Transforming institutional racism at an Australian hospital

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Abstract

Objectives. The aims of this study were to: (1) examine institutional racism's role in creating health outcome discrepancies for Aboriginal and Torres Strait Islander peoples; and (2) assess the management of institutional racism in an Australian hospital and health service (HHS).

Methods. A literature review informed consideration of institutional racism and the health outcome disparities it produces. Publicly available information, provided by an Australian HHS, was used to assess change in an Australian HHS in five key areas of institutional racism: inclusion in governance, policy implementation, service delivery, employment and financial accountability. These findings were compared with a 2014 case study.

Results. The literature concurs that outcome disparity is a defining characteristic of institutional racism, but there is contention about processes. Transformative change was detected in the areas of governance, service delivery and employment at an Australian HHS, but there was no change in financial accountability or policy implementation.

Conclusions. The health outcomes of some racial groups can be damaged by institutional racism. An external assessment tool can help hospitals and health services to change.

What is known about the topic? Institutional racism theory is still developing. An external assessment tool to measure, monitor and report on institutional racism has been developed in Australia.
What does this paper add? This study on institutional racism has useful propositions for healthcare organisations experiencing disparities in outcomes between racial groups.
What are the implications for practitioners? The deleterious effects of institutional racism occur regardless of practitioner capability. The role for practitioners in ameliorating institutional racism is to recognise the key indicator of poorer health outcomes, and to then seek change within their hospital or healthcare organisation.

Introduction

Institutional racism is a major contributor to the health gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. This study describes the nature and management of institutional racism and considers recent changes in an Australian hospital and health service (HHS) to illustrate the potential for organisational transformation.

Institutional racism was first named as a phenomenon more than 50 years ago. A rich and varied literature has developed since from international contributors who concur that a defining characteristic of institutional racism is disparity of outcomes,

particularly in health care. In Australia, the poorer healthcare outcomes of Aboriginal and Torres Strait Islander people are well evidenced and continue to be reported.

What is institutional racism?

In 1967, Carmichael and Hamilton[1] described institutional racism as the covert means operated by established and respected societal forces for the purpose of subordinating and maintaining control over a racial group; in effect, they regarded institutional racism as a form of colonialism. The well-documented disparities in health outcomes for racial groups in

some societies, even when socioeconomic status is taken into account, have been attributed to institutional racism in many studies.[2–17]

A recent critique of the development of racism theory over the preceding 50 years contends that the opportunity to elaborate an overarching theory of racism with cultural, institutional and individual levels has been lost with today's theoretical offerings only providing 'one-dimensional and reductionist explanations of race relations'.[18(p574)] Regardless of this lack of strategic theory development, the diverse literature covers key questions relevant to health care about institutional racism including: is it caused by the personal racism of individual employees or the processes, structure and governance of an organisation; is it a deliberate action or inaction of society or its key organisations; can it be applied to individual organisations or is it a total societal condition; how does institutional racism deliver healthcare discrepancies; and how does resistance to eliminating institutional racism manifest?

The conceptual challenge of a society deliberately constructing and maintaining racist institutions, presented by Carmichael and Hamilton,[1] has led to alternative perspectives. One view of institutional racism suggests informal organisational barriers that impede minorities.[19] Along these lines, the Macpherson report of the UK inquiry into Stephen Lawrence's murder defined institutional racism as follows:[20]

. . .the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people. (Sec. 6.34)

Likewise, van Ryn and Fu[21] regard institutional racism in health as being the sum of practitioner behaviours. A further retreat from the worldview of Carmichael and Hamilton[1] is the attribution of these racist individual behaviours to an unconscious bias rather than overt personal racism.[22]

Macpherson has been criticised as conflating personal racism with institutional racism, attributing the action, or inaction, of institutions to the people who inhabit it rather than the structure, policies and practices of the institution.[23] According to Spangaro *et al.*[24] institutional racism is embedded in the processes, values, attitudes and behaviours of an organisation. A European study of Roma health outcomes concluded that 'structural mechanisms of racism do not require the action of individuals, but rather reflect the structure of societal institutions that create and perpetuate health inequalities'.[25(p410)] Racism exists within the policies or structure of an institution in the absence of racist individuals.[26]

Conversely, personal racism is reinforced by institutional racism's promotion of policies, behaviours and attitudes, which advantage Whites to the detriment of other racial groups.[12] A point supported by Bailey *et al.*[27] in their description of the myriad ways in which racial discrimination is fostered by society with mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care and criminal justice to create a system of subjugation that reinforces discriminatory beliefs and values. Conversely, Barter and

Eggington[28] contend that laws prohibiting interpersonal racism, such as Australia's *Racial Discrimination Act 1975*, have a powerful educative effect that affects society and institutions. The distinction between overt personal racism and covert institutional racism needs to be maintained, along with an understanding that the potency of institutional racism is derived from its influence on the policies, governance and structure of an organisation and not the racist actions of people who work in it.

Carmichael and Hamilton[1] posited deliberate intent behind institutional racism, a position supported by contemporary theorists who emphasise the systematic nature of institutional racism used by governments, and other power systems, to exclude or marginalise some racial groups.[29] Others contend that institutional racism exists regardless of intent. Institutional racism is indirect and 'may or may not be intentional'.[2(p10)] Came *et al.*[15] concur that institutional racism depends on organisational practices and outcomes and not the intention of an institution's employees. Of course, regardless of whether institutional racism is intentional or unintentional, the effect is that institutions deliver a lesser benefit to Aboriginal people.[30] Intent is therefore immaterial to defining institutional racism, although it provides information about how to manage a specific situation. Indeed, the act of exposing and naming institutional racism to an organisation's management turns the unintentional into intentional when no response is elicited.

In Australia, an overarching societal view of institutional racism in health, aligned with Carmichael and Hamilton, has emerged.[31,32] Institutional or systemic racism is 'the racist production, control, and access to material, informational, and symbolic resources within a society'.[33(p153)] Similarly, in New Zealand, it was contended that 'institutional racism is having the power to have one's prejudices embedded in the institutions and systems of a society, thus disadvantaging one group and privileging another'.[34(p88)] A US study examining disparities in preterm birth demonstrated theory convergence with a description of institutional racism as the 'overt and covert policies, practices, and laws that reinforce racial inequality, white superiority and subordination of certain racial groups in relation to access to resources, opportunities, and power'.[35(p480)]

Contemporary theory development has also led to a greater focus on institutional racism within organisations and their policies and procedures that increase power disparities between racial groups.[36,37] In an organisation-focused approach, institutional discrimination is displayed in the policies, procedures, governance and structures of the organisation.[2,38] This organisational view assists remediation of institutional racism within hospitals or other healthcare settings.

Within a week of the release in the UK of the Macpherson report, the role of institutional racism in the poorer health outcomes for some ethnic groups was raised.[39] This consideration was echoed in North America by Jones in her allegory of the gardener's tale, describing the differential access by races in a society to goods, services and opportunities and concluding that 'institutionalised racism is normative, sometimes legalised, and often manifests as inherited disadvantage'.[40(p1212)] In New Zealand, a study of poorer cancer survival rates of Maori concluded that individual caregivers did not provide differential care for Maori and non-Maori patients; outcome inequity was

caused by the manner in which cancer services were staffed, funded, organised and located.[7] These attributes of institutional racism reflect the New Zealand health system's historical development and the continuing failure to understand and change organisations that deliver these outcomes. Came and Humphries[36] described five sites of institutional racism in health systems: (1) the tyranny of the majority; (2) including biomedical evidence and excluding Indigenous evidence; (3) culturally incompetent policy makers; (4) flawed consultation (asking the wrong questions of the wrong people); and (5) Indigenous policy implementation requiring non-Indigenous agreement.

In Australia, models of care neglect to address Aboriginal and Torres Strait Islander needs, resulting in worse outcomes, including less or no treatment and poor survival rates.[8,10] In the US, institutional racism 'looks like cancer centers with mostly White, middle class patients and Black neighbourhoods with city hospitals, known for indigent care'.[11(p285)] Although there is still contention about the precise nature and operational mechanisms of institutional racism, a more detailed picture of how institutional racism delivers poorer health outcomes for some racial groups is emerging from the literature.

What can be done about institutional racism?

A range of actions for the reduction or elimination of institutional racism in organisations has been proposed. First, the redistribution of political power at every level of government would challenge the ways in which the laws, institutions and policies in Australia are currently constructed to 'privilege the interests of the dominant cultural group'.[41(p504)] Recognition of Aboriginal and Torres Strait Islander people within the law can provide a basis for system-wide stewardship and a foundation of good governance to deliver better policies and programs for Aboriginal and Torres Strait Islander health in this country.[42]

Cultural education and antiracism training have been proposed to ameliorate institutional racism.[43] However, these tactics will be ineffective given that the effect of institutional racism is driven by factors beyond the behaviour of individual staff. Focusing on the motivations and intentions of individuals cannot eliminate the structures that generate racial disparities.[44] The role for individual practitioners is in recognising poorer outcomes and pursuing organisational change. Lasting change only occurs within health systems by examining processes of power imbalance and identity.[45] These measures can include: changing historical funding levels to Indigenous health providers; including Indigenous paradigms within service specifications; increased access to government; and representation on advisory boards and steering groups.[36]

Organisational leadership is vital for retooling the structures and processes to reduce institutional racism.[46] Ongoing leadership vigilance can prevent institutional racism creeping back in when implicit routines are unquestioned or regarded as ideologically neutral. Employment practices matter; a lack of diversity in the midwifery profession has been linked with higher levels of infant mortality for African American and Native American children.[17] Finally, both equity and quality assurance processes have been proposed as the means to change institutional racism.[44]

Resistance to dismantling institutional racism can manifest in denial: 'when white people say race does not matter and there are only small pockets of racism within Australian society, they are speaking from a position whereby the possessive nature of their race privilege remains invisible to them'.[47(p92)] Understanding the complexity and harmfulness of institutional racism can be difficult for 'those who have neither the eyes to see it in practice nor the moral sensitivity to feel its outcomes'.[36(p106)] Consequently, non-Indigenous health staff often require tangible explanations and practical training to understand the importance of and mechanisms for change.[48] Furthermore, a lack of clarity about institutional racism and its management can create additional tension and increase resistance to transformation.[49] Bowser proposes that 'institutional racism requires institutions to reinforce one another to maintain White racial advantage'.[18(p582)] The consequence for any organisation that transforms a racist structure may be abandonment by Whites, the organisation 'will be progressively devalued and alternative ways will be sought to fulfil its role and functions if it no longer preserves White advantage'.[18(p583)] Strategies to reduce institutional racism in organisations need to assess and manage the risks of resistance.

What is the effect of institutional racism on Aboriginal and Torres Strait Islander people?

In Australia there is considerable evidence of poorer outcomes in hospitals and healthcare facilities for Aboriginal and Torres Strait Islander people. The extent of the effect was indicated in the recent report on the Closing the Gap targets from the Australian Institute of Health and Welfare, which attributes 53% of the health gap between non-Indigenous Australians and Aboriginal and Torres Strait Islander people to the social determinants of health and risk factors.[50] The remaining 47% of the health gap may be attributed to institutional racism, interpersonal racism and intergenerational trauma. Examples of poorer health outcomes in health care include cancer treatment, where Aboriginal and Torres Strait Islander patients are less likely to receive treatment and wait longer for surgery.[10,51,52] In addition, Aboriginal and Torres Strait Islander people are less likely to receive appropriate treatment for coronary heart disease after hospitalisation.[53,54] Aboriginal and Torres Islander patients hospitalised for digestive tract disease have a significantly lower likelihood of receiving the corresponding procedure than non-Indigenous patients,[54] and waiting times for elective surgery are longer for Aboriginal and Torres Strait Islander patients.[55]

Methods

An Australian-designed external assessment tool to measure institutional racism, using only publicly available information for both criteria selection and assessment to enhance transparency and verification, is formed in a matrix of five key indicators:[56] (1) inclusion in governance; (2) policy implementation; (3) service delivery; (4) employment; and (5) financial accountability (see Appendix 1).

The genesis of the matrix occurred during an investigation commissioned by the chief executive of the Cairns and Hinterland Health and Hospital Service (CHHHS) in 2014 into whether on-going racial harassment of Aboriginal and Torres

Strait Islander employees was occurring (H. Marrie, unpubl. obs.). The investigation revealed signs of institutional racism. In an HHS where Aboriginal and Torres Strait Islander people account for as many as one-third of hospital admissions, these signs included no representation in the governance structure, no Aboriginal and Torres Strait Islander community consultative mechanism, a declining Indigenous workforce, no public reporting on Indigenous health expenditure and poor annual reporting on progress in closing the Indigenous health gap. These outcomes were present despite specific Commonwealth and Queensland Health policies designed to address these issues. Marrie and Marrie[56] noted the absence of a relevant tool capable of delivering an objective, evidence-based assessment of levels of institutional racism in any setting, such as for health, justice administration, or child welfare, and decided to create the Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services. Inspiration for the design came from the Seattle Human Services Coalition's Identifying Institutional Racism Folio.[57] The matrix was designed as a desktop tool that focused on measuring closing the Indigenous health gap policy implementation, accountability and transparency, and would only use publicly available information provided by hospitals and healthcare organisations (notably annual reports, health service agreements, strategic and operational plans) in the assessment process. This constructed an assessment process that is open, transparent, verifiable and publicly available. The initial design was as a national template incorporating criteria largely drawn from Tier 3 Health System Performance indicators from the Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures endorsed by the Australian Health Ministers' Advisory Council in 2011;[58] adjustments were made to accommodate Queensland Health's legislative and closing the Indigenous health gap policy settings. The matrix was trialled on the CHHHS in June 2014 as a private initiative,[56] and as a personal response to the Australian Human Rights Commission's National Anti-Racism Strategy 2010–20 'Racism – It Stops With Me' campaign (H. Marrie, unpubl. obs.). The 2014 CHHHS case study found an extremely high level of institutional racism.[56] After attracting considerable interest and favourable reviews, the methodology was endorsed by Queensland's peak Indigenous health body, the Queensland Aboriginal and Islander Health Council, and then extended to an audit of all Queensland's 16 HHSs for the Queensland Anti-Discrimination Commissioner in 2017.[59] Additional development and validation of the matrix within the broader Australian healthcare environment is a future research opportunity

Results and Discussion

CHHHS: transforming institutional racism

Marrie and Marrie's 2014 case study of CHHHS used data from 2012–13 governance documents to deliver a score rating for 36 separate measures within five key indicators of inclusion in governance, policy implementation, service delivery, employment and financial accountability.[56] The total score was 14/140, an extremely high level of institutional racism (the lower the score, the higher the level of institutional racism). The assessment was repeated as part of a larger jurisdictional study using a slightly revised matrix and based on the 2014–15 reporting

period,[59] returning a marginally improved score of 17/140. Using 2016–17 data,[60] CHHHS scored 39/140, an overall improvement of 25 points over 4 years, with the institutional racism level now rated as 'very high'. The relationship between intent and institutional racism has been considered above; in this context, CHHHS is clearly aware of its institutional racism and a failure to act would constitute a deliberate act of institutional racism.

Externally observable changes[60] at CHHHS between 2012–13 and 2016–17 include appointing an Indigenous person to the Board, establishing an Aboriginal and Torres Strait Islander Health Community Consultation Committee, the first among the 16 public HHSs in Queensland, re-establishing the Executive Director of Aboriginal and Torres Strait Islander Health position abolished in June 2013 when the Division of Aboriginal and Torres Strait Islander Health was amalgamated into a 'super' division, reporting data on discharges against medical advice and potentially preventable hospitalisations and establishing an Indigenous Traineeship Program.

Key areas that have not been addressed are financial accountability and overall levels of Aboriginal and Torres Strait Islander employment within CHHHS.

CHHHS is funded under its service agreement with Queensland Health to provide a range of services to Aboriginal and Torres Strait Islander people.[61] These services include dental, chronic disease management, sexual and reproductive health, cardiac and respiratory outreach, Indigenous hospital liaison, cultural capability, Indigenous mental health and Indigenous alcohol and other drug outreach services. There is no indication of the Commonwealth or Queensland Government source of these funds, how much money is allocated to each of these services or their effectiveness. Therefore, no information is provided to enable Aboriginal and Torres Strait Islander communities to determine whether they are getting 'value for money', or whether the funding accurately reflects need. Although this issue of lack of financial accountability equally affects all 16 of Queensland's public HHSs, something of a 'breakthrough' was achieved by Torres and Cape Hospital and Health Service in its 2016–17 annual report, where a table of programs funded by Queensland and the Commonwealth detailed how A\$9 092 382 was allocated between 20 programs.[62]

Employment of Aboriginal and Torres Strait Islander people in the CHHHS workforce is also a key concern. Although an Indigenous Traineeship Program has been established, the CHHHS does not provide overall data on the number of Aboriginal and Torres Strait Islander staff or their occupational categories. The 2014 case study noted a decline in Indigenous staff from 4.25% in 2010 to 2.97% in 2013. No data on Indigenous employment has been provided in either the 2014–15 or 2016–17 annual reports.[56] Within the CHHHS region, 12.6% of the total population identify as Aboriginal and/or Torres Strait Islander.[60] As of 30 June 2017, the CHHHS employed over 5800 full-time, part-time and casual staff.[60] Achieving population equity within a workforce requires staff numbers that reflect the local demographics; for CHHHS, this would be around 600 Indigenous staff within a total of 5800. The absence of employment data means that there is no way of knowing whether the decline continues or whether numbers are improving. Furthermore, more Aboriginal and Torres Strait Islander staff

help address cultural competency, reduce discharge against medical advice rates and reduce overall levels of interpersonal racism.

These actions show CHHHS actively transforming institutional racism within their organisation. Although there is more work to do, particularly in policy implementation and financial accountability, these steps demonstrate organisational recognition and engagement. The utility of an external assessment tool to measure, monitor and report on institutional racism has been demonstrated.

Although matrix assessments could be used to 'name and shame', its authors emphasise its utility as a framework for discussion between HHSs and Aboriginal and Torres Strait Islander people to resolve issues raised by a matrix assessment.[56] Australian human rights agencies have also noted the value of this quantitative tool to assess institutional racism in the health system.[63,64]

Finally, the initial CHHHS case study[56] and the subsequent assessment of Queensland's 16 HHSs[59] identified the structural source of institutional racism as Queensland's *Hospital and Health Boards Act 2011*. A clear starting point to address the power imbalance in HHS governance is amending s.23(2) of the Act to require Aboriginal and Torres Strait Islander representation on all HHS boards. Currently, only four of the 16 HHSs have such representation. Marrie[59] goes even further, arguing that the structural driver of institutional racism at the state jurisdictional level begins at the national level in the National Health Reform Agreement 2011.[65]

Conclusion

The failure rate for organisational change is high at 70%.[66] Hospitals are not an exception and are regarded as having considerable resistance to change.[67–69] Combining a hospital-specific organisational characteristic with the expected additional resistance to transforming institutional racism creates further difficulties. Despite these barriers, CHHHS has, aided by an effective external assessment tool, started to transform an organisational heritage of institutional racism. Further investigation of the internal management process undertaken by CHHHS in achieving these outcomes would provide useful learnings.

Competing interests

Christopher Bourke is an employee of Australian Healthcare & Hospitals Association, of which CHHHS is a member. He is also a member of the Uluru Statement Working Group; Co-Chair of the ACT Reconciliation Day Council; and a member of the National Health Leadership Forum. Henrietta Marrie and Adrian Marrie are owners of Bukal Consultancy Services P/L which undertook a consultancy for CHHHS that finished in 2014.

Acknowledgements

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Appendix 1.   Matrix template
Thirteen-point matrix for identifying, measuring and monitoring institutional (Inst.) racism within public hospitals and health services (reproduced with permission from Marrie and Marrie[56])

Key Indicators and Criteria		Scoring	Score
1. Participation in organisation leadership/governance			
• Legal visibility in relevant health service legislation		20	?
• Aboriginal and Torres Strait Islander representation at health service board level		10	?
• Representation at Executive Management level		10	?
	Total	**40**	**?**
2. Policy implementation			
• Closing the Gap in Aboriginal and Torres Strait Islander health outcomes		10	?
• Community engagement		10	?
• Public Reporting and Accountability in annual reports		10	?
	Total	**30**	**?**
3. Service delivery			
• Aboriginal and Torres Strait Islander Health Service Plan		10	?
• Cultural competence		10	?
• Selected Health Service Performance Indicators		10	?
	Total	**30**	**?**
4. Recruitment and employment			
• Aboriginal and Torres Strait Islander health workforce development		10	?
• Aboriginal and Torres Strait Islander participation in health workforce		10	?
	Total	**20**	**?**
5. Financial Accountability and Reporting: Closing the Gap Funding			
• Common wealth contribution		10	?
• State/Territory contribution		10	?
	Total	**20**	**?**
Score		**140**	**?**

Institutional Rating scored against criteria

Score:	>110	80–109	60–79	40–59	20–39	<20
Evidence of Inst. Racism:	Very low	Low	Moderate	High	Very high	Extreme