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Submission: Inquiry into racism, hate and violence directed at Aboriginal and Torres Strait Islander people

RACP Aboriginal and Torres Strait Islander Health Committee

1 May 2026



We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs' Inquiry into racism, hate and violence directed at Aboriginal and Torres Strait Islander people and seeks to contribute to its progress.

The RACP is committed to improving health equity as a fundamental human right and recognises that racism, hate and violence are inseparable from the ongoing impacts of colonisation at interpersonal, institutional and structural levels[1]. Representing over 33,000 trainees and Fellows across 33 specialties, the RACP trains and educates physicians in adult medicine, paediatrics and child health. RACP members regularly care for Aboriginal and Torres Strait Islander patients and have a key role in addressing racism, hate and violence in the healthcare system.

Research consistently demonstrates that racism in the Australian healthcare system is a product of a colonial-settler state, shaped by the dispossession and exclusion of Aboriginal and Torres Strait Islander people and the privileging of Western models of care over Indigenous knowledge systems, which continue to influence how care is designed, governed, and delivered[2]. Evidence further shows that harms associated with racism, hate and violence directed at Aboriginal and Torres Strait Islander people are interconnected and cumulative, driving inequities in health, education, justice and social outcomes across the life course[3*].

Evidence demonstrates that racism in the healthcare system undermines equitable access to care, compromises patient safety and reduces service engagement[4]. At the same time, racially motivated hate and violence have profound and lasting impacts on individual and community wellbeing. These impacts extend beyond immediate injury to include psychological trauma (both diagnosed and undiagnosed), chronic stress, and intergenerational harm[5]. Recent incidents involving racially motivated hate and threats of violence against Aboriginal and Torres Strait Islander communities – including an attempted terrorist attack targeting protesters at an Invasion Day rally in Perth earlier this year and 'booing' during Welcome to Country ceremonies at ANZAC Day services across Australia – highlight the ongoing and pervasive nature of these risks[6][7].

Australia is a signatory to international human rights frameworks, including the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which affirms the rights of Aboriginal and Torres Strait Islander people to equality, dignity and freedom from discrimination and violence[8]. However, significant gaps remain in the policy, legal and institutional protections against racism, hate and violence – requiring urgent action across all sectors and levels of government[9].

The RACP's submission outlines the systemic and structural nature of racism and its impacts on the health of Aboriginal and Torres Strait Islander people. It also identifies limitations of the Racial Discrimination Act 1975 (Cth) – calling for reforms to better align existing frameworks with international human rights standards that protect the rights of Aboriginal and Torres Strait Islander people and other racialised communities.

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[*] This statement reflects a substantial body of Australian and international evidence on structural and interpersonal racism, Indigenous health inequities, and the ongoing impacts of colonisation on health systems and outcomes (see references).

Recommendations

- **Recognise racism, hate and violence as a patient safety risk:** Explicitly classify racism, hate and violence as risks to patient safety in national safety and quality of care frameworks, requiring reporting, investigation, and system-level responses.

- **Strengthen enforceable legal and professional standards:** While racism, hate and violence are increasingly embedded within professional standards and accreditation frameworks, they are not yet consistently enforced as legally binding obligations. The Inquiry should recommend that cultural safety and 'freedom from racism, hate and violence' be embedded as enforceable duties across health regulation and accreditation systems, including through the Australian Health Practitioner Regulation Agency and the Australian Medical Council. Regulatory and accreditation consequences must apply to both individual practitioners and health services where breaches occur, recognising that failures in cultural safety represent failures in patient safety and quality of care.

- **Reform anti-discrimination and complaints mechanisms to address systemic harm and improve accessibility:** Strengthen the Racial Discrimination Act 1975 (Cth) and related complaints processes to better respond to systemic racism, hate, and violence in healthcare. This includes reducing reliance on individual complaint initiation, developing a uniform approach across jurisdictions to improve accessibility and consistency, and ensuring culturally safe legal support so Aboriginal and Torres Strait Islander people are not burdened with proving systemic harm in isolation.

- **Make cultural safety a mandatory, system-wide enforceable standard of care**: Embed cultural safety as a core, enforceable requirement across all healthcare settings, integrated into accreditation, funding, and performance frameworks. Compliance must be monitored through measurable indicators and linked to institutional consequences where cultural safety failures contribute to harm.

- **Mandate sustained Aboriginal and Torres Strait Islander governance and decision-making authority at all levels of the healthcare system:** Strengthen and resource advisory mechanisms such as Aboriginal and Torres Strait Islander Health Committees and Community Advisory Groups as decision-shaping bodies with defined authority, not symbolic consultation, to capture lived experiences. These structures must be properly funded, independent, and embedded within commissioning, safety, and accountability frameworks.

- **Strengthen institutional accountability for racism, hate and violence as systemic failures:** Require health service boards and executives to be accountable for preventing and responding to racism, hate and violence through mandatory reporting, public transparency, and inclusion of cultural safety and anti-racism indicators in performance frameworks.

- **Transform workforce systems to eliminate racism, hate and violence and support retention:** Establish national targets to grow and retain the Aboriginal and Torres Strait Islander health workforce. Workplace environments must be governed under Work Health and Safety frameworks that explicitly recognise racism, hate and violence as occupational hazards, requiring proactive prevention and zero-tolerance enforcement.

- **Mandate national data collection and transparency:** All health services must collect and publicly report standardised data on racism, hate, violence and culturally unsafe care

experienced by patients and staff. This data must be used for national benchmarking, accountability and system improvement.

- Strengthen investment in Aboriginal Community Controlled Health Organisations: Sustained investment in Aboriginal Community Controlled Health Organisations must be prioritised as core infrastructure for culturally safe care delivery and system reform.

- Establish a National Taskforce on racism, hate and violence in healthcare: This needs Aboriginal and Torres Strait Islander leadership to:

    - Set national standards for cultural safety and anti-racism, including cultural safety indicators to guide uniform compliance across systems and jurisdictions.
    - Oversee implementation of legal, regulatory and system reforms.
    - Monitor racism, hate and violence as a patient safety risk.
    - Coordinate national reporting and accountability frameworks.
    - Advise governments on legislative and funding reform.
    - Report annually to Parliament on progress and system failures.

Submissions

The nature, prevalence and impact of racism, hate and violence towards First Nations people, including trends over time.

Racism, hate and violence are interconnected and generate cumulative harms to the health and wellbeing of Aboriginal and Torres Strait Islander people

Racism, hate and violence are distinct but interconnected drivers of harm that generate cumulative impacts on the health and wellbeing of Aboriginal and Torres Strait Islander people. These harms operate across interpersonal, institutional and structural levels, shaping both outcomes and experiences of healthcare[10]. Leading public health frameworks – including the National Agreement on Closing the Gap, the National Aboriginal and Torres Strait Islander Health Plan 2021–2031, and the Aboriginal Community Controlled Health model – recognise racism as a key determinant of health[11]. These frameworks also acknowledge that 'structural racism' – understood as the interaction of multiple institutions and systems producing cumulative inequities across the life course – is a central driver of disparities in health, social, justice and economic outcomes[12].

While interpersonal, institutional and structural forms of racism are well recognised within health policy, the specific and compounding harms associated with racialised hate and violence are less consistently captured in health and safety frameworks. Racialised hate and violence represent distinct, though interconnected, forms of harm, with differing impacts on health outcomes and engagement with healthcare services[13].

Racialised hate operates through dehumanising attitudes, racial hostility, and discrimination that erode dignity, cultural safety, and trust in health services[14]. This contributes to cumulative psychological harm and reduced service engagement[15]. Violence – including physical, verbal, threatened, or anticipated harm – is a more acute manifestation of this continuum and has a direct impact on service access and continuity of care[16]. In particular, anticipation of harm and heightened vigilance in clinical environments contribute to delayed presentation and interrupted care[17]. The harms associated with racism, hate and violence frequently overlap, as sustained exposure to discriminatory attitudes and structural racism create conditions where violence is normalised, unchallenged, or escalated in broader institutional settings[18].

Exposure to racism, hate and violence drive disparities in outcomes across the life course

Despite efforts under the National Agreement on Closing the Gap to address the disparity in average life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians – a key indicator of health equity – progress against this target remains largely unchanged since implementation and it is not on track to be met by 2031[19]. Notably, there are significant limitations in the accuracy and completeness of data used to monitor this target, constraining a full understanding of progress and need [20].

Aboriginal and Torres Strait Islander people continue to have a higher burden of disease – around 2.3 times that of non-Indigenous Australians – with chronic conditions such as cardiovascular disease, diabetes, respiratory illness, and kidney disease disproportionately affecting communities[21].

Aboriginal and Torres Strait Islander babies are twice as likely to be born with low birthweight compared to non-Indigenous babies, which is a key predictor of lifelong health risk[22]. At the same time, mental health, trauma (including physical and psychological) and substance use disorders represent the leading contributors to the burden of disease, with significantly higher rates of psychological distress and suicide linked to experiences of racism, trauma, and social exclusion[23].

Racism is embedded within a broader context of structural violence and cross-system failures that have direct health consequences. Aboriginal and Torres Strait Islander people comprise only 3.8% of the population, yet account for around 37% of the adult prison population, with imprisonment rates increasing by 15% between 2019 and 2023[24]. Deaths in custody also occur at disproportionately higher rates and younger ages than for non-Indigenous people. As of December 2025, there have been 629 Aboriginal and Torres Strait Islander deaths in custody – the highest in four decades[25]. Between 2024 and 2025 there were 33 reported deaths – marking a significantly higher number of deaths in custody (including in prison, police, and youth detention settings)[26]. Many of these deaths are associated with chronic disease, suicide, or inadequate access to timely and culturally safe care, all of which are linked to preventable harm and mortality[27].

Violence in the community also reflects the interconnected nature of racism, hate and violence on health and wellbeing. Aboriginal and Torres Strait Islander people are hospitalised for family and domestic violence at rates up to 32 times higher than non-Indigenous Australians[28]. Women are significantly overrepresented in domestic violence related homicides, with perpetrators often being current or former intimate partners – including non-Indigenous men in cross-cultural contexts[29].

Reports of racism in healthcare are high and increasing

National data indicates that at least 20% of Aboriginal and Torres Strait Islander people report experiencing racism in healthcare settings, with higher rates in some jurisdictions[30]. More recent data suggests that incidents of racism are rising, with 51.8% of Aboriginal and Torres Strait Islander adults reporting experiences of interpersonal racism when seeking care from health services since the 2023 Indigenous Voice Referendum – a significant increase from previous years[31]. Reports of vicarious racism also remain elevated with 78.8% of Aboriginal and Torres Strait Islander adults indirectly witnessing or hearing about discriminatory behaviour in healthcare settings[32].

While 33% of Aboriginal and Torres Strait Islander people report experiences of racism, reporting across systems is low – suggesting the true prevalence of racism and harm is not accurately captured through formal reporting mechanisms. This limits the effectiveness of system level responses[33].

Racism, hate and violence is a serious risk to patient safety and quality of care

The persistence of racism, hate and violence within healthcare settings is fundamentally incompatible with the delivery of safe, high-quality care. The Quintuple Aim – which extends the Quadruple Aim to explicitly include health equity – requires health systems to improve population health, enhance patient experience, support the workforce, reduce costs, and achieve equity[34]. Racism directly undermines each of these aims, contributing to preventable harm, reduced access to care, poorer clinical outcomes, and workforce distress.

Despite this, racism, hate and violence are not consistently recognised or addressed as core patient safety risks within existing regulatory and quality frameworks[35]. This represents a critical gap in fulfilling the duty of care owed to Aboriginal and Torres Strait Islander people and preventable harm. Addressing this gap requires both formal recognition of racism as a patient safety risk and the establishment of enforceable accountability mechanisms across the healthcare system[36].

Aboriginal and Torres Strait Islander patients self-discharge against medical advice at five times the rate of non-Indigenous Australians[37]. Racism is a key driver of this pattern, with many patients' reporting interpersonal racism, absence of cultural safety in hospitals, experiences of isolation and loneliness, mistrust in the health system or association of hospitals with death as reasons for leaving care early[38]. Discharge against medical advice can lead to delayed diagnosis, undertreatment of critical health conditions, service disengagement and premature death[39].

Evidence from coronial inquests demonstrate that structural racism contributes directly to preventable morbidity and mortality. Analysis of coronial findings relating to rheumatic heart disease deaths in the remote Queensland town of Doomadgee, have described many of these mortalities as '100% preventable' and 'attributable to systemic failures'[40]. Institutional racism, fragmented service delivery, and failures to listen to patients and families were central contributors to these outcomes[41]. Patients were frequently discharged without adequate assessment, and families were required to advocate persistently for escalation of care – demonstrating a failure of basic clinical safety processes[42]. Aboriginal and Torres Strait Islander people experience a vastly disproportionate burden of rheumatic heart disease – up to 582 times higher than non-Indigenous populations – yet without corresponding access to timely, appropriate, and culturally safe healthcare[43]. This disparity reflects structural inequities rather than biological difference, and is compounded by patient experiences of dismissal, disbelief, and unsafe care environments[44].

Further evidence from the Bamaga Hospital investigation reinforces these findings, identifying failures in clinical governance, communication, and escalation of care in the death of a young Torres Strait Islander child[45]. The Bamaga Hospital investigation highlighted missed opportunities for early intervention, inadequate responses to parental concerns, and systemic gaps in service delivery in a remote context[46]. These failures occurred within a broader context of inequitable access to healthcare and culturally unsafe care environments[47].

Experiences of racism, hate and violence impact childhood outcomes into adulthood

The prevalence of racism across systems generates cumulative and intergenerational exposure to violence and harm, with institutional drivers compounding disadvantage over the life course and contributing to persistent inequities in health and wellbeing outcomes[48].

Aboriginal and Torres Strait Islander children are approximately 21 times more likely to be in youth detention than their non-Indigenous counterparts, experience higher rates of repeat contact, and are more likely to be involved in the youth justice system from an earlier age – with some children as young as 10 years of age experiencing incarceration[49]. Data indicates that around 45% of Aboriginal and Torres Strait Islander children in custodial settings are more likely to return to supervision within 12 months of initial contact[50]. The disproportionate involvement of Aboriginal and Torres Strait Islander

children in the youth justice system reflects broader structural inequities, exposing them to harmful environments that compound trauma, disrupt healthy development, and contribute to poorer physical, mental and social outcomes in adulthood[51].

Racism, hate and violence effects workforce sustainability and access to healthcare

Racism in the health system is embedded in institutional practices, hierarchies (including within medical schools and specialist colleges) and norms, shaping career progression, workplace safety, and professional inclusion[52]. This has direct implications for workforce sustainability and access to culturally safe care, as it drives low retention rates of Aboriginal and Torres Strait Islander health workers and inhibits equitable representation across the healthcare system [53].

The prevalence of Aboriginal and Torres Strait Islander health workers, including physicians, experiencing racism and discrimination is high. The 2025 Medical Training Survey found that 38% of Aboriginal and Torres Strait Islander doctors in training experienced or witnessed racism, more than double the rate of their non-Indigenous peers, while over half were exposed to bullying, discrimination, harassment or racism overall[54].

Beyond direct experiences of racism, Aboriginal and Torres Strait Islander health workers carry a disproportionate and often unrecognised 'burden of care'. This includes additional cultural responsibilities, supporting Aboriginal and Torres Strait Islander patients and families, educating non-Indigenous colleagues, and navigating culturally unsafe work environments[55]. The unrecognised burden of care contributes to higher rates of burnout, moral distress, and workforce attrition[56]. Systemic assumptions that Aboriginal and Torres Strait Islander health workers are singularly responsible for improving Aboriginal and Torres Strait Islander health outcomes also compounds these dynamics – shifting structural responsibility onto individuals[57].

Initiatives that are effective in combating racism targeted at First Nations people and reduce individual and collective harm.

Self-determination and whole-of-systems reform that captures the lived experiences of Aboriginal and Torres Strait Islander people is needed

Addressing the impacts of racism, hate and violence requires a coordinated, whole-of-systems response. Approaches to combatting racism, hate and violence must extend beyond individual level interventions and embed structural reform across the health system, justice systems, education and employment sectors. Central to this is the recognition and operationalisation of Aboriginal and Torres Strait Islander self-determination in policy design, service delivery, and evaluation[58].

The RACP Aboriginal and Torres Strait Islander Health Committee and Consumer Advisory Group are critical to ensuring that lived experience meaningfully informs policy, clinical practice, and healthcare system reforms. By capturing the lived experiences and perspectives of Aboriginal and Torres Strait Islander people, systems will be better positioned to identify structural barriers, strengthen accountability, and design responses that are culturally safe, equitable, and effective. This needs to be embedded in governance and decision-making processes to advance justice and equity [59].

Sustained investment in Aboriginal and Torres Strait Islander trainee physicians

Sustained investment in Aboriginal and Torres Strait Islander trainee physicians is a critical component of reform, with current national workforce data showing Aboriginal and Torres Strait Islander doctors remain significantly underrepresented in the specialist workforce, comprising approximately 0.3% of all medical specialists in Australia. This highlights a profound workforce inequity with direct implications for access to culturally safe care and health outcomes[60].

The small number of physicians also reflects structural inequity in specialist progression, with Aboriginal and Torres Strait Islander doctors remaining concentrated in earlier training stages and few progressing to Fellowship across specialty colleges[61]. National workforce reporting highlights persistent barriers in recruitment, retention, and advancement through specialty training pathways, contributing to long-term 'lag indicators' of representation[62]. In some specialties, the low number of Fellows results in little to no historical representation, emphasising the limited nature of specialist diversification in certain disciplines[63].

Aboriginal and Torres Strait Islander physicians play a key role in reducing the health harms associated with racism, hate, and violence by fostering cultural safety and accountability. Their presence helps ensure that healthcare teams are more aware of unconscious biases and systemic racism, which promotes respectful care and communication with patients. They also build trust with communities through shared cultural backgrounds, which can reduce feelings of fear and mistrust – improving patient engagement with healthcare services.

Aboriginal and Torres Strait Islander physicians also act as educators – challenging stereotypes, providing anti-racism training, and advocating for policies that promote equity and cultural awareness in the healthcare system. This helps shift attitudes towards understanding the impacts of historical racism and violence on health and wellbeing and ensures that Aboriginal and Torres Strait Islander patients are treated with dignity and respect. Their leadership and visibility in the workforce also disrupt racist narratives, which encourages more inclusive and supportive environments for all.

Addressing interpersonal racism through workforce education and accountability

To prevent interpersonal racism in healthcare settings, sustained investment in workforce education alongside robust accountability mechanisms is essential[64]. Healthcare services must provide high-quality, ongoing professional development in cultural safety that supports critical reflection and behaviour change. This includes building awareness of unconscious bias, understanding the impacts of colonisation and systemic racism, and strengthening culturally responsive clinical practice[65].

Education alone is insufficient without accountability. Healthcare systems must implement clear processes to identify, respond to, and prevent culturally unsafe behaviours. Embedding cultural safety within undergraduate and specialist training programs will help to ensure a future workforce capable of delivering equitable and respectful care[66].

Addressing racism through the social determinants of health

Addressing the social determinants of health, particularly poverty, is essential to eliminating racism and achieving health equity. Racism and poverty are deeply interconnected, with each reinforcing inequities in housing, education, employment, income security, and contact with the justice system[67]. These overlapping structural disadvantages compound over time, driving persistent and preventable disparities in health outcomes for Aboriginal and Torres Strait Islander people[68].

Community-led initiatives such as those developed by organisations like Wilya Janta demonstrate the importance of addressing these determinants through self-determined, place-based approaches. Policies that meaningfully reduce poverty through access to safe and affordable housing, quality education, secure and culturally safe employment, and adequate income support are also critical anti-racism measures[69].

The effectiveness of avenues for reporting and responding to racism against Aboriginal and Torres Strait Islander people, including the consistency, timeliness and appropriateness of outcomes across jurisdictions and institutions.

Without reform to the Racial Discrimination Act 1975 (Cth) to address structural racism and embed proactive obligations on institutions, complaint mechanisms will continue to fall short in preventing harm caused by exposure to racism, hate and violence.

Fragmentation across systems limits consistency and accountability

Current avenues for reporting and responding to racism, hate and violence are fragmented across jurisdictions, sectors, and institutions, resulting in inconsistent, opaque, and often ineffective outcomes[70]. Multiple complaint pathways – including through health services, professional regulators, human rights commissions, and ombudsman bodies – operate independently under different standards, processes, and levels of accountability[71]. This fragmentation limits the ability to identify systemic patterns of racism or drive coordinated reform. Responses to racism, hate and violence are often siloed, with limited data sharing, inconsistent monitoring, and an absence of a coherent national approach to addressing harm across systems[72].

Complaint-based frameworks drive reactive responses and underreporting

The Racial Discrimination Act 1975 (Cth) underpins many formal reporting pathways but remains primarily complaint-driven and focused on individual acts of discrimination, effectively placing the burden on Aboriginal and Torres Strait Islander people to initiate and sustain complaints[73]. These processes are often not culturally safe or accessible, contributing to significant underreporting – particularly in healthcare settings where power imbalances, fear of repercussions, and prior experiences of racism, hate and violence further inhibit engagement[74]. Underreporting is also compounded in smaller or remote communities, where maintaining confidentiality and privacy is difficult, and where high visibility and limited anonymity can discourage disclosure[75].

Outcome data demonstrates the limitations of these reporting mechanisms, with fewer than half of complaints resolved through conciliation and many being terminated, withdrawn, or discontinued

due to evidentiary thresholds, jurisdictional constraints or procedural burden[76]. This reinforces concerns that complaint-based systems rarely deliver timely or meaningful redress and reproduce inequity by relying on individual navigation of complex processes[77].

Broader system performance and accountability settings also reflect the inefficiencies of existing frameworks, where formal legal protections are not consistently translated into operational action. In New South Wales, there have been repeated attempts to strengthen provisions designed to address racial vilification and violence, but enforcement outcomes remain low[78]. Since commencement in 2018, only seven people have been charged for race related offences, and one person convicted, with several matters not proceeding or resulting in no sustained conviction outcomes[79].

While escalation mechanisms, such as Ryan's Rule (Queensland), are intended to provide an additional pathway for families and patients to raise urgent concerns, their effectiveness is constrained by cultural and systemic barriers for Aboriginal and Torres Strait Islander people. In places such as Bamaga and Doomadgee – where kinship, community relationships, and prior experiences of institutional racism shape how care is experienced – escalation is not always perceived as safe or effective. Families may feel reluctant to challenge clinical authority or activate formal escalation processes that are embedded in the same system responsible for previous harm[80].

Structural racism is not adequately captured or addressed in legislative frameworks

Australia's current legislative framework does not enable systemic investigations or adequately recognise the collective rights of Aboriginal and Torres Strait Islander people, such as self-determination, limiting its effectiveness in addressing the root causes of racism and health inequity[81]. Under the Racial Discrimination Act 1975 (Cth), there is no requirement for health services and other organisations to monitor racism, hate and violence or implement systemic change. This significantly reduces organisational capacity, even where racism is identified, to mandate meaningful reform and contributes to environments that continue to perpetuate harm[82].

Cultural safety as an enforceable standard within reporting and accountability systems

Existing mechanisms for reporting and responding to racism, hate, and violence are significantly constrained when cultural safety is not embedded and consistently applied as an enforceable standard of care across jurisdictions and institutions. Embedding enforceable cultural safety standards within regulatory and complaints frameworks would improve consistency, transparency, and timeliness of responses, while strengthening institutional accountability – contributing to safer, more equitable healthcare for Aboriginal and Torres Strait Islander people[83].

If you require further information or would like to engage with us, please contact the Head of Indigenous Affairs – Australia via lee.bradfield@racp.edu.au . We look forward to hearing from you.

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