data concerning cultural diversity in Australian workplaces [114]. The Indigenous Health Priorities Policy of Medical Deans Australia and New Zealand mandates Australian medical schools to report on Aboriginal and/or Torres Strait Islander student recruitment, ensuring transparency and promoting the inclusion of individuals with lived experience and expertise in relevant roles [115, 116, 117, 118].

Evidence based research demonstrates that the application of quota systems ensures diversity goals and targets [105, 107]. The right to self representation is greatly correlated with the right to self determination, as enshrined by the UN declaration on the rights of Indigenous peoples [116, 117].

Victoria's first Indigenous Labour senator Jana Stewart is superheading the push, which goes beyond Labor's current gender rules to boost the number of multicultural and linguistically diverse MPs [119]. Details regarding Stewart's quota figure and how she will define diversity are yet to be finalised, this serves as a contemporary example of the implementation of cultural diversification methods to being implemented in Australia's political landscape [119].

The Federation of Ethnic Communities' Councils of Australia (FECCA) is the national peak body for representing Australia's culturally and linguistically diverse communities and their affiliated groups [120]. Through advocacy, policy development, and promotion, FECCA advances the interests of its constituents to governmental bodies and the broader community [120]. Grounded in principles of empowerment and inclusivity, FECCA formulates policies aimed at the collective welfare of all Australians and promotes its overarching mission to secure rightful recognition of the needs and aspirations of Australians from diverse cultural and linguistic backgrounds within public policy frameworks [120].

Conclusively, initiatives and governance concerning people of cultural and linguistic diversity are made more effective by the guidance and perspective of these communities. Hence, their leadership actively challenges Australia's history of racism and manifests an idea of paternalism [116, 121]. Hence, by removing racial binding from positions that require sensitivity to an applicant's socio- cultural context, this enables the appointment of the most suited candidate, based on meritocracy.

Definitions

Aboriginal and/or Torres Strait Islander peoples:

Aboriginal and/or Torres Strait Islander peoples is a grouping term for the many diverse Indigenous nations across Australia. We use this term throughout our policy cognizant of the unique experiences, cultural practices and languages of these nation groups.

Cultural competence:

The act and process of learning the customs, histories and diverse experiences of a culture in order to cultivate your ability to interact with persons from that culture in a manner that is safe and mutually beneficial [122].

Cultural humility:

A term coined by Melanie Tervalon and Jann Murray-García that refers to a practice of cultural reflexivity, in which difference is understood not as residing in a patient but as existing between two equally valid cultural experiences [123]. Cultural humility encourages clinicians to think critically about the ways in which their own inculturation shapes their interactions and relationships. It also recognises that one cannot ever become fully 'competent' in another's culture, and therefore is a lifelong commitment to learning [122].

Culturally and Linguistically Diverse ：

Culturally and Linguistically Diverse refers to Australians who were born overseas, have a parent that was born overseas and are linguistically/ culturally diverse. Culturally and Linguistically Diverse individuals tend to speak a different language at home and have may have differing religious affiliations [124].

Culturally responsive care:

A cyclical and ongoing approach to patient centred-care that includes paying particular attention to social and cultural factors affecting a therapeutic consultation, proactively and appropriately responding to the patient and their family with whom they are interacting, as well as reflecting on the cultural appropriateness of their consultation [125].

Cultural safety:

A term introduced by Irihapeti Ramsden, a Maori nurse in Aotearoa (New Zealand) that denotes environments and interactions where marginalised individuals feel safe within their identity, culture and community group, facing no discrimination, denial or challenge to who they are [126]. This is most often created by those engaging with Aboriginal and/or Torres Strait Islander, global First Nations and Culturally and Linguistically Diverse communities by demonstrating cultural competency, humility, shared respect and true partnership [127].

Cultural security:

A subtly different concept from cultural safety. It is the identification of a stronger obligation to actively implement culturally appropriate guidelines, procedures and policies. This is particularly relevant for people working with Aboriginal and/or Torres Strait Islander, global First Nations and Culturally and Linguistically Diverse individuals [127].

Cultural training:

A term utilised in this document to refer to the following trainings and any other trainings pertaining to the creation of culturally safe environments: cultural safety, cultural sensitivity, cultural humility, cultural competency, cultural responsiveness, anti-racist, and bystander training.

Discrimination:

Treating individuals differently according to race [7].

Ethnic Zoning:

Segregation of residential areas, workplaces or opportunities on the basis of race, culture or ethnicity either implicitly through economic, social or political structures or explicitly through legal frameworks [113].

Ethnocentrism:

The act of judging another culture or race based on preconceptions that are grounded in the views and values of one's own culture; for instance, in relation to language, behaviour or customs [116].

Global First Nations:

Global First Nations Indigenous peoples around the world. These identities experience injustice, particularly in regard to the racial discrimination and often dispossession they face due to their cultural identity. We use this grouping term cognizant of the incomparable diversity that exists between First Nations groups.

Implicit/unconscious racism:

Implicit/unconscious racism refers to the social stereotypes that one forms about certain groups of people outside of their conscious awareness. An instance of unintentional interpersonal racism could also be classed as implicit racism [128].

Indigenous Australian:

A term that refers to all Australian First Nations people [129].

Institutional racism:

Institutionalised racism often takes the form of inherited advantage and refers to the "differential access to goods, services and opportunities of society by race" [7]. This type of racism, having been ingrained into our institutions of custom, practice and law, is a structural form of discrimination [7].

Interpersonal racism:

Interpersonal racism refers to the personal prejudices and biases that an individual may hold. This form of racism can be intentional or unintentional [7].

Intersectionality:

A framework identified by Kimberlé Crenshaw in 1989 to delineate the ways in which multiple forms of inequality or disadvantage can compound each other and create unique challenges [130]. Intersectionality refers to, not simply the sum of disadvantages, but the ways in which they intersect within marginalised individuals/groups to produce a different discrimination altogether. An example of this may be found in the amalgamation and interplay of racism, sexism, ageism, homophobia, transphobia, ableism, classism, xenophobia, etc [130].

Racialisation:

The political, social and cultural processes and practices where race is utilised as an explanation or a means of understanding an event [131].

Social determinants of health:

A framework put forward by the WHO to define the systems and processes which govern the conditions in which individuals are born into, age, live and work. This includes but is not limited to education, work, socioeconomic status (SES), sex, gender, race, social support and social environment [132].

Stolen generation

Refers to the Aboriginal and Torres Strait Islander children that were removed from their families by force under government legislation.

Terra Nullius

Meaning 'empty land' suggesting the vacancy of the land of Australia before colonisation

Microaggression:

A comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalised group [133].

Prejudice:

Harbouring assumptions regarding the motives, intentions and abilities of individuals according to their race [7].

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