Implementing the cultural determinants of health: our knowledges and cultures in a health system that is not free of racism

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Our Indigeneity is authenticated and central to the commentary contained in this perspective article. Centring our ways of being, knowing and doing rightfully places our knowledges and cultures, visibly, in the work that we do as policy actors, who have relational and obligatory responsibilities, to our families and communities, relating to respect, reverence and reciprocity. These are cultural protocols of practice that are inherently enshrined in the way that we are expected to behave, when doing the doing, of the work that we do, as policy actors in research and beyond (Supporting Information).

In Australia, Aboriginal and Torres Strait Islander people's (hereafter respectfully referred to as Indigenous) health outcomes remain unjustifiably poor, with policy making requiring urgent reframing.

Policies produced and implemented by policy makers and health care providers are being dominated by Western European Australian biomedical knowledge systems. If we are to reform a health system that is failing to reduce health inequities and is not free of racism, the cultural determinants of health (CDoH), which are the knowledges and cultures held and owned by Indigenous peoples, must be front and centre to transforming government services.[1] When designing, implementing and evaluating policies and services, power sharing, underpinned by doing things with, and not to, Indigenous people, is critical, while brokering systems change that guarantees:

- privileging of Indigenous voices, control, direction and codesign;
- leadership by and collaboration with Indigenous scholars and experts; and
- greater self-determination, decision making, governance and control by Indigenous Peoples, who are the disruptors, deconstructors and decolonisers of Western knowledge systems and cultures.[2-4]

Importantly, CDoH are key to improving health and wellbeing for Indigenous Peoples.[5] The CDoH are based on Indigenous knowledges, are rights-centred, and provide a stand-alone determinant of health for all Aboriginal and Torres Strait Islander Peoples.[6] The CDoH reflect the United Nations Declaration on the Rights of Indigenous Peoples, including but not limited to: self-determination; freedom from discrimination; individual and collective rights; freedom from assimilation and destruction of culture; connection to, custodianship and utilisation of Country and traditional lands; and protection and promotion of traditional knowledge and Indigenous intellectual property.[6-8]

Professor Ngaire Brown describes the CDoH as:

> [CDoH] originate from and promote a strength based perspective, acknowledging that stronger connections to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health including education, economic stability and community safety.[8]

Although a readiness to implement CDoH exists, there remains deep-seated resistance stemming from systemic institutional racism, inherent in structural elements of organisations, including within their subsystems, where unknowingly individuals perpetuate racism and are complicit in sustaining health inequities.[2] Along with an unwillingness to recognise and respect Indigenous Australian's values, knowledges and cultures, the implementation of CDoH within policies and health care practice is prevented.[2] Policy analysis, research and services must normalise Indigenous knowledges and voices that move beyond the European Australian biomedical lens on health and, rigorously and intentionally, interrogates racialised systems and structures of racism. Genuine leadership and engagement of Indigenous people in such system interrogation is imperative.

Despite being rejected by the majority of Australian voters, the Australian Medical Association demonstrated such leadership by fully endorsing the proposed Indigenous Voice to Parliament, aimed at permanently privileging an Aboriginal and Torres Strait Islander voice of knowledges, in the design and implementation of policies, as they related to Indigenous Australians.[9]

For system leaders and decision makers, including clinicians and health care providers, to contribute to transforming government services,[1] it is imperative that they know that the cultures of Aboriginal and Torres Strait Islander Peoples are about our knowledges that have been scientifically developed for well over 65 000 years. Our knowledges relate to cultural ways of knowing, being and doing that encapsulate lived experiences and oral knowledges obtained from stories told by communities, leaders or community-controlled organisations.[2] These knowledges also include the six domains of culture, namely: connection to Country; Indigenous beliefs and knowledge; Indigenous languages; family, kinship and community; cultural expression and continuity; and self-determination and leadership.[10]

Indigenous peoples' oral knowledges and stories are devalued and often dismissed as irrelevant.[2] This

non-Indigenous viewpoint is further exacerbated when we consider that the space where knowledge systems interact is a highly contested area[11] that fails to avoid the dominance or diminishing of one knowledge system over the other.[12,13] Presently, Western European Australian knowledge systems, especially biomedical sciences, dominate Indigenous peoples' knowledge systems, thus reinforcing the continuation of colonisation processes.[2] These imbalances continue and maintain the historical and ongoing lack of relationships, connection and understanding between Indigenous and non-Indigenous people and their cultures.

Non-Indigenous people will never understand Indigenous peoples' world views but what they do need to know and prioritise when working with Indigenous Peoples within health systems, is that our culture is about our knowledges and, importantly, that our knowledges count.[2] Critically, non-Indigenous Australians must take a purposeful journey of learning, by walking alongside Indigenous peoples, with a willingness to listen, with open minds and hearts, to hear the knowledges contained in stories.[2] Crucially, the legacy of colonisation must be understood, especially the impacts of past racist policies that prohibited Indigenous Australians from practising their cultures and knowledges and demoralising their very existence. Similarly, systemic racism and its structural biases and institutional impediments must be understood, otherwise implementation of the CDoH cannot occur.[2]

Australia must acknowledge that a new approach is warranted for resolving complex organisational structural and systemwide systems of racism. Notably, an approach is needed that provides the means for sharing power, authority and opportunity to enable the voices of Indigenous Australians to be heard, so that they can express their knowledges and cultures of ways of being, knowing and doing in the production, implementation and evaluation of public health policies, programs and services. Permanently embedding, Indigenous knowledges and Indigenous cultures (the CDoH), into the design, delivery and evaluation of policies, programs and services, is urgently required. Using policy tools and instruments that give effect to Indigenous knowledges, and cultures, of ways of being, knowing and doing, into public health policies and practices, is essential. This process requires health systems to ensure these are normalised and included by default.

Tackling systems and their subsystems is paramount when enabling, embedding and enacting Indigenous knowledges and cultures within a health system that is not free of racism.[13] Understanding the interconnectedness of the complexities within systems when applying system thinking approaches assists in understanding the wholeness of a social phenomenon, in contrast to a linear and often limiting public health response of cause and effect. Importantly, systems must be consistent with Indigenous Australians' values, knowledges and cultures, and must be underpinned by six guiding principles, as follows:[2,13]

- the voices, knowledges, cultures and worldviews of Indigenous communities must be privileged in a way that makes it permissible to work within that cultural context — a cultural match;
- community-led, community-owned and community-determined solutions and priorities that adopt a place-based approach to codesigning initiatives in equal partnership with governments is paramount;
- community-directed inclusive decision-making coalitions that are elected by community and are held accountable to community are imperative;
- rebuilding Indigenous nations by means of revitalising, reclaiming and embedding language and lore throughout communities in Australia is warranted;
- governance structures that are conducive to embedding Indigenous Australian's voices, knowledges, cultures and worldviews of ways of being, knowing and doing into policy and program production, implementation and evaluation are mandatory; and
- accountability mechanisms that hold governments accountable to communities are a necessity (personal communication from DM).

Until these principles become normalised, transforming government services through systems levels, change will remain impossible. Current racialised attitudes and institutionally racist rules of racism will remain as barriers, and improvements to health outcomes for Indigenous Australians will continue to be unattainable.

We invite all within the health care sector to take a purposeful journey of learning by walking alongside Aboriginal and Torres Strait Islander people, and listening to their knowledges of cultural ways of being, knowing and doing, with open minds and hearts. Gaining a deeper understanding of the profoundly damaging impacts of colonisation and previous racist and exclusionary government policies through truth telling can shift policy and practice. By including and acting upon the CDoH, all non-Indigenous health practitioners and systems can be part of reversing centuries of exclusion through racism, and racially driven health inequities, which have been the normalised experience of Aboriginal and Torres Strait Islander People.

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Supporting Information

Additional Supporting Information is included with the online version of this article.