Australian Commission on **Safety and Quality** in Health Care

Evidence to inform options for standards for cultural safety

Rapid literature review and environmental scan:
Standards for First Nations cultural safety in health care

Prepared by: Jayde Fuller, Director, Indigenous Regulatory Practice

Prepared for: Australian Commission on Safety and Quality in Health Care

Date: July 2026

Acknowledgement of Country

This work was conducted on Quandamooka Country. The Quandamooka peoples include the Nunukul, Nughi and Goenpul peoples. Their Country takes in Minjerribah (North Stradbroke Island), Moorgumpin (Moreton Island) and the sea Country of Moreton Bay. I acknowledge them as Traditional Custodians of this land and sea. I pay my respects to their Elders, past and present. Sovereignty was never ceded.

I am a Gamilaraay woman. My Country is in north-western New South Wales – vast, dry and alive. I carry it with me wherever this work takes me. I acknowledge the Gamilaraay people and our Elders, past and present. My obligations to community underpin everything I do.

This review draws on research, practice and testimony by indigenous peoples across four jurisdictions. I acknowledge the intellectual and cultural labour of researchers, Elders, community members and health practitioners. Their knowledge makes this work possible.

This work is offered in the spirit of that accountability.

Document information

Suggested citation: Fuller J. Evidence to inform options for standards for cultural safety: rapid literature review and environmental scan. Sydney: ACSQHC; 2026.

About the author: Jayde Fuller is a Gamilaraay woman and the Director of Indigenous Regulatory Practice. She has extensive experience in health regulation, cultural safety policy and Indigenous health governance. She managed the consultation process that produced the National Scheme's cultural safety definition embedded in the National Registration and Accreditation Scheme.

Published by the Australian Commission on Safety and Quality in Health Care
Level 5, 255 Elizabeth Street, Sydney NSW 2000
Phone: (02) 9126 3600
Email: mail@safetyandquality.gov.au
Website: safetyandquality.gov.au
ISBN: 978-1-923353-66-4

© Australian Commission on Safety and Quality in Health Care 2026
All material and work produced by the Australian Commission on Safety and Quality in Health Care (the Commission) is protected by copyright. The Commission reserves the right to set out the terms and conditions for the use of such material.

As far as practicable, material for which the copyright is owned by a third party will be clearly labelled. The Commission has made all reasonable efforts to ensure that this material has been reproduced in this publication with the full consent of the copyright owners.

With the exception of any material protected by a trademark, any content provided by third parties and where otherwise noted, all material presented in this publication is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International licence.

If you would like to reproduce all or part of this resource, please complete our online form at safetyandquality.gov.au/permission-request.

Disclaimer
The content of this document is published in good faith by the Commission for information purposes. The document is not intended to provide guidance on particular healthcare choices. You should contact your health care provider for information or advice on particular healthcare choices.
The Commission does not accept any legal liability for any injury, loss or damage incurred by the use of, or reliance on, this document.

Contents

Acknowledgement of Country 2
Document information 2
Contents 3
Executive summary 5
Background 5
Scope and methodology 5
Key findings 5
Background 7
Aboriginal and Torres Strait Islander health and the health system 7
Cultural safety in health care 8
Policy and regulatory context 8
Objective 9
Research questions 9
Scope 9
Definitions and terminology 10
Limitations 11
Reference list – Background 13
Part A: Rapid literature review 14
Introduction 14
Methodology 14
Results 21
Analysis 22
Discussion 42
Conclusion 45
Reference list – Part A 47
Part B: Environmental scan 52
Introduction 52
Methodology 53
Results 55
International Scan 78
Analysis 86
Discussion 89
Conclusions 92
Reference list – Part B 96
Appendix A: Search strategy - Part A (Rapid Literature Review) 101
A.1 Summary search log 101
A.2 Database-specific search strings 102

Appendix B: Search strategy - Part B (Environmental Scan) 106
Appendix C: PRISMA flow diagram – Part A 108
Appendix D: Abbreviations and acronyms 112
Glossary 114

Executive summary

Background

This report was commissioned by the Australian Commission on Safety and Quality in Health Care (the Commission). It presents a rapid literature review and an environmental scan. Together, they address a critical gap in Australia's health system. Formal obligations for culturally safe care exist, but the structural mechanisms to enforce and measure them, and to hold the system accountable, are missing.

This review provides an evidence base to inform the Commission's options for a national cultural safety standard. This standard could take a range of forms and need not sit within the National Safety and Quality Health Service (NSQHS) Standards.[1] It examines what the evidence shows about how cultural safety can be defined, measured and held to account in hospital care, including what a move from competency-based to accountability-based approaches could involve.

Scope and methodology

This report has two parts. Part A is a rapid literature review of 145 peer-reviewed papers. The search covered eight bibliographic databases and was run on 23 April 2026. The papers span four jurisdictions: Australia (48%), Canada (31%), Aotearoa New Zealand (12%) and the United States (6%). They cover the period 2011–2026, with two exceptions for key foundational papers. A culturally adapted quality assessment was applied at full-text review.

Part B is an environmental scan of the policy landscape across the same four jurisdictions. It examines four policy areas: definitional and conceptual frameworks; regulatory and standards instruments; governance and accountability structures; and implementation models and measurement. The scan identifies what is currently in place, what is missing, and what other jurisdictions have achieved.

Both parts address five research questions (RQs) developed by Jayde Fuller in consultation with, and approved by, the Commission:

1. RQ A asks what cultural safety means.
2. RQ B asks how it should be measured.
3. RQ C asks what governance mechanisms drive system-level change.
4. RQ D asks what conditions produce structural transformation, and what Australia's comparator jurisdictions reveal.
5. RQ E asks what is required to shift the National Standards from a competency to an accountability approach.

Key findings

The findings that follow translate the architectural gap identified in this scan into the specific elements the combined evidence supports. They are offered as inputs to the Commission's options analysis and stakeholder engagement, not as a determination of which instrument should carry them.

As established throughout this review, whether the review of the National Standards, a standalone national cultural safety standard or another model is the most appropriate vehicle is a question for the consultation that should follow.[1] What the evidence does identify is the set of features any such instrument would need to share to close the accountability gap rather than reproduce it. Each feature below should therefore be read as a design direction for consultation: evidence-supported in substance, with its final form, sequencing and implementation appropriately shaped by Aboriginal and Torres Strait Islander communities and the stakeholders the Commission engages.

1. The evidence supports aligning the definitional language of any national standard with the National Scheme's binding definition of cultural safety. The National Scheme defines cultural safety as a patient-determined outcome, shaped by ongoing practitioner reflection on knowledge, skills, attitudes and power differentials. This alignment would replace competency-based framing across all relevant Standard actions. It should be explicitly cross-referenced to the *National Scheme's Aboriginal and Torres Strait Islander Health Strategy 2026–2031* to ensure regulatory coherence.[2,3]

2. The evidence supports establishing binding, specific organisational requirements directed at demonstrable outcomes in the experience of Aboriginal and Torres Strait Islander patients and communities, rather than at process documentation. Such requirements would specify what organisations must show has changed, not what they must have completed, and would include explicit criteria for assessor judgment during accreditation surveys. The *BCCNM practice standard* and the *Health Standards Organization* national standard provide directly relevant architectural precedents.[4,5]

3. The evidence supports requiring community-reported cultural safety measurement as a condition of accreditation. No nationally scaled, Aboriginal and Torres Strait Islander-governed measurement framework for cultural safety in health care currently exists in Australia – itself a structural finding requiring remedy. Any measurement infrastructure would need to be co-designed and co-governed with Aboriginal and Torres Strait Islander communities and organisations, consistent with the *Maiam nayri Wingara Indigenous Data Sovereignty Principles*[6] and *Ownership, Control, Access and Possession (OCAP)* principles.[7] The *AIHW Cultural Safety Monitoring Framework* offers a starting point, with its scope and governance subject to that co-design process; self-assessed compliance documentation would not satisfy this feature.[8]

4. The evidence supports requiring accredited health services to publicly report progress against cultural safety outcomes annually, using formats and channels accessible to the Aboriginal and Torres Strait Islander communities each service serves. Public reporting obligations would specify minimum content – including patient experience data, workforce cultural safety training outcomes, and progress against service-level improvement plans – with compliance forming a condition of accreditation.

5. The evidence supports establishing an Aboriginal and Torres Strait Islander community oversight mechanism with formal authority rather than advisory status, able to assess organisational cultural safety performance between accreditation cycles. Such a mechanism would be independently resourced and empowered to receive concerns from Aboriginal and Torres Strait Islander patients and communities outside formal complaints processes. It would be co-designed with the community-controlled health sector, including the National Aboriginal Community Controlled Health Organisation (NACCHO) and its affiliates, and would draw on existing community-controlled governance models.

Background

The Australian Commission on Safety and Quality in Health Care (the Commission) has been funded by the Australian Government Department of Health, Disability and Ageing (the Department) to review model standards for cultural safety for Aboriginal and Torres Strait Islander peoples and to develop options for a national cultural safety standard for hospitals. This project also includes informing the development of Aboriginal and Torres Strait Islander cultural safety requirements for inclusion in the third edition of the National Standards.

The Commission commissioned a rapid literature review and environmental scan on cultural safety and best-practice models of cultural safety in health care, including models outside the hospital system. The findings will support the Commission's broader evidence-gathering and analytical objectives for the Standards for First Nations Cultural Safety Review project. They will inform options and recommendations to improve cultural safety in hospital settings in Australia.

The Commission is currently reviewing and developing the third edition of the National Standards. A key objective is to strengthen cultural safety in hospital care. The goal is to move from measuring institutional activity to requiring evidence of culturally safe care. That evidence must come from Aboriginal and Torres Strait Islander patients, families and communities.

This report - a rapid literature review (Part A) and environmental scan (Part B) - provides a significant component of the evidence base for that work.

Aboriginal and Torres Strait Islander health and the health system

Aboriginal and Torres Strait Islander peoples have sustained sophisticated systems of knowledge, law, governance and healing for over 60,000 years. Their resilience and self-determination are the starting point for any honest analysis of Aboriginal and Torres Strait Islander health. The health system's relationship with indigenous peoples must be understood in this context. It is not a story of deficit. It is a story of a system that has repeatedly failed people who have always known how to care for themselves.

Aboriginal and Torres Strait Islander peoples in Australia experience significantly poorer health outcomes across most indicators compared with non-Indigenous Australians.[14] These disparities are not explained by individual behaviour or biology. They are the predictable consequence of colonial structures: dispossession, disruption of culture and family, institutional racism and systematic underfunding of Aboriginal and Torres Strait Islander-controlled health services. These structures shaped the health system. It continues to reproduce them.

Part A's evidence is consistent: these outcomes are neither inevitable nor primarily the result of clinical failure. Poor outcomes result from governance arrangements that vest decision-making authority in institutions rather than communities. These arrangements measure process compliance rather than patient experience. They have not addressed the conditions that make indigenous peoples unsafe in the health system.

Aboriginal Community Controlled Health Organisations (ACCHOs) are community-owned and governed primary health care services. They are represented nationally by NACCHO, the sector's peak body; each ACCHO is independently incorporated and governed by its local community. ACCHOs are the strongest domestic evidence that change is possible. They consistently deliver better health outcomes for Aboriginal and Torres Strait Islander patients, with stronger cultural safety, higher patient trust and more integrated care than mainstream services.[18] They are not an alternative to the mainstream system. They are evidence of what the mainstream system could produce if governed differently.

Cultural safety in health care

Cultural safety is distinct from related concepts used across the Australian health system: cultural awareness, cultural sensitivity, and cultural competency. This distinction is not semantic. Each concept makes different assumptions about where the problem lies, who is responsible, and what success looks like.

Cultural safety was developed in Aotearoa by Ngāi Tahu nurse-academic Dr Irihapeti Ramsden.[9-11] Her formulation established that cultural safety is an outcome of nursing education that 'enables safe service to be defined by those who receive the service.' That principle – that the recipient determines safety – is the core of the concept. Cultural safety is not something a health practitioner demonstrates or an institution certifies. It is something a patient or community experiences - or does not.

The Australian Health Practitioner Regulation Agency (Ahpra) administers the National Registration and Accreditation Scheme (NRAS), which covers 16 regulated health professions in Australia. The NRAS definition of cultural safety, embedded in the codes of conduct and registration standards for all 16 professions,[2] is:

> Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

The Commission's definition of cultural safety is a modified version of the NRAS definition.[12] The strongest definitions share five core components. These are: recipient determination; acknowledgement of power differentials; explicit anti-racism requirements; cultural safety as an ongoing practice; and critical self-reflection.

The author of this report managed the consultation process that produced the National Scheme's definition of cultural safety.[2] The definitional architecture of this report reflects that background, and the Commission-endorsed definition is used throughout.

Policy and regulatory context

This review sits within a layered policy and regulatory context. The key instruments are:

- The National Registration and Accreditation Scheme (NRAS), established under the *Health Practitioner Regulation National Law,*[17] as in force in each state and territory. The NRAS governs the registration and conduct of all 16 regulated health professions. It carries statutory authority to impose conditions on practitioners found to be practising in a culturally unsafe manner.
- The *National Standards (Second Edition)*,[13] which provide the accreditation framework for hospitals and health services. Standard 1 (Clinical Governance) and Standard 2 (Partnering with Consumers) are the primary instruments for cultural safety under the current edition. A third edition is under development.[1]
- The *National Aboriginal and Torres Strait Islander Health Plan 2021-2031.*[14] This sets the Commonwealth's overarching policy framework for closing the health gap. Culturally safe health services are a central commitment.
- The *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025.*[2] This governs implementation across the NRAS. Progress is reported through Ahpra's annual reporting cycle.

- The *AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research.*[15] This governs research involving Aboriginal and Torres Strait Islander Peoples and informs the ethical framework for this review.
- The *Australian Government Framework for Governance of Indigenous Data (Indigenous Data Sovereignty principles)*.[16] This framework informs the collection, management, and use of data about Indigenous peoples in this review.
- State and territory health department strategies and frameworks, which embed cultural safety as a policy principle. Application is inconsistent across jurisdictions, and there is no uniform definitional or accountability architecture.

A consistent pattern emerges across these instruments. Obligations, definitions, and policy commitments all exist. But enforcement mechanisms, outcome measurement frameworks, and independent accountability structures are absent or fragmented. This review maps that gap and identifies what is required to close it.

Objective

This review examines the evidence on culturally safe care in hospital settings, as defined by indigenous patients and communities. It identifies the measurement frameworks, governance mechanisms and structural conditions needed to drive change. The aim is to inform options for a national cultural safety standard. A particular focus is what a move from competency-based to accountability-based regulation of cultural safety could involve.

Research questions

The rapid literature review and environmental scan are informed by five research questions developed by Jayde Fuller in consultation with, and approved by, the Commission:

Research Question A (RQ A)

What does the evidence base tell us about what culturally safe care means in hospital settings, as determined by First Nations patients and communities?

Research Question B (RQ B)

What measurement frameworks and indicators have been developed that centre First Nations patient and community experience, rather than institutional self-assessment?

Research Question C (RQ C)

What governance and accountability mechanisms have demonstrably driven systems-level change, rather than compliance activity?

Research Question D (RQ D)

What conditions are required for cultural safety standards to generate structural transformation – and what do the divergent trajectories of Aotearoa and Canada tell us about those conditions?

Research Question E (RQ E)

What is required to shift the NSQHS Standards from a competency-based to an accountability-based regulatory logic for cultural safety?

Scope

Inclusions

Both Part A and Part B include sources from four jurisdictions: Australia, Canada, Aotearoa, and the United States of America. These jurisdictions share structural features of settler-colonial health systems. Comparing their trajectories reveals what political and institutional choices make culturally safe care achievable.

Part A included peer-reviewed literature published between 2011 and 2026. Two pre-specified exceptions were made for key foundational papers. All sources were in English. Sources focused on indigenous peoples in all four jurisdictions. These included Aboriginal and Torres Strait Islander peoples (Australia) and Māori peoples (Aotearoa). Also included were First Nations, Métis and Inuit peoples (Canada) and Native American, Alaska Native, and Native Hawaiian Peoples (United States of America). Sources addressed cultural safety in hospital and health service settings and met a minimum quality threshold.

Part B included policies, strategies, standards, and regulatory instruments from the Commonwealth, state and territory governments, and equivalent international bodies. Sources were published between 2011 and 2026. They were sourced from government health department websites, regulatory bodies, accrediting organisations, and Aboriginal and Torres Strait Islander health bodies. All sources were relevant to at least one of the four policy functions.

Exclusions

Sources were excluded on the following grounds. They focused on populations other than indigenous peoples in the four specified jurisdictions. They were published before 2011, unless they meet the pre-specified exception criteria. They were not available in English. They addressed settings outside the scope of the National Standards, such as aged care. They focused on clinical topics unrelated to cultural safety, governance or accountability. Or they could not be retrieved.

The United States of America was included in the literature review because of the breadth of relevant evidence. It was applied selectively in the environmental scan due to significant differences in health system architecture. Sources were excluded based on topic relevance, not geography.

Definitions and terminology

This review uses the following terminology consistently:

Aboriginal and Torres Strait Islander peoples / First Nations peoples / indigenous peoples: All terms are used in this report. 'First Nations peoples' is used as the overarching term when referring to findings from across Canada and the United States of America.

'Aboriginal and Torres Strait Islander peoples' is used when referring specifically to Australia. 'Aboriginal' and 'Torres Strait Islander' are used separately where the evidence distinguishes between these groups.

‘Indigenous peoples’ with a lower case ‘i ’ to refer to findings from across all four jurisdictions, as specified by the Commission’s style guide.

Cultural safety: Used in accordance with the Commission-endorsed definition throughout this report.[3]Cultural safety is an outcome determined by those who receive care. It is distinguished from cultural awareness, cultural sensitivity, and cultural competency. All three place responsibility with the individual practitioner, not the system.

Structural racism: Refers to the systems, policies, institutional practices, and cultural norms that produce and reproduce racial inequity. In health care, structural racism is not primarily

about individual prejudice. It is about how institutions are designed and how power is distributed within them.

Accountability-based regulation: A regulatory approach in which standards require evidence that outcomes have been achieved. In this context, it means indigenous patients must experience care as safe, not just that specified activities have been completed, and is distinct from competency-based regulation, which measures practitioner or institutional inputs and processes.

Māori: The Indigenous peoples of Aotearoa New Zealand. The diacritical mark (macron) is used throughout this report in accordance with standard te reo Māori orthography.

Aotearoa / Aotearoa New Zealand: Both terms are used in this report. 'Aotearoa' is the te reo Māori name for New Zealand. 'Aotearoa' is used when the context concerns Māori health or policy. 'Aotearoa New Zealand' is used when referring to the jurisdiction more broadly.

Turtle Island: Some sources use this term to refer to North America, particularly in Indigenous contexts in Canada and the USA. Where authors use this term, it is preserved.

Limitations

The following limitations apply to this review and should be read alongside the findings:

- *Rapid review methodology:* Part A uses rapid literature review methods, which are reproducible and systematic but accelerated. Unlike a full systematic review, the timeframe did not permit dual independent screening or formal inter-rater reliability testing. All screening was conducted by the author (Jayde Fuller). This limitation was known at inception and accepted, given the Commission's policy timeframe.
- *Single-reviewer screening:* The risk of selection bias is partly reduced by transparent, predefined eligibility criteria applied at both screening stages. A culturally adapted quality assessment framework was also applied at full-text review. However, the possibility of inconsistency cannot be fully eliminated.
- *Hospital-specific evidence is thin.* The strongest evidence comes from primary care, community-controlled health services and specific clinical contexts – including nephrology, paediatrics and mental health. Acute inpatient hospital settings – the primary environment in which the National Standards operate – are underrepresented. This gap is itself a finding: the Commission is reviewing standards for a setting that is under-researched in the cultural safety literature.
- *Absence of NSQHS evaluation evidence:* There are no strong studies directly evaluating whether the National Standards Second Edition produces culturally safe care in practice. The evidence is richer on what standards say than on what they do. The Commission is therefore reviewing standards without a strong evidence base on their own effects.
- *Underrepresentation of urban indigenous populations:* The evidence base skews toward remote, rural, and community-controlled settings. Urban Aboriginal and Torres Strait Islander patients – who access mainstream hospital services in the largest numbers – are less visible in the literature. Recommendations should not assume that evidence from remote or community-controlled settings transfers directly to urban acute settings.
- *USA evidence applied selectively:* The United States was included in Part A because of the depth of available evidence. It was applied selectively in Part B due to significant differences in health system architecture. USA evidence is used where findings are generalisable to the regulatory context, not where they depend on USA-specific structures.

- *Grey literature:* Part B's environmental scan relies on purposively selected grey literature and policy documents. This literature is not peer-reviewed. Some sources – including the Weenthunga Health Network's *Cultural Safety Accreditation and CPD Upskilling Framework and Strategy 2026–2031* – are unpublished. The relevance and authority of each source are assessed in context, with unpublished status noted where applicable.

Reference list – Background

1. Australian Commission on Safety and Quality in Health Care. Third edition engagement hub [Internet]. Sydney: ACSQHC; 2025 [cited 2025]. Available from: https://www.safetyandquality.gov.au
2. Australian Health Practitioner Regulation Agency. The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025. Melbourne: Ahpra; 2020. Available from: https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx
3. Australian Health Practitioner Regulation Agency. National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2026–2031. Melbourne: Ahpra; 2026.
4. BC College of Nurses and Midwives. Indigenous Cultural Safety, Cultural Humility and Anti-Racism Practice Standard. In force 25 February 2022. Vancouver: BCCNM; 2022.
5. Health Standards Organization. HSO 75000:2022 British Columbia Cultural Safety and Humility Standard. Ottawa: Health Standards Organization; 2022.
6. Maiam nayri Wingara Indigenous Data Sovereignty Collective, Australian Indigenous Governance Institute. Indigenous Data Sovereignty Communique. Canberra, ACT: Maiam nayri Wingara; 2018.
7. First Nations Information Governance Centre. Ownership, Control, Access and Possession (OCAP): the path to First Nations information governance. Ottawa, ON: First Nations Information Governance Centre; 2014.
8. Australian Institute of Health and Welfare. Cultural safety in health care for Indigenous Australians: monitoring framework. Canberra: AIHW; 2023.
9. Ramsden IM. Kawa Whakaruruhau: cultural safety in nursing education in Aotearoa. Wellington: Ministry of Education; 1990.
10. Ramsden IM. Cultural safety in nursing education in Aotearoa (New Zealand). Nursing Praxis in New Zealand. 1993;8(3):4–10.
11. Ramsden IM. Cultural safety and nursing education in Aotearoa and Te Waipounamu [doctoral thesis]. Wellington: Victoria University of Wellington; 2002.
12. Australian Commission on Safety and Quality in Health Care. ACSQHC Combined Glossary. February 2026. Sydney: Australian Commission on Safety and Quality in Health Care; 2026.
13. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. Sydney: ACSQHC; 2021.
14. Australian Government Department of Health and Aged Care. National Aboriginal and Torres Strait Islander Health Plan 2021–2031. Canberra: Department of Health and Aged Care; 2021.
15. Australian Institute of Aboriginal and Torres Strait Islander Studies. AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research. Canberra, ACT: Australian Institute of Aboriginal and Torres Strait Islander Studies; 2020.
16. Department of the Prime Minister and Cabinet. Australian Government Framework for Governance of Indigenous Data. Canberra: PM&C; 2021.
17. Health Practitioner Regulation National Law (Queensland) Act 2023 (Qld).
18. Panaretto KS, Wenitong M, Button S, Ring IT. Aboriginal community controlled health services: leading the way in primary care. Medical Journal of Australia. 2014;200(11):649–652. doi:10.5694/mja13.00005

Part A: Rapid literature review

Introduction

This section presents the rapid literature review (Part A) of the Rapid Literature Review and Environmental Scan commissioned by the Australian Commission on Safety and Quality in Health Care (the Commission).

A rapid literature review applies systematic and reproducible search methods within an accelerated timeframe, making it appropriate for policy and regulatory contexts where evidence must inform decision-making within defined project parameters. Unlike a full systematic review, which prioritises exhaustive retrieval across all available evidence, a rapid literature review provides a structured, transparent, and defensible evidence base calibrated to the scope and timeframe of the Commission.

This review was conducted in accordance with the endorsed search strategy and methodology document (M1 deliverable), which sets out full methodological detail, including the approved research questions, database selection, search string logic, and screening criteria.

Methodology

Search strategy

The search strategy and methodology were developed by Jayde Fuller, Director of Indigenous Regulatory Practice, and endorsed by the Commission. The full search strategy is found in Appendix A.

The search strategy is structured around:

- three core concepts, each comprising primary and related terms as detailed in Table 1 and structured to follow the search string logic (Concept 1 terms AND Concept 2 terms AND Concept 3 terms);
- five research questions;
- bibliographic databases comprising peer-reviewed and published literature using MeSH and free-text terms across eight databases; and
- defined limits detailed in Table 2.

The database search (Stage 1 – Identification) was executed on 23 April 2026.

Core concepts

The concepts detailed in Table 1 identify the primary terms used to build the search strategy.

Table 1. Core concepts, primary and related terms used in the search strategy.

Domain	Primary terms	Related and synonymous terms
Concept 1	Cultural safety	• Cultural humility • Cultural competency/competence • Cultural responsiveness • Culturally safe care • Culturally appropriate care

Domain	Primary terms	Related and synonymous terms
		• Racism in health care • Structural racism • Anti-racism
Concept 2	• Indigenous Peoples • First Nations Peoples • Aboriginal Peoples	**Australia** • Aboriginal and Torres Strait Islander Peoples • Aboriginal Peoples • Torres Strait Islander Peoples • First Nations peoples (Australia) • Indigenous Australians **Aotearoa (New Zealand)** • Māori • Māori health • Tangata whenua • Pacific Peoples (where relevant to Indigenous health equity comparators) **Canada (Turtle Island)** • First Nations (Canada) • Métis • Inuit • Indigenous Peoples (Canada) • Aboriginal Peoples of Canada **United States of America (Turtle Island** • American Indian • Alaska Native • Native American • Indigenous Peoples (United States) • Tribal health
Concept 3	• Health care • Health services	• Hospital* • Inpatient care • Primary health care • Community health • Health system* • Healthcare provider* • Clinician*

Research questions

The Rapid Literature Review (Part A) and Environmental Scan (Part B) are informed by five approved research questions developed by Jayde Fuller in consultation with, and approved by, the Commission.

Research Question A. (RQ A)

What does the evidence base tell us about what culturally safe care means in hospital settings, as determined by First Nations patients and communities?

Research Question B. (RQ B)

What measurement frameworks and indicators have been developed that centre First Nations patient and community experience, rather than institutional self-assessment?

Research Question C. (RQ C)

What governance and accountability mechanisms have demonstrably driven systems-level change, rather than compliance activity?

Research Question D. (RQ D)

What conditions are required for cultural safety standards to generate structural transformation – and what do the divergent trajectories of Aotearoa and Canada tell us about those conditions?

Research Question E. (RQ E)

What is required to shift the National Safety and Quality Health Service Standards (NSQHS) from a competency-based to an accountability-based regulatory logic for cultural safety?

Bibliographic databases

Eight databases were searched for peer-reviewed and published literature:

- MEDLINE (PubMed)
- Embase (Elsevier)
- CINAHL (Cumulative Index of Nursing and Allied Health Literature) (EBSCO)
- PsycINFO (APA/EBSCO)
- Scopus (Elsevier)
- Web of Science (Clarivate)
- Indigenous Studies Portal
- Informit (Aboriginal and Torres Strait Islander Health Collection) (RMIT/Informit)

Forward and backward citation chasing were applied to key papers identified through the database search. This approach captures literature that may not be indexed in mainstream databases, particularly Indigenous-authored and community-controlled research.

Limits

The following limits are applied consistently across all database searches and grey literature sources, in accordance with the Commission's date parameters and evidence specifications.

Table 2. Limits

Limit type	Parameter
Date range	2011–2026 (as specified in the RFQ). This range captures a 15-year evidence base and aligns with the period following the implementation of the 2011 *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*.[1] Exception: foundational theoretical and conceptual literature predating 2011 will be included where it directly underpins the analytical framework for the research questions. This applies specifically to seminal works on the origins and definition of cultural safety (including Ramsden 1992, 2002) and foundational regulatory theory literature that has not been superseded.
Language	English language only (as specified in the RFQ). Non-English language publications will be excluded at the screening stage and recorded in the search log.
Document types	All evidence types will be considered, including: • Peer-reviewed journal articles • Published books and book chapters • Grey literature (government reports, policy documents, guidelines, protocols) • Conference abstracts • Think-tank and advocacy white papers Exclusions: editorials, letters to the editor, and opinion pieces without a documented evidence base will be excluded unless they present original data or analysis directly relevant to the research question.
Geographic scope	The geographic scope spans four settler-colonial jurisdictions with comparable Indigenous healthcare and health regulatory contexts: Australia, Aotearoa (New Zealand), Canada (Turtle Island) and the United States of America (Turtle Island). The jurisdictional population terms listed under Concept 2 in Table 1 were incorporated into search strings to support more precise retrieval of findings. Literature with a primary focus on other jurisdictions will be excluded unless it presents comparative findings that directly address one or more of the four target countries.
Study population	Literature must address First Nations, Aboriginal, Indigenous, Māori, or equivalent population groups in the context of health care. Generic cultural competency or diversity literature that does not specifically address Indigenous Peoples will be excluded.

Screening and selection process

The screening and search process was conducted in two stages by the author (Jayde Fuller).

Stage 1 included title and abstract screening, with all retrieved records assessed against the limits outlined in Table 2.

Stage 2 included full-text review against the agreed inclusion criteria established in the endorsed search strategy (M1 deliverable).

Database searches retrieved 6,560 records. These were pooled with the 347 Commission First Nations Library records and deduplicated together in EndNote, from which 3,194 duplicate records were removed. After deduplication, 3,708 records were carried forward to screening. A further two records were entered independently of the database searches, with no screening decision recorded, giving 3,710 records screened.

Title and abstract screening was conducted by Jayde Fuller against predefined eligibility criteria, resulting in 3,190 records excluded and 520 records progressing to full-text review.

Exclusion reasons at the title/abstract stage were:

- E1 – topic not relevant (n=2,912);
- E2 – not an Indigenous population (n=98);
- E3 – not Australia, Canada, New Zealand, or USA (n=70);
- E4 – duplicate (n=1);
- E5 – not in English (n=4);
- E6 – not available/retracted (n=105).

A full-text review of 520 records resulted in 375 exclusions, with 145 papers meeting all inclusion criteria.

Full-text exclusion reasons were:

- F1 – Indigenous data not disaggregated / not First Nations-specific (n=33);
- F2 – study design or evidence quality insufficient (n=153);
- F3 – does not address the research questions (RQs A – E) (n=151);
- F4 – competency model only, no accountability or governance angle (n=7);
- F5 – conference abstract only, full text unavailable (n=18);
- F6 – outside geographic scope (Australia, Canada, New Zealand, USA) (n=9);
- F7 – other (n=4).

Following full-text review, 145 papers were included, and 375 were excluded. A PRISMA flow diagram is included in Appendix C.

Quality assessment

Eight quality assessment criteria, with a numerical rating guide, were applied at Stage 2 of the screening process (full-text review) to ensure that the data being screened was culturally informed and appropriate by centring Indigenous voices, research ethics, and community benefit. These criteria are detailed in Table 3.

Table 3. Quality assessment guide

Quality Assessment Guide - Culturally-Informed Criteria			
#	**Assessment Criterion**	**Strong**	**Moderate / Weak**
1	**Community involvement in research design**	Community co-designed or community-led; First Nations researchers involved	Community consulted but not in design, or not stated.
2	**Research conducted WITH rather than ABOUT the community**	Participants are active agents; methods are participatory (yarning, co-design, PAR)	Extractive research design; community as data source only
3	**Use of community-determined definitions of cultural safety**	Cultural safety is defined by First Nations people in the study	Cultural safety is defined solely by institutions, clinicians, or researchers
4	**Indigenous Data Sovereignty – who owns and benefits?**	Data governance is clearly stated; findings benefit the community directly	No data governance stated; benefits accrue to the institution or the researcher
5	**Alignment with AIATSIS Code of Ethics**	Explicitly references or is demonstrably consistent with AIATSIS principles.	No reference to Indigenous research ethics frameworks
6	**Transferability to hospital / acute care settings (for RQ A)**	Set in hospital/acute care or clearly transferable; inpatient focus	Primary/community health setting only; limited transferability

7	**Methodological rigour (for quantitative/mixed methods studies)**	Validated tools; adequate sample size; clear analysis; limitations stated	Small sample, unclear methods, or significant limitations not disclosed
8	**Recency and context relevance**	Published 2015–2026; Australian, Aotearoa, or comparable settler-colonial context	Pre-2015 (unless foundational); context is not directly comparable

Rating guide: STRONG = meets 6–8 criteria | MODERATE = meets 3–5 | WEAK = meets 0–2 | N/A = non-empirical (e.g. policy document, theoretical paper, describe rather than rate)

Results

Overview of included literature

The final corpus of 145 papers spans four jurisdictions: Australia (n=70, 48%), Canada (n=45, 31%), Aotearoa New Zealand (n=18, 12%) and the United States (n=8, 6%). The remaining four papers comprise two multi-country comparative studies and two papers whose jurisdiction is not specified, bringing the total to 145.

Papers were published between 2011 and 2026, except for two foundational papers predating 2011, which were included under the pre-specified exception for seminal theoretical literature directly underpinning the analytical framework. [1-2]

Quality was assessed using a culturally adapted framework (Table 3):

- 55 papers (38%) were rated Strong, 74 (51%) Moderate (including one Moderate to Strong), 12 (8%) Weak, and four (3%) were not rated (N/A), typically policy documents and commentaries for which standard quality criteria were inappropriate.

The most prevalent thematic tags were:

- Cultural Safety (n=61 papers as primary tag), Service Delivery (n=42), and Governance (n=41).

Coverage was broadest for RQ A (community-defined cultural safety; n=113 papers, 78% of corpus) and narrowest for RQ E (NSQHS regulatory logic; n=44 papers, 30%).

Table 4 summarises the characteristics of the included literature.

Table 4. Characteristics of included literature - Part A rapid literature review

Source: Author's own analysis. n = number of papers. % = percentage of total corpus (n=145), rounded to nearest whole number.

Characteristic	n	%
Country/jurisdiction		
Australia	**70**	48%
Canada (Turtle Island)	**45**	31%
Aotearoa New Zealand	**19**	13%
USA (Turtle Island)	**7**	5%
Multi-country or comparative	**2**	1%
Not specified	**2**	1%
Total	**145**	100%
Study design		
Qualitative (incl. yarning, interviews, thematic analysis, ethnography, case study)	**69**	48%

Characteristic	n	%
Review (systematic, scoping, rapid, narrative, integrative)	**28**	19%
Policy, theoretical or commentary	**21**	14%
Quantitative/epidemiological (incl. RCT, survey, cross-sectional)	**10**	7%
Participatory / community-based research (incl. PAR, CBPR, PhotoYarning)	**9**	6%
Mixed methods	**8**	6%
Total	**145**	100%
Evidence quality (culturally-adapted assessment framework – see Table 3)		
Strong	**55**	38%
Moderate (incl. Moderate to Strong)	**75**	52%
Weak	**12**	8%
N/A or unrated	**3**	2%
Total	**145**	100%
Publication period		
1996–2009 (foundational literature, pre-date limit exception)	**2**	1%
2011–2019	**26**	18%
2020–2026	**117**	81%
Total	**145**	100%
Note: The Commission specified the date limit of 2011–2026. Two foundational papers predating 2011 were included under the pre-specified exception for seminal theoretical literature directly underpinning the analytical framework. [1-2]		
Research question coverage (papers with primary [Y] or partial [P] relevance)		
RQ A - Community-defined cultural safety	**113**	78%
RQ D - Structural conditions (Aotearoa NZ / Canada)	**82**	57%
RQ C - Governance and accountability mechanisms	**75**	52%
RQ B - Measurement frameworks	**70**	48%
RQ E - NSQHS regulatory logic	**44**	30%
Note: Papers may be relevant to more than one research question. Percentages reflect the proportion of the total corpus (n=145). The author assessed RQ relevance at full-text review stage.		

Analysis

RQ A: What does the evidence base tell us about what culturally safe care means in hospital settings, as determined by First Nations patients and communities?

At the heart of research question A lies the concept of self-determination. Across 145 papers spanning four jurisdictions, the evidence base is consistent on one foundational point. Cultural safety in hospital settings cannot be defined by institutions on behalf of

communities. It must be determined by indigenous patients, families, and communities themselves.[3-6]

The evidence reveals not a single definition, but a set of converging principles. These are organised across five themes:

1. Power, rights, self-determination and governance;
2. Culture as medicine;
3. Structural and systemic accountability;
4. Relational and workforce practice; and
5. Access and physical environment.

Jurisdictional variation exists. In Aotearoa, New Zealand, Te Tiriti o Waitangi[2] grounds the evidence base. In Turtle Island, Canada, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)[1] shapes the literature. Despite this variation, the core claim is consistent across all four settler-colonial contexts. Cultural safety is a political and structural condition, not a clinical competency.[3,7-10]

1. Power, rights, self-determination and governance

Across the included literature, the most consistent finding is that cultural safety in hospital settings is not a clinical outcome that institutions can produce on behalf of indigenous peoples. It is a political condition that requires the redistribution of power, and the evidence base is clear that this distinction is not semantic.[3,11-13] It is the difference between cultural safety as a regulatory artefact and cultural safety as a lived reality.

Power

Power, in this context, operates at all three levels simultaneously. At the structural level, it concerns who controls governance, resources, and decision-making in health systems.[3,11] At the legal level, the evidence establishes cultural safety as a justiciable standard – an enforceable right, not a professional aspiration.[12] At the relational level, Jennings and colleagues show that power is present in every clinical encounter.[13] It shapes who speaks, whose knowledge counts, and whether trust is possible at all. Cultural safety requires change at all three levels - not just the last one.

Rights

The legal dimension of this power claim is most explicitly grounded in international human rights law, as argued by Palu and colleagues. Mele Lua Palu, Pacific Islander scholar and public health researcher at Charles Darwin University, and colleagues ground cultural safety within international human rights law.[12] Theirs is the first article in the included literature to do so. Cultural safety, they argue, is an enforceable right under *Article 12 of the International Covenant on Economic, Social and Cultural Rights.*

This reorientation carries direct regulatory consequences. It shifts cultural safety from a professional competency to a justiciable standard. Health systems must show – not merely assert – that the right has been fulfilled. In Canada, *Joyce's Principle* operationalises a comparable logic.[14] Quebec-based researcher Kimberley Borwick and colleagues document its application as an enforcement mechanism in clinical settings.[15] Indigenous Peoples have the right to equitable, culturally safe healthcare. That right imposes a duty of accountability on health institutions.[15]

Self-determination

What self-determination looks like in practice varies by jurisdiction, but the structural logic is consistent across the evidence base. Once cultural safety is framed as a right, the obligation shifts from practitioner to institution. The institution must produce evidence that the right has been met, not evidence of what staff were trained to do. The standard moves from training inputs to patient experience.

This rights framing translates, across all four jurisdictions, into a consistent demand: self-determination and governance authority first, service quality second.[5,14,16-19] In the United States of America, the term 'cultural safety' is less prevalent.[20] The literature instead uses 'structural competency' and 'cultural humility.' But the underlying priority is consistent: Indigenous communities centre governance authority and self-determination before service design.

What varies across jurisdictions is the defining authority and the policy framework – not the principle itself. In Aotearoa New Zealand, cultural safety is defined by Māori communities and grounded in *Te Tiriti* obligations.[5,16] In Canada, the *TRC Calls to Action* and Indigenous governance structures such as the First Nations Health Authority (FNHA) shape the framework.[4,21] In Australia, the Ahpra definition was developed in partnership with and decided upon by Aboriginal and Torres Strait Islander peoples. It is now embedded across all regulated health professions through the *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025.*[22] In the United States, tribal nations and the Indian Health Service set the terms.

Joseph Gone, Aaniiih-Gros Ventre Professor of Anthropology and Global Health at Harvard University, documents three community-governed mental health programmes serving American Indian communities.[20] Each centre's culture as the primary therapeutic modality – not as an adjunct. Governance authority rests with the community. Communities determine eligibility, programme design, and whether care meets the standard of cultural safety.[20] Gone's findings are significant for three reasons. First, they show power redistribution in practice - communities hold authority, not institutions. Second, they provide the USA with evidence for the cross-jurisdictional claim that self-determination precedes service quality. Third, Gone's distinction between 'culture as treatment' and 'cultural adaptation' is taken up directly in the Culture as Medicine section below.[20]

Governance

The structural expression of self-determination is governance authority - not consultation. In Canada, the First Nations Health Authority (FNHA) represents the most structurally comprehensive realisation of self-determined health governance in the included literature.[4] The FNHA was established in 2013, following more than a decade of negotiation. It took over health planning, management, and service delivery from the federal government for First Nations in British Columbia (BC). The tripartite arrangement involves the FNHA, the Government of Canada, and the Province of BC. Its foundational principle is reciprocal accountability. Each party is accountable to the others. First Nations communities, however, hold ultimate authority over what constitutes safe, quality care - not as advisors to that determination, but as its authors.[4]

Tla'amin First Nation and Coast Salish man and former FNHA CEO Joe Gallagher, along with colleagues, detail how this architecture operationalises self-determination.[4] Communities determine eligibility, programme design, and the standards against which care

is assessed.[4] Edmundson and colleagues extend this analysis.[23] The FNHA's self-assessment framework engages accreditation on Indigenous terms.[23] It replaces the binary met/unmet logic of conventional accreditation with a continuum accountable to community-defined standards of safety. Governance is not separate from self-determination. It is its operational expression.

In Australia, comparable principles operate at a smaller scale through Indigenous Reference Groups and community advisory structures. Kaurna, Narungga, and Ngarrindjeri woman, Kelli Owen and colleagues document Indigenous Reference Groups in nephrology services.[24] These groups drove substantive practice change - not through compliance monitoring, but through direct governance authority over service design.[24]

Barkindji Katrina Clark and colleagues reach consistent findings in their analysis of Indigenous-led COVID-19 vaccination programmes across Australia and Canada.[25] Where governance authority sat with communities rather than with state health departments, programme effectiveness was demonstrably greater.[25]

Not all reform efforts produce equivalent structural change. In Aotearoa, Ngaire Rae and colleagues apply a critical *Te Tiriti* analysis to the *Interim New Zealand Health Plan.*[16] Despite its reform ambitions, the framework falls short of Treaty-grounded accountability. It positions Māori as partners in implementation rather than as architects of the system.[16] The accountability gap - between rhetorical commitment to self-determination and its structural realisation - is consistently documented across jurisdictions. The mechanisms sustaining that gap are well evidenced.

Cree Métis woman Lisa Bourque Bearskin and colleagues draw on the lived experiences of Indigenous healthcare professionals in Canada.[26] Bourque Bearskin is the Canadian Institute of Health Research Indigenous Health Nursing Research Chair at the University of Victoria. Their work shows how the accountability gap operates from inside the health system. Those most responsible for implementing cultural safety are simultaneously subject to the institutional racism the system is intended to redress.[26]

Heather Came and colleagues provide empirical evidence from Aotearoa of institutional racism operating within policy machinery.[27] Came terms the mechanism "Crown filters" - interpretive processes that consistently translate Māori health priorities into settler-colonial frameworks before they reach implementation.[27]

Anishinaabe-Opwaaganasiniing Dr Lana Ray and colleagues name the broader dynamic ‘shapeshifting structural racism.’[17(p3)] Structural racism adapts to absorb reform efforts without ceding actual power. Interventions that appear to address the problem - inquests, competency training, access initiatives - can reinforce the underlying architecture rather than dismantle it.[28] Canadian anthropologist Megan Muller Da Silva traces analogous mechanisms at the level of the clinical encounter.[29] She identifies four pervasive discourses in emergency departments that circulate indigenous-specific racism through clinical decision-making - rendering it invisible as such.[29]

Taken together, these findings establish that self-determination and governance authority are preconditions for culturally safe hospital care, not merely aspirational features. The evidence is strongest where Indigenous governance authority is explicit, structural, and resourced.[4,23-25] It is most limited where self-determination is treated as a form of consultation rather than decision-making authority. The implication for regulatory frameworks is direct. Cultural safety standards that position indigenous peoples as advisors - rather than as authors - do not meet the threshold set by the evidence.

Where the gap has narrowed, structural authority - not rhetoric - is the common lever. The FNHA model is the most comprehensive example in the included literature.[4,23] First Nations peoples hold authority to define and measure what cultural safety means - not as advisors to that determination, but as its authors.

In Australia, Indigenous Reference Groups drove practice change in nephrology services through direct governance authority over service design.[24] Aboriginal and Torres Strait Islander and First Nations-led COVID-19 vaccination programmes in Australia and Canada produced outcomes that state-directed programmes did not. [25] Community governance authority was the differentiating variable.[25] *Joyce's Principle* provides a legal mechanism: it makes cultural safety an enforceable right, not an aspiration.[14] Long and colleagues evaluated healthcare programmes in Canada that were authenticated as culturally safe by First Nations communities.[30]

Consistent features included governance authority, community-led design, and accountability to community-defined standards - not to external benchmarks. These examples do not resolve the accountability gap across systems. They do identify what structural redistribution of authority produces when genuinely enacted.

2. Culture as medicine

Culture is therapeutic, not just a sensitivity checkbox. The Western biomedical model of healthcare is but one approach to caring for and healing people. Indigenous peoples have practised holistic healing and wellness for over 60,000 years to keep individuals and communities well. In this way, culture is therapeutic and medicine.[20] For cultural safety, this theme matters: it reframes what hospitals must accommodate. Culture is not an add-on to biomedical care. Indigenous healing knowledge is care in its own right.

In South Australia, Ngangkari – Anangu traditional healers from the APY Lands – are now formally embedded in hospital and primary care settings.[31] This is through a partnership between the Anangu Ngangkari Tjutaku Aboriginal Corporation (ANTAC) and the North Adelaide Local Health Network.[31] Ngangkari provide spiritual, emotional, and physical care alongside biomedical treatment. Formal evaluation of the model is underway; peer-reviewed published findings are not yet available.

Gone's framework helps explain what structurally distinguishes models like Ngangkari from cultural adaptation approaches. Professor Gone draws a critical distinction between two models.[20] 'Culture as treatment' starts from First Nations therapeutic traditions, asking how they can be harnessed as healing services in their own right.[20] 'Cultural adaptation' modifies mainstream evidence-based treatments to be culturally responsive – the cultural competence model.[20] Professor Cameron Lacey and colleagues' *Hui Process Framework* is an example of 'cultural adaptation', which is culturally grounded and drawn from Māori protocols. [32]

Ngāpuhi researcher Ebony Komene and colleagues argue the *Hui Process Framework* is insufficient without whakawhanaungatanga – genuine connection – at the bedside.[33] Despite the framework's integrated and relational approach, it is not yet embedded among non-Indigenous health practitioners. Patients can still walk away from a clinical encounter feeling unwelcome or disconnected, despite health practitioners being taught 'cultural adaptation' models.[33]

This is not just about practice. It is about epistemological authority. Indigenous Peoples define safety on their own terms – it is not defined for them through a Westernised lens. Culture is therapeutic when it's practised, not when it's performed. The examples here are

illustrative, not exhaustive. The claim rests on the consistency of the pattern across the wider evidence base, not on these cases alone.

3. Structural and systemic accountability

Performative compliance is not accountability. Structural and systemic accountability encompasses the institutional dimension, the policies, data practices, and power structures that either enable or undermine safety.

Bourque Bearskin and colleagues highlight the accountability gap from inside the system.[26] First Nations healthcare practitioners are assigned to implement cultural safety, but are set up to fail when structural conditions do not exist.[26] This results in workforce governance failures reproducing performative governance. The gap is not between intention and capacity – it is between stated commitment and structural reality.

Non-Indigenous health practitioners practising in culturally unsafe ways are not outside this argument – they are central to it. Ray and colleagues show how structural racism circulates through individual clinical practice, often without the practitioner recognising it as such.[28] Da Silva identifies four specific discourses through which non-Indigenous practitioners in emergency departments reproduce Indigenous-specific racism through everyday clinical decision-making.[29] The accountability gap is not only between institutions and communities. It operates through individual clinical encounters, and non-Indigenous practitioners are its primary conduit.

Structural accountability is inseparable from the social determinants of health and from cultural and clinical safety. First Nations scholar Ashley Goodman and colleagues emphasise upstream accountability for structural forces that determine who arrives sick and why.[34] Social determinants such as housing, income, historical dispossession, poverty, substance use stigma and postcode all compound in the eyes of providers. Race alone doesn't explain who receives unsafe care.

At the structural level in hospitals, this manifests in predictable ways. Patients arrive without accurate identification in data systems – meaning disparities cannot be tracked, and institutions cannot be held to account.[35] Triage protocols are not designed for cultural safety. Complaint mechanisms are inaccessible or absent.[36] Interpreter services are inconsistent, leaving patients unable to communicate their needs or understand their care.[37] Physical environments signal whose knowledge and healing practices are welcome – and whose are not.[34] These are not individual failures. They are structural design outcomes. Goodman illustrates this with a 'locked smudging room – nominally cultural but practically inaccessible.'[34]

The question stands: what does it look like when institutions move beyond aspiration into governance? Nuu-chah-nulth Janice Johnson and qualitative analyst, Leena Hasan clearly articulate what cultural safety policies at a hospital level need to achieve this.[36] A complaints process accessible to First Nations patients and families – one that does not require navigating the institutions that failed them.[36] A culturally safe triage protocol that does not compound disadvantage at first contact, where the risk of early departure without care is highest.[36] Human resource accountability requirements that embed cultural safety obligations into role descriptions, performance frameworks, and consequences for practitioners – not just training completion.[36] Measurement mechanisms that assess what patients actually experience, not what institutions report delivering.[36]

McLardie-Hore argues that without accurate patient identification, outcomes cannot be tracked, disparities cannot be measured, and institutions cannot be held to account.[35]

Institutions cannot claim cultural safety without being able to measure it. You cannot measure it without accurately identifying First Nations patients.

Taken together, this evidence base shows that structural and systemic accountability is not a higher aspiration layered atop cultural safety practice. It is the precondition for it. The locked smudging room is not an anomaly. It is the predictable output of institutions that have adopted the language of cultural safety without redesigning the governance architecture to match. When accountability remains at the level of individual conduct rather than institutional design, the burden of transformation falls on those least positioned to carry it.

Johnson and Hasan's four governance requirements establish the minimum infrastructure through which stated commitment becomes an enforceable obligation.[36] McLardie-Hore closes the loop: without accurate patient identification, there is no outcome data.[35] Without outcome data, there is no measurement. Without measurement, institutions cannot be held to account. The gap between intention and outcome in institutional cultural safety is not a capacity problem. It is a design problem – and design problems require redesign, not retraining.[38]

4. Relational and workforce practice

The contemporary health system is underpinned by efficiency logic. This logic undermines the relational conditions indigenous peoples require for cultural safety – and reproduces racism through clinical decision-making itself.[29]

Across three studies examining indigenous patient experiences, a consistent set of relational conditions for culturally safe care emerges:

- Indigenous health practitioners on staff;
- Trust;
- Meaningful time commitment and relationship building;
- Family-centred care;
- Continuity of care;
- Language/communication.[37,39-40]

These conditions impose a structural contradiction to what the neoliberal clinical encounter is designed to deliver. Da Silva highlights the moral economy of care acutely apparent in the emergency department.[29] Scarce medical resources are distributed to patients based on an assessment of deservingness and need – often clouded by racial stereotypes.[29]

Clinical research consistently shows that racial bias shapes treatment decisions irrespective of whether providers are conscious of those biases.[29] This is not simply a matter of individual prejudice. Clinical decision-making is itself embedded within cultural ideology. The healthcare encounter reproduces the same socio-political hierarchies that operate across broader society. Critically, even practitioners acting in good faith perpetuate discriminatory outcomes when they fail to recognise the ideological conditions shaping their judgements. The solution cannot be individual training or goodwill – it requires structural transformation of how the clinical encounter is designed and resourced.

5. Access and physical environment

Access and environment are not peripheral to cultural safety. They are the conditions that determine whether it is possible at all, from the first barrier to entry to the last interaction at discharge.

Firstly, access to healthcare services is a precondition for safety; you cannot be safe in a system you cannot reach by distance. Associate Professor Nina Sivertsen at Flinders University highlights indigenous women's mainstream hospital birthing experiences in Australia, Aotearoa, and Turtle Island (Canada and the United States).[41] Women universally reported that hospital evacuation produced a geographic and emotional disconnect from community, a lack of social supports and feelings of isolation, lack of meaningfulness and concern about the well-being of older children left behind in communities.[41]

Secondly, the physical environment in hospital settings plays an important role in patients' experiences of cultural safety. Dr Daphne Nash's research highlights a range of design elements that Aboriginal and Torres Strait Islander patients have identified to improve cultural safety:

- Increased patient room size to include family members;
- Larger windows with views of natural environments;
- Direct access to outdoor courtyards or balconies;
- Integrated Indigenous signage, graphics and art;
- Options for shared rooms in facilities with a larger proportion of Indigenous inpatients.[42(p186)]

Physical space is not neutral – it can affirm or deny one's cultural identity. It determines whether a space feels like a place to belong or a threat. Métis Dr Renée Monchalin captures how profoundly physical space matters for Métis women. One patient stated: 'I would prefer to have my health care provided over a cup of tea any day.'[43]

Relational safety and physical accessibility converge at discharge. Both are maintained or lost in the continuity of care between the hospital and the community. Discharge without follow-up – or without an integrated handover between health practitioners – creates a simultaneous cliff edge in access and relational safety. [37,39-40]

RQ B: What measurement frameworks and indicators have been developed that centre First Nations patient and community experience, rather than institutional assessment?

Across the included literature, a convergent pattern emerges on cultural safety measurement. Community-designed and patient-reported tools are consistently positioned as the primary evidence base, not as supplements to institutional audit frameworks.

The evidence draws on individual studies across four jurisdictions rather than a formal thematic synthesis. The following presents individual study synopses. The claims rest on convergence across them, not on any single source. The pattern is nonetheless consistent. Tools designed by and with Indigenous communities produce fundamentally different evidence than those imposed by institutions. Validation with indigenous peoples emerges as a prerequisite for legitimacy, not an optional add-on.

Importantly, not all measurements are equal. Tools designed by and with indigenous communities produce fundamentally different evidence than those imposed by institutions. Validation with indigenous peoples is a prerequisite for legitimacy, not an optional add-on.

Patient reported

Patient-reported methods serve two interconnected functions in the literature: capturing individual indigenous patient experience through validated measurement tools and

indicators. The second uses that experience as the primary evidence base for co-designing frameworks and informing care. Both functions are represented in the reviewed literature, and both are necessary. Measurement without co-design produces data that does not change systems. Co-design without rigorous capture of patient experience lacks an evidence-based approach grounded in indigenous perspectives.

Storytelling/yarning

Canadian-based researcher Hannah Doyle and colleagues used a storytelling method to measure First Nations Elders' healthcare experiences.[44]

> Storytelling represents a traditional practice of knowledge translation for many First Nations, Métis, and Inuit communities, connecting Indigenous Peoples to cultural teachings and supports, thereby allowing the building and strengthening of relationships between patients, families, and healthcare providers.[44(p1)]

Storytelling is also known as the 'yarning' method among Aboriginal and Torres Strait Islander peoples in Australia.

Doyle argues that storytelling serves both as a culturally safe mode of patient recognition and as a meaningful feedback mechanism. It fosters the kinds of system-level conversations that conventional evaluation approaches fail to produce.

Patient experience survey

Catherine Gerard and colleagues from the Health Quality and Safety Commission in New Zealand reiterate two points. The first is the statutory imperative. The second is the importance of listening to and acting on the strong consumer and whānau voice through patient experience surveys.[45] Gerard makes an important distinction between patient satisfaction and patient experience surveys. They argue that satisfaction surveys are subjective and biased, and tend to be overwhelmingly positive. By contrast, patient experience surveys are more objective and address specific aspects of care that can prompt specific actions to generate service improvement.[45]

The most developed Australian tool for measuring Aboriginal and Torres Strait Islander patient experience of cultural safety in hospitals was validated by Elvidge and colleagues. They found that culturally grounded measurement instruments produce more actionable data than generic patient satisfaction surveys.[46]

Critically, patient experience surveys must be developed by First Nations Peoples to ensure a culturally appropriate framing that elicits the most useful data. Patient experience surveys are a valuable primary source of data for hospital boards and policymakers. These surveys inform the level of cultural safety within a health service and identify areas for improvement.

Conceptual framework

Métis Dr Pamela Roach and colleagues developed a framework for high-quality Indigenous virtual care, built on the domains of access, relationships, quality, and safety. It was constructed from semi-structured interviews with First Nations patients and primary care providers rather than from institutional definitions of quality.[47] The Roach framework is a co-design artefact rather than a measurement instrument. Patient experience is the input from which the framework itself is built, not the outcome being assessed. This distinction matters because it shows that when Indigenous patients define quality, the resulting framework

differs structurally from conventional quality measurement models. It foregrounds relationships and cultural continuity in ways that institutionally derived frameworks do not.

FIRST approach

Nova Scotia-based Dr Margot Latimer and colleagues developed the FIRST approach from Two-Eyed Seeing methodology with Mi'kmaw and Wolastoqey communities, gathering healthcare experiences with Mi'kmaw and Wolastoqey communities. They gathered healthcare experiences from First Nations children, youth, Elders and health providers across four communities.[48] The approach foregrounds patient experience as the primary data source for understanding what needs to change. It serves not as qualitative supplementation to clinical outcome data, but as the originating evidence base.

Qualitative interview/narrative

Researcher Dr Patricia Bradley's qualitative interview study with Aboriginal and Torres Strait Islander women in acute mental health inpatient settings in Australia provides important evidence of the most coercive service-delivery environment in the healthcare system.[49] Recording the words of Aboriginal and Torres Strait Islander women within an inpatient unit for the first time. The study documents what factors promote or impede a culturally safe environment in conditions of constrained autonomy. In this setting, the structural barriers to culturally safe care are most visible, and patient voice has historically been the least prioritised.

Community led

Community led measurement is collective self-determination in practice. Where patient-reported tools centre individual experience, community led approaches locate the locus of validity with communities and Indigenous practitioners as a collective. They act not as respondents to institutional frameworks, but as architects of the measurement system itself.

A foundational challenge to measurement assumptions

Before any tool can be designed, the question of what a health measurement actually measures must be settled. Ngāti Toarangatira, Ngāti Koata, Ngā Ruahine Associate Professor Esther Willing critiques Quality-Adjusted-Life-Years and Disability-Adjusted-Life-Years as philosophically incompatible with Māori worldviews. She makes this argument at a foundational level. Standard health measurement frameworks embed assumptions about individualism, productivity and mortality that are incommensurable with Māori concepts of health and wellbeing.[50]

Proposing whānau as the unit of care is not a methodological adjustment – it is a challenge to the epistemological architecture of health measurement itself. Tools that adopt conventional assumptions without scrutiny do not measure cultural safety. They measure institutional compliance with a culturally unsafe norm. This is the starting point for all community led measurement work.

Tool development by and with the community

In Australia, Kay Brumpton and colleagues developed a tool to assess whether GP registrars conduct a culturally safe consultation. Cultural safety is determined by Aboriginal and Torres Strait Islander peoples in alignment with the Ahpra definition. The tool was built by Aboriginal

and Torres Strait Islander practitioners and researchers, not from institutional competency frameworks.[51]

Researcher Alyssa Cormick and colleagues' Health Journey Mapping resource was co-designed with the community through participatory action research. The tools reflect the structural barriers Aboriginal and Torres Strait Islander patients encounter – fragmented systems, unclear navigation, and culturally unsafe transitions. They do not reflect the institutional processes that accreditation typically measures.[52]

Dr Sarah Fraser and colleagues took a different approach, developing an Aboriginal Patient Journey Mapping tool through interface research methodology. This brought Aboriginal and Torres Strait Islander and biomedical knowledge together at a knowledge interface, guided by Aboriginal co-researchers.[53] When applied to paediatric burn care in a tertiary setting, the tool revealed an important finding. Cultural safety and biomedical quality can be assessed simultaneously at the individual, service and system level.

Critically, Fraser found that engaging an innovative methodology beyond biomedical standards of care uncovered quality gaps that conventional quality improvement approaches could not identify. These gaps included the absence of Aboriginal and Torres Strait Islander Health Workers, late and limited involvement of Aboriginal liaison officers, and post-discharge abandonment of cultural support.[53] Hon Associate Professor Kate Anderson and colleagues established something important through yarning with Aboriginal and Torres Strait Islander stakeholders. Co-design is not a methodology that can be applied to pre-set questions. It requires Aboriginal and Torres Strait Islander governance over the scope, design and ownership of the tool itself.[54]

Community authentication as the validity criterion

Ryanna Coones Long's Treaty 6 community authentication model represents the strongest current example of community-led validation in the measurement literature.[30] The Cree Elders and community members of the Wâhkohtowin Research Group held final authority on what 'authentic' meant. No domain was accepted without community endorsement. This is the methodological standard the literature increasingly reflects: authentication by community is not a consultation step; it is the validity criterion.

Third-party audit

A third-party audit is institutional accountability. Where patient-reported and community led tools centre on recipients' experiences, audit tools assess whether institutional conditions for cultural safety exist and are consistently applied.

What existing audit tools can and cannot do

Jessica Muller and colleagues' scoping review of existing cultural safety audit tools assessed them against the Indigenous Allied Health Australia (IAHA) cultural responsiveness framework. This is the strongest current systematic appraisal of the audit landscape.[55] The review found that existing tools vary significantly in their grounding in Aboriginal and Torres Strait Islander evidence and community involvement in development.

Facilitators of implementation include Aboriginal and Torres Strait Islander governance structures and leadership; barriers include inadequate resourcing and the absence of accountability mechanisms. What existing audit tools cannot yet do, however, is measure culturally safe practice rather than compliance activity. The evidence regarding this limitation is addressed directly in what follows, drawing on the training literature and the standardised

patient model. It is the central methodological challenge for any standards framework that relies on audit as its primary accountability mechanism.

Gimuy Walubara Yidinji Elder and scholar Henrietta Marrie, and non-Indigenous husband Adrian Marrie developed a *Matrix* for identifying, measuring and monitoring institutional racism in public hospitals and health services.[56] The *Matrix* is hospital-specific, which is rare in this evidence base. It scores a service against five key indicators: governance, policy implementation, service delivery, recruitment and employment, and financial accountability.[56]

These indicators are broken into 13 weighted criteria, scored out of 140. Governance carries the heaviest weighting. This reflects the authors' position that excluding Aboriginal and Torres Strait Islander people from decision-making is a primary signifier of institutional racism. Sub-criteria are developed with local communities and community-controlled health services, so the tool measures what each community wants assessed.

The *Matrix* draws only on publicly available information, such as annual reports, legislation and health service agreements. This makes each score verifiable, publishable and comparable across services over time. It therefore works as both an external audit and an internal report card for tracking progress. Applied to the Cairns and Hinterland Hospital and Health Service, the *Matrix* returned a score of 14 out of 140.[56] This falls in the "extreme" band for evidence of institutional racism. The Matrix matters for measurement because it assesses institutional conditions rather than individual attitudes, and because Aboriginal authorship anchors its legitimacy.

Waljen Associate Professor Tamara Mackean and colleagues' framework for assessing cultural safety in Australian public policy provides a complementary instrument to the Muller audit landscape.[57] Developed through a collaborative inquiry process combining Aboriginal and non-Indigenous researcher perspectives, the framework operationalises cultural safety across five concepts. These are: reflexivity, dialogue, reducing power differences, decolonisation, and regardful care. These were derived from the cultural safety literature and validated against contemporary policy writings by leading Aboriginal and Torres Strait Islander thinkers.

The framework is applicable as a tool for critical, systemic analysis of public policy, including standards frameworks. It examines how this affects Aboriginal and Torres Strait Islander peoples and identifies specific areas where performance can be improved to achieve culturally safe policy. Its relevance to the Commission's review is direct. It provides an existing, tested instrument against which any proposed national cultural safety standard could be assessed as a policy instrument.

The training evidence problem

Assistant Professor Billie-Jo Hardy and colleagues' systematic review of cultural safety training interventions reports mixed results. While training alone may improve clinical outcomes, there is limited evidence that it improves culturally safe practice.[58] This is not a peripheral finding – it is the central evidentiary challenge for a standards framework that currently leans heavily on workforce training actions. Audit tools that measure training completion cannot resolve this gap; they can only document that the activity occurred. The evidence on training is mixed rather than uniformly negative – some interventions show gains on specific clinical measures. The consistent limitation is that training alone does not demonstrably produce culturally safe practice.

Beyond self-assessment: the standardised patient model

Cree-Métis Professor Janet Smylie and colleagues randomised controlled trial using unannounced First Nations standardised patients represents the most methodologically rigorous accountability mechanism in the literature. It is the first of its kind.[59] A 'standardised patient' is a trained person who presents to a service as a patient to assess real-world practice. Here, the assessors are First Nations peoples, so the institution cannot perform for an observer, because the assessor is the patient. This approach resolves the fundamental gap that conventional audit frameworks cannot close. It is the distance between what institutions report about themselves and what First Nations patients actually experience.

The evidence across patient-reported, community-led and third-party audit approaches converges on a single structural finding. Legitimacy in cultural safety measurement is determined by those receiving care, not by those delivering it. Patient experience tools, community authentication processes and Indigenous-governed co-design frameworks do not supplement institutional audit – they precede it. What institutions measure about themselves tells us what institutions are prepared to account for. What communities report tells us what is actually happening.

This finding carries a direct methodological implication for any strengthening of the National Standards. Standards that measure activity – training delivered, partnerships formed, resources produced – cannot substitute for standards that require evidence of patient experience and community-authenticated outcomes. Measurement frameworks that do not centre First Nations patient voice are not neutral instruments. They are accountability mechanisms designed to answer the wrong question. In short, the measurement task is to shift the assessment from process to outcomes. Those outcomes are defined by Aboriginal and Torres Strait Islander patients and communities and are largely evidenced through qualitative, experience-based methods.

RQ C: What governance and accountability mechanisms have demonstrably driven systems-level change, rather than compliance activity?

Structural racism in health systems is a governance failure. The evidence consistently shows that accountability to community, not compliance with institutional standards, is what produces safe care.

The governance architecture is the problem

Existing health governance structures do not produce cultural safety – they produce its opposite, because institutional accountability flows upward to government, not outward to the community.

Professor Sarah Fraser and colleagues from the University of Montreal argue that systemic racism in health is structurally maintained. It is maintained by policies, funding rules, and professional norms that privilege Western clinical knowledge over Inuit knowledge. This produces racialised systems of care rather than culturally safe ones.[38] They take this further by saying that separating "clinical" from "cultural" knowledge is not scientifically justified. It is a political and economic construct that reinforces colonial hierarchy.[38]

Cultural safety will not emerge from current systems unless governance is redesigned. Governance must ensure that Inuit knowledge, authority, and accountability are embedded within the system rather than at its margins.

Rights-based frameworks as the accountability floor

Te Tiriti,[2] *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*[1], and the *Truth and Reconciliation Commission of Canada (TRC): Calls to Action*[21] are not aspirational documents. They are accountability frameworks with enforcement implications that health systems have systematically avoided.

Gitxsan First Nation Dr Morgan and colleagues show that *TRC Calls to Action*[21] and *UNDRIP*[1] must be operationalised in everyday healthcare decision-making.[17] Morgan et al shows that this accountability must extend beyond individual clinicians to institutions, health authorities, and ministries. First Nations family and community involvement should be embedded at every level of the system, not added as an afterthought.

Wiradjuri, Ngemba-Wailwaan researcher Khwanruethai Ngampromwongse and Truwulay researcher Alana Gall critically examine the *National Preventive Health Strategy 2021–2030.*[60] They argue that it fails to meaningfully engage with the structural determinants of health inequities affecting Aboriginal and Torres Strait Islander peoples.[18] Writing as Aboriginal public health professionals, they identify specific implementation failures.

The Strategy focuses predominantly on individual behavioural risk factors rather than the broader sociopolitical and cultural contexts that drive poorer health outcomes. It also neglects the enduring impacts of colonisation, systemic racism, and intergenerational trauma. Finally, it does not embed Aboriginal and Torres Strait Islander sovereignty, self-determination, or community authority in governance and implementation.

These are not design aspirations the Strategy falls short of – they are structural absences that make genuine implementation of culturally safe preventive health impossible. Ngampromwongse and Gall call for the re-Indigenisation of the health system and a series of recommendations grounded in structural reform. This is driven by the urgent need for systems transformation led by, and accountable to, Aboriginal and Torres Strait Islander peoples as supported by Torres Strait Islander obstetrician and gynaecologist, Dr Alicia Veasey.[61].

Ontario-based researcher Brianna Marie Stefanon and colleagues reinforce this point in the rural and remote context. They find that effective First Nations health systems depend on First Nations rightsholders, stable funding, and culturally appropriate care. They also depend on collaborative governance that supports self-governance rather than bureaucratic fragmentation.[62]

Ontario-based Dr Suzanne Von der Porten's review explains why these frameworks so often stall at the policy level. State recognition, sovereignty, and rights language are frequently filtered through colonial institutions that preserve external control, making genuine Indigenous nation-to-nation authority difficult to realise.[11]

Together, these papers show that rights frameworks are not optional ideals, but the baseline standard systems are currently failing to meet.

What institutional governance actually produces

Institutional governance can support partial improvements, but it does not generate the authority needed for systemic change. This applies to health services generally; however, the focus of this review is the hospital setting specifically.

Professor Stephanie Topp and colleagues show that Aboriginal and Torres Strait Islander Health Workers remain constrained by racially structured governance. The role is essential, but the institution itself still produces disrespect, limited participation, and weak support.[63]

The Marrie *Matrix* gives this a concrete Australian measure: at the Cairns and Hinterland Hospital and Health Service, the governance indicator scored almost nothing, and the service rated in the "extreme" band overall.[56]

Gumbaynggir Dr Julieann Coombes and colleagues likewise show that Aboriginal and Torres Strait Islander liaison and discharge interventions can improve outcomes. This happens only when the institution enables local coordination, cultural brokerage, and continuity of care.[64]

Ontario-based medical anthropologist Associate Professor Marion Maar and colleagues show that reconciliation-based collaborations can create relational gains. Yet these gains remain contingent on Indigenous guidance and ethical partnership rather than on institutional goodwill alone.[65]

Professor Lisa Wood and colleagues add that organisational reform in non-government organisations is only meaningful in specific conditions. It is meaningful when Aboriginal and Torres Strait Islander representation and cultural governance are embedded across structures, not tacked on as an add-on.[66]

Overall, these studies show that institutional governance can host indigenous-responsive roles, but without deeper structural reform, it cannot convert them into systems-level change.

What community-controlled governance produces

The evidence consistently shows that indigenous-governed and community-controlled models produce accountability relationships that institutional governance cannot.

Manitoba-based researcher Rachel Eni and colleagues show that for Manitoba First Nations, genuine self-governance means several things. It means authority over their own laws and protocols, control over resources, and accountability on their own terms.[19]

Alberta-based researcher Cheryl Sheldon and colleagues show the same principle in practice. The Indigenous Support Line succeeded because Indigenous Peoples led its design, staffing, evaluation, and ethical direction. This happened within an ethical space that respected Indigenous and Western approaches.[67] Quebec-based Associate Professor Marie-Claude Tremblay and colleagues similarly find that indigenous led navigation roles are central to culturally safe access. Broader capacity-building works best when it is developed in partnership with indigenous communities.[68]

Gallagher and colleagues provide a concrete proof of concept through the First Nations Health Authority. There, nation-based directives shifted decision-making, data control, and service design closer to First Nations communities through reciprocal accountability.[4]

Alberta-based Associate Professor Susan Chatwood and colleagues add the epistemological base. They show that First Nations health stewardship is grounded in values such as community voice, kinship, respect, holism, and empowerment. These values were identified through consensus across circumpolar Indigenous nations.[69]

Together, these sources show that community-controlled governance does more than improve services. It creates the ethical and relational accountability structures through which

health systems become answerable to Indigenous Peoples. These sources are stronger on governance design and process than on measured patient outcomes. The outcome-and-impact evidence remains comparatively thin, consistent with the gap noted elsewhere in this review.

RQ D: What conditions are required for cultural safety standards to generate structural transformation – and what do the divergent trajectories of Aotearoa and Canada tell us about those conditions?

The structural conditions that enable or constrain culturally safe care are political choices, not resource limitations. Aotearoa and Canada show what dedicated legislative obligation, Indigenous governance infrastructure, and rights-based accountability produce, while Australia's trajectory shows what happens in their absence.

Why these jurisdictions are the right comparators

Narungga and Ngarrindjeri epidemiologist Dr Stephen Harfield's 2024 systematic review across Australia, Canada, New Zealand, and the United States shows that indigenous adolescents encounter the same recurring barriers and enablers to primary care across settler-colonial health systems. These especially include trust, relationships, culturally safe environments, racism, and indigenous workforce presence.[70]

Marie-Claude Tremblay and colleagues in Canada likewise show in their 2023 rapid review across Australia, the United States, Canada, and New Zealand that cultural safety roles follow similar structural patterns across jurisdictions. Their effectiveness, however, depends on institutional conditions such as authority, coordination, and Indigenous partnership.[68]

These studies justify the comparison on different grounds. Harfield's systematic review establishes that the systems are structurally comparable. The same barriers and enablers recur across Australia, Canada, New Zealand, and the United States. They include trust, relationships, culturally safe environments, racism, and indigenous workforce presence.[70]

Tremblay and colleagues add the explanatory variable. Cultural safety roles follow similar structural patterns across these jurisdictions. Their effectiveness depends on whether institutions provide enabling conditions such as authority, coordination, and indigenous partnership.[68] Together, they show that the structural similarity makes comparison valid, while the differences in enabling conditions reveal what political and institutional choices produce.

Canada – legislative response versus inquiry fatigue

Canada shows what becomes possible when a death is treated as a governance failure rather than a tragic exception. Joyce Echaquan's death produced a legislative and systemic response through *Joyce's Principle.*[14] This makes it a useful counterpoint to Australia's familiar pattern of inquiries that expose harm but do not reliably change structure.

Eni and colleagues, show that decolonising health requires First Nation control of healthcare, traditional medicine, full community participation, and the active dismantling of colonial structures.[19] Their argument is important here because it shows that meaningful change depends on shifting power, not merely improving service delivery at the margins.

Assistant Professor Renee Monchalin, a Métis scholar, traces how colonial law, racism, and exclusion have shaped Métis health, identity, and access in Canada.[71] Her work reinforces

the point that health inequity is structurally produced, not accidental. Legal and policy frameworks are part of the problem unless they are deliberately redesigned.

Sheldon and colleagues, working with Alberta Health Services and Indigenous community leadership, show what rights-based architecture can produce in practice.[67] Their Indigenous Support Line was Indigenous-led, culturally safe, and built through a Wisdom Council that shaped service design, implementation, and accountability.[67] That example matters because it shows how institutional response can move beyond recognition toward operational change when indigenous authority is embedded in the system.

The structural change here is not the service itself but where authority over it sits. The Wisdom Council gave First Nations peoples decision rights over the Line's design, staffing, evaluation and ethical direction, including its accountability arrangements. This was not an advisory voice within an institution that kept control. That is the distinction that matters for regulation. The Line moved beyond recognition toward operational change precisely because Indigenous authority was embedded in the governance of the service, not consulted at its margins.

Two lessons follow. First, the locus of accountability is decisive. This matters where indigenous communities hold authority over how a service is evaluated and held to account, not only how it is delivered. Culturally safe practice then becomes a structural obligation rather than a goodwill activity. Second, the change was operational and modest in scale, yet durable. This was because it rested on a governance structure (the Wisdom Council) rather than on individual initiative or training. For hospital accreditation, the transferable principle is that standards would need to require Indigenous-governed structures with genuine authority over how cultural safety is assessed. This goes beyond partnership or consultation provisions that leave institutional control intact.

Together, the Canadian evidence does not show a solved problem. It does show something Australia rarely produces at scale. When harm becomes visible, law and system design can be used to create obligations, not just commentary. *Joyce's Principle* is a rights-based response that converts public harm into a structural mandate, rather than leaving it at the level of inquiry and apology.

Aotearoa – structural gains and their reversibility

If Canada shows that law can respond to harm, Aotearoa shows what happens when Māori authority is built directly into health system architecture. At the same time, it shows how quickly those gains can be dismantled when protected only by ordinary statutes rather than stronger constitutional safeguards.

Ngāi Tahu/Rangitāne scholar Irihapeti Ramsden and Elaine Papps in Dunedin laid the groundwork for cultural safety in the 1990s. They treated it as a Treaty-grounded response to colonial inequity and embedded it in nursing education. This made the concept a structural challenge to the health system rather than a personal attitude adjustment.[5] That chronology matters because it shows that Aotearoa's later reforms were not inventing indigenous health governance from scratch. They were drawing on a much older critique of unequal power and culturally unsafe care.

Ngāi Tahu scholar Annabel Ahuriri-Driscoll and colleagues later showed that the 2022 reforms translated that legacy into formal architecture. This worked through Te Aka Whai Ora, Iwi Māori Partnership Boards, and explicit *Te Tiriti* obligations. This gave Māori authority and shared decision-making a legislative foothold.[72]

Heather Came and colleagues showed in 2024 that the disestablishment of Te Aka Whai Ora reversed those gains. It reduced Māori control and reasserted Crown dominance in the name of ordinary administrative reform.[73]

Te Aka Whai Ora was removed not because the whole health system had to be rebuilt. It was a separate statutory authority whose legal basis could be repealed and whose functions could be transferred by amending legislation passed under urgency. That makes it a cautionary example of durability. Even meaningful indigenous governance remains politically reversible when it is protected only by ordinary statute rather than stronger constitutional or entrenched.

The lesson is that Treaty-based change can produce real institutional power, but without constitutional protection, it remains reversible and politically contingent.

Australia – structural absence as political choice

Set against Canada and Aotearoa, Australia's trajectory looks less like policy delay and more like structural refusal. The issue is not that Australia lacks evidence about racism, workforce barriers, or the requirements of cultural safety. It is that governments have repeatedly declined to create the kind of Indigenous governance architecture and enforceable accountability that comparative jurisdictions have shown to matter.

Bronwyn Wilkes, Gundungurra, and colleagues argue that racism is embedded in the foundational structure of the Australian health system. They argue that cultural safety requires institutional accountability and the ceding of power to Aboriginal and Torres Strait Islander Peoples.[6] Their analysis is particularly important for a clear reason. It shows that cultural safety is already recognised in the *Health Practitioner Regulation National Law*[78] and the codes of conduct for registered practitioners. Yet those statutory obligations have not prevented the rise in racism in healthcare settings.

In the 18 months following the Voice referendum, more than half of Aboriginal and Torres Strait Islander adults reported discrimination when seeking healthcare. Vicarious racism was also widespread. This shows that the political climate is not incidental to cultural safety but part of the structural conditions in which it either advances or retreats.[6(p92)]

The same pattern appears in the workforce literature. Associate Professor Sally Nathan and colleagues, with Aboriginal Reference Group leadership, show that career development for Aboriginal and Torres Strait Islander staff is undermined by several factors. These include racism from colleagues, lack of cultural awareness, limited mentoring, weak managerial support, and inflexible human resource policies. These problems are especially acute in government and other mainstream services.[74]

Professor Stephanie Topp shows that Aboriginal and Torres Strait Islander Health Workers remain constrained by low-status workforce structures and organisational racism. This persists despite their central role in culturally safe care.[63]

Dr Hannah Woodall and colleagues show that culturally safe telehealth in Australia depends on consultation skills, pre-existing relationships, and local cultural and community knowledge.[75] That makes telehealth a useful workaround for access barriers, but not a solution to the deeper structural problem. Its cultural safety still depends on the same relational and organisational conditions that the broader system often fails to provide.

Taken together, the comparison shows that the structural conditions that enable or constrain culturally safe care are political choices, not resource limitations. Canada shows that visible

harm can be converted into legislative and institutional response. Aotearoa shows that Māori governance can be built directly into health architecture, but also that statutory gains can be dismantled. Australia shows the consequences of failing to build those structures at all.

RQ E: What is required to shift the NSQHS Standards from a competency-based to an accountability-based regulatory logic for cultural safety?

The National Standards now need to be read at two levels. The first is the current second edition as the operative regulatory baseline. The second is the draft third edition as the emerging policy direction under consultation.

The draft third edition clearly signals an intention to strengthen cultural safety. It also seeks to embed Aboriginal and Torres Strait Islander-specific requirements. It seeks to address racism as a safety issue, and to place greater weight on governance, partnership, and patient experience. However, it remains a consultation draft rather than an implemented accountability regime. The question for this section is therefore not whether cultural safety is mentioned. The question is what would be required for the standards to move from a competency-based model of expected behaviour. It must become an accountability-based model that can show safe outcomes for Aboriginal and Torres Strait Islander patients.

What accreditation can do

McPhail and colleagues provide the clearest Australian anchor for what accreditation should be doing in principle. They describe healthcare accreditation as a form of external peer review. It relies on clear standards, capable assessors, and a regulatory environment. That environment drives performance, quality, and continuous improvement rather than merely recording compliance.[76]

Their account also shows the limits of a system that treats accreditation as a market of multiple layers and service excellence language. Such a system does not guarantee that standards produce better care. That is the key benchmark for RQ E. If the National Standards framework is to become accountable for cultural safety, it must do more than specify actions. It must require evidence that those actions improve care as experienced by Aboriginal and Torres Strait Islander peoples.

What is missing

What is missing in the National Standards cultural safety literature is a direct evaluation of whether the second edition produces culturally safe care in practice. The available evidence is richer on what standards say than on what standards do, and richer on implementation language than on outcome verification. That gap is important because it shows the framework is still oriented toward documenting organisational activity rather than requiring proof of safety.

In regulatory terms, that is the difference between two logics. The first is a competency logic, where the focus is on whether staff and services appear to know and do the right things. The other is an accountability logic, where the focus is on whether Aboriginal and Torres Strait Islander patients actually experience care as culturally safe. To be precise, there is little evaluation of the National Standards specifically; the available evidence speaks more to national standards and accreditation regimes generally. This partly reflects timing – review and consultation on the current edition has only recently occurred and is not yet published in this form. The absence is therefore itself a gap in the published literature.

What the overlap tells

The overlap in the evidence base is not a weakness to explain away; it is the point to make explicit. Papers such as Topp, Woodall, Tremblay, Fraser, and Harfield [38,63,68,70,75]are in the RQ E set for a reason. They show the structural conditions a regulatory framework would have to capture if it were serious about accountability.

These conditions include:

- Indigenous workforce authority;
- community governance;
- relational care; and
- institutional change.

The fact that these are the papers doing the heavy lifting tells its own story. The evidence most directly evaluating cultural safety within national standards is largely absent. By contrast, the evidence that explains why standards alone are insufficient is strong.

Where studies do engage more directly with cultural safety frameworks, they point in the same direction. Arnold-Ujvari and colleagues show in kidney care that cultural safety is not achieved by biomedical competence or policy intent alone.[77] It requires critical reflection, communication, minimising power differences, decolonisation, and the eradication of institutional racism. Crucially, they emphasise that cultural safety is determined by the people receiving care, not by the institutions delivering it.[77] That makes a purely procedural or educational response insufficient. If the standards are to drive accountability, they need to be linked to evidence that indigenous people themselves judge the care to be safe.

Palawa public health physician, Professor Ian Anderson AO and colleagues sharpen the governance lesson.[79] Their analysis of the Voice referendum shows why the Aboriginal and Torres Strait Islander voice matters in any reform agenda aimed at addressing structural racism.[79] Consultation without authority leaves decision-making unchanged.

Read alongside the draft third edition currently under consultation, this matters because the draft contains stronger language on partnership, leadership, racism, and whole-of-system responsibility. But the academic literature suggests that those commitments only become meaningful under one condition. Indigenous governance must shape the framework's design, the selection of evidence, and the assessment of whether standards are met.

What is required

Shifting from a competency-based to an accountability-based regulatory logic would, whichever instrument carries it, require three linked changes:

1. Cultural safety must be assessed through outcomes that are validated by Aboriginal and Torres Strait Islander patients, families, and communities. It should not be inferred from training modules, policies, or self-assessment.
2. Accreditation needs a stronger external review and clearer consequences where services fail to show culturally safe care in practice, not just compliance with process.
3. Third, Aboriginal and Torres Strait Islander governance must shape what counts as evidence, how cultural safety is assessed, and how findings are acted upon.

The National Standards provide the current compliance baseline, while the draft third edition signals an intent to strengthen cultural safety and anti-racism. The academic literature,

however, shows that accountability will only be achieved if the standards are tied to patient-authenticated outcomes, Indigenous governance, and credible external review. Until that happens, the standards framework remains closer to a competency-based aspiration than an accountability-based regulatory regime for cultural safety.

Discussion

The five research questions pursued in this review were designed to build a cumulative argument, not produce parallel findings. Taken together, they converge on a structural conclusion. Cultural safety in Australian hospital settings is not constrained by a lack of evidence about what is needed. It is constrained by the systematic absence of the governance architecture, accountability mechanisms, and Indigenous authority that the evidence consistently identifies as necessary. The following discussion interprets those findings in context. It also identifies implications for the Commission's work. Finally, it names the gaps and contested areas that the evidence base has not resolved.

What the findings mean for cultural safety standards in Australian health care

The most significant finding across all research questions concerns a gap. It is the distance between what the literature establishes about cultural safety and what current regulatory frameworks require.

- RQ A establishes that cultural safety is a structural and political concept – it encompasses practitioner attitudes and behaviour but cannot be reduced to them. The evidence is clear that the transfer of power and the dismantling of institutional racism are the primary conditions. Practitioner-level change alone, without structural reform, does not produce culturally safe care.
- RQ B shows that measurement of cultural safety must be led by those receiving care. Community-designed and patient-reported tools are the primary evidence base, not supplements to institutional audit.
- RQ C shows that accountability to the community, not compliance with institutional standards, is what produces safe care. Governance without indigenous authority produces structural racism rather than cultural insensitivity or unsafety.
- RQ D reveals that the structural conditions enabling culturally safe care in comparable jurisdictions are political choices that Australia has not made.
- RQ E finds that the National Standards are oriented toward documenting compliance activity. They do not require evidence that Aboriginal and Torres Strait Islander patients experience care as safe.

Each research question illuminates a different dimension of the same structural finding. Standards that measure organisational activity – training delivered, policies adopted, partnerships formed – cannot substitute for standards that require evidence of patient experience and community-authenticated outcomes. Addressing this gap is a clear priority for the current policy cycle, and the consultation that follows is well placed to consider how best to do so.

Implications for the Commission's work

The evidence base points to four linked implications for the Commission's work on cultural safety standards.

1. The definition of cultural safety should precede and shape the standards. The literature shows that cultural safety is not a competency to be trained and assessed.

It is a relational and structural condition determined by those receiving care. Standards built on a competency model – focusing on whether practitioners know and do the right things – cannot produce the accountability that a structural model requires.

The draft third edition's stronger language on racism, governance, and whole-of-system responsibility moves in the right direction, but changes in language alone do not deliver accountability. The Commission should specify what constitutes evidence of cultural safety. That specification must be grounded in the experiences of Aboriginal and Torres Strait Islander patients rather than in institutional self-assessment.

2. Measurement should shift from institutional to community led. The RQ B evidence shows that the tools most capable of capturing whether care is culturally safe are those designed by and with indigenous communities. These include patient experience surveys developed by indigenous peoples, community authentication processes, and indigenous-governed co-design frameworks. They also include patient-reported approaches such as storytelling and the *FIRST methodology*.[48]

   These are not supplementary data sources. They are the primary evidence base. Standards that require hospitals to show cultural safety need to specify that the evidence must come from those receiving care, not from those delivering it.

3. Aboriginal and Torres Strait Islander governance needs to shape the standards framework itself. The RQ C evidence consistently shows that accountability to the community – not compliance with institutional standards – produces systems-level change.

   For the National Standards framework to move from competency-based aspiration to accountability-based regime, Aboriginal and Torres Strait Islander governance must do more than inform the standards' content. It must have authority over what counts as evidence, how cultural safety is assessed, and how findings are applied. The Anderson co-design evidence makes this explicit.[54] Co-design is not a methodology that can be applied to pre-set questions. It requires Aboriginal and Torres Strait Islander governance over scope, design, and ownership.

4. The Commission's standards currently operate within a structural gap that the standards alone cannot close. The RQ D comparative evidence shows that the jurisdictions producing the most significant advances in indigenous health governance did so through legislative obligation. They also did so by transferring genuine governance authority. Canada acted in accordance with the *TRC Calls to Action*[21] and *Joyce's Principle*.[14] Aotearoa acted through *Te Tiriti*[2] obligations and (until its disestablishment) Te Aka Whai Ora.

   Australia has neither a Treaty framework nor a legislative mandate equivalent to those in comparable jurisdictions. Standards without structural architecture produce aspirational language rather than enforceable accountability. The Commission should name this gap and frame the standards accordingly. The standards are a necessary contribution to accountability, but they require legislative and political reinforcement to become durable.

Gaps in the evidence base

Three gaps in the evidence base require acknowledgement, not as methodological limitations but as findings in their own right.

The first is the thinness of hospital-specific evidence. The strongest evidence in this review comes from primary care, community-controlled health services, and specific clinical contexts. Acute inpatient hospital settings – the primary environment in which the National Standards operate – are underrepresented. Bradley's qualitative study with Aboriginal women in acute mental health inpatient settings is one of the very few studies. It generates evidence from within a hospital inpatient unit.[49] The most coercive service delivery environment in the health system is also the environment about which the least is known. That is not a coincidence.

One partial exception is the Marrie *Matrix,* a hospital-specific Australian instrument for auditing institutional racism, though it measures institutional conditions rather than patient-experienced outcomes.[56]

The second gap is the lack of evidence of evaluation of the National Standards themselves. There are no strong studies directly evaluating whether the second edition produces culturally safe care in practice. The evidence is richer on what the Standards say than on what they do. This means the Commission is reviewing a framework that has not generated its own outcome evidence. That is the finding RQ E identifies. It is also a gap that the following consultation is well placed to address. That could include building outcome-evidence requirements into any revised or new standard from the outset.

The third gap is the underrepresentation of urban and diverse indigenous populations. The evidence base skews toward remote, rural, and community-controlled settings. Urban indigenous patients – who access mainstream hospital services in the largest numbers – are less visible in the literature. Monchalin's work with urban Métis women in Toronto provides a partial comparator, but the Australian urban hospital context remains poorly evidenced.[43]

What is contested or uncertain

Three areas of genuine contest and uncertainty in the evidence base should be named rather than resolved.

The definition of cultural safety remains contested. Ramsden's original formulation – Treaty-grounded, practitioner-reflexive, focused on the transfer of power. It sits in tension with most regulatory definitions embedded in practitioner codes. These codes tend to frame cultural safety as a practitioner competency rather than a condition determined by patients.

This orientation is not accidental. Competency-based frameworks are administratively tractable – they are easier to design, audit, and enforce than outcome-based ones. Measurement that depends on patient determination requires systems of indigenous governance that most health institutions lack. The evidence base suggests this is less a failure of intent than a failure of structural architecture. When governance authority and patient-led measurement mechanisms are absent, competency documentation becomes the default.

The Ahpra definition represents the closest existing regulatory formulation to Ramsden's intent. It specifies that Aboriginal and Torres Strait Islander individuals, families and communities determine cultural safety. It also explicitly addresses power differentials and the

eradication of racism. Yet even that formulation sits in tension with the community-led definitions that emerge from patient-experience and indigenous-governance literature. There, determination means authority, not just acknowledgement.

The draft third edition's language on cultural safety reflects this definitional contest without resolving it. Until the standards specify a definition grounded in Aboriginal and Torres Strait Islander authority rather than a regulatory/standards compromise, the definitional contest will continue to produce inconsistent implementation.

The effectiveness of cultural safety training as a mechanism for producing safe care is genuinely uncertain. Hardy and colleagues' systematic review finds limited evidence that training alone improves culturally safe practice, even where it may improve clinical outcomes.[58] That finding does not mean training is valueless – it means training alone is insufficient. Standards that rely primarily on training mechanisms are unlikely to drive the outcomes they are designed to produce. The draft third edition's continued emphasis on workforce education needs to be weighed against this evidence.

The durability of standards-based reform in the current Australian political climate is uncertain. The disestablishment of Te Aka Whai Ora in Aotearoa showed that structural gains protected only by ordinary statute are politically reversible.[73]

The Australian evidence includes the post-referendum increase in reported discrimination and the structural constraints identified by Wilkes and colleagues.[6] The political conditions in which the Commission is working are not neutral. Standards that require Aboriginal and Torres Strait Islander governance, patient-authenticated outcomes, and enforceable accountability are more durable than those reliant on political goodwill.

The Commission's choices about the strength and specificity of any accountability requirements are pivotal. These choices will determine whether those standards can survive changes in the political climate.

Conclusion

The literature reviewed for this report does not leave the Commission without direction. It leaves it without the option of incremental adjustment. The evidence is clear that cultural safety in Australian hospital settings will not be achieved by better training, stronger language, or more comprehensive self-assessment frameworks.[58] It will be achieved when Aboriginal and Torres Strait Islander patients determine whether care is safe,[3] and when communities hold authority over how that determination is made.[10-13] Cultural safety also requires standards that demand evidence of outcomes rather than documentation of activity.[58]

The evidence points to four concrete levers through which the Commission's review can begin to shift.

First, the definition of cultural safety should be specified before the standards are designed. It must be grounded in Aboriginal and Torres Strait Islander authority rather than regulatory compromise. It must make explicit that cultural safety is determined by those receiving care, not those delivering it.[3]

Second, measurement must move from institutional self-assessment to community-led and patient-validated tools. The evidence base is clear that the most capable measurement approaches are those designed by and with Indigenous communities.[46,48-50]

Third, Aboriginal and Torres Strait Islander governance must shape more than the content of the standards. It must also shape what counts as evidence, how cultural safety is assessed, and how findings generate consequences. [4,23-25]

Fourth, the Commission should name honestly that standards alone cannot close the structural gap. The jurisdictions producing the most significant advances in indigenous health governance did so through legislative obligation and the transfer of genuine governance authority. This is a structural architecture Australia has not yet built.[5,14,19]

None of these levers requires waiting for legislative change to begin. The Commission is well placed to lead. It has the mandate to specify patient-determined safety as the evidentiary standard. It can require Aboriginal and Torres Strait Islander governance over assessment design and the inclusion of evidence requirements for build outcomes in any revised or new standard from the outset. The question the evidence puts to the Commission is not whether the direction is clear. The direction is clear. The real question is whether the standards will be written with enough specificity and consequence to make that direction enforceable.

Reference list – Part A

1. United Nations General Assembly. United Nations Declaration on the Rights of Indigenous Peoples: resolution adopted by the General Assembly, 13 September 2007. New York: United Nations; 2007. Available from: https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf
2. Te Tiriti o Waitangi [Treaty of Waitangi]. Wellington: Archives New Zealand | Puna Mātauranga o Aotearoa; 1840. Available from: https://www.archives.govt.nz/the-treaty-of-waitangi
3. Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine SJ, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. International Journal for Equity in Health. 2019;18(1):174. doi:10.1186/s12939-019-1082-3
4. Gallagher J. The First Nations Health Authority: A transformation in healthcare for BC First Nations. Healthcare Management Forum. 2015;28(6):255–61.
5. Papps E, Ramsden I. Cultural safety in nursing: The New Zealand experience. International Journal for Quality in Health Care. 1996;8(5):491–497.
6. Wilkes B. Embedding cultural safety to combat racism against Aboriginal and Torres Strait Islander peoples: Advice for healthcare settings. Australian Journal of General Practice. 2026;55(3):91–6.
7. Curtis E, Loring B, Jones R, Tipene-Leach D, Walker C, Paine S-J, et al. Refining the definitions of cultural safety, cultural competency and Indigenous health: lessons from Aotearoa New Zealand. Intern. 2025;24(1):107.
8. Kurtz DLM, Janke R, Vinek J, Wells T, Hutchinson P, Froste A. Health Sciences cultural safety education in Australia, Canada, New Zealand, and the United States: a literature review. International Journal of Medical Education. 2018;9:271–85.
9. Metzl JM, Hansen H. Structural competency: Theorizing a new medical engagement with stigma and inequality. Soc Sci Med. 2014;103:126–33.
10. Ramsden IM. Cultural safety and nursing education in Aotearoa and Te Waipounamu [doctoral thesis]. Wellington: Victoria University of Wellington; 2002.
11. von der Porten S, de Loë RC. Canadian indigenous governance literature: A review. AlterNative. 2012;8(1):1–14. Available from: https://search.informit.org/doi/10.3316/informit.006343452432798
12. Palu ML, Wenham K, Shagar P. The Role of Cultural Safety Within a Human Rights-Based Approach to Improve Indigenous Peoples' Health: A Scoping Review. Journal of Advanced Nursing. 2025;81(7):3600–3614. doi:10.1111/jan.16685
13. Jennings W. The power of talk and power in talk: A systematic review of Indigenous narratives of culturally safe healthcare communication. Australian Journal of Primary Health. 2018;24(2):109–15.
14. Council of the Atikamekw of Manawan and Council of the Atikamekw Nation. Joyce's Principle: Atikamekw Nehirowisiw. Brief presented to the Government of Canada and the Government of Quebec. Manawan: 2020. Available from: https://principedejoyce.com/sn_uploads/principe/Joyce_s_Principle_brief___Eng.pdf
15. Borwick K, Loignon C, Viscogliosi C, et al.Culturally Safe Care Barriers and Facilitators in Organ Transplantation and Donation According to First Nations and Health Professionals in Quebec, Canada. Progress in Transplantation. 2024;34(3):96–102.

16. Rae N. A critical Tiriti analysis of Te Pae Tata: the Interim New Zealand Health Plan. The New Zealand Medical Journal. 2023;136(1573):88–93.

17. Morgan J. Calls to Action: Truth, Reconciliation, and Indigenous Rights for Supportive Decision-Making in Healthcare. International Journal of Indigenous Health. 2021;16(1):243–60.

18. Ngampromwongse K, Gall A. 10 years of preventive health in Australia. Part 2 - centring First Nations sovereignty. Public Health Research & Practice. 2025;35. doi:10.1071/PU24023

19. Eni R, Phillips-Beck W, Achan GK, et al. Decolonizing health in Canada: A Manitoba first nation perspective. International Journal for Equity in Health. 2021;20(1):206. doi:10.1186/s12939-021-01539-7

20. Gone JP. Re-imagining mental health services for American Indian communities: Centering Indigenous perspectives. American Journal of Community Psychology. 2022

21. Truth and Reconciliation Commission of Canada. Truth and Reconciliation Commission of Canada: Calls to Action. Winnipeg: TRC; 2015. Available from: https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf

22. Australian Health Practitioner Regulation Agency. The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025. Melbourne: Ahpra; 2020. Available from: https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx

23. Edmundson L. The First Nations Health Authority's Self-Assessment Aligning With the British Columbia Cultural Safety and Humility Standard. Healthcare Quarterly. 2024;27(2):56–61.

24. Owen KJ, Cundale K, Hughes JT, et al. From talk to action: Indigenous Reference Groups drive practice change in kidney transplantation care. Medical Journal of Australia. 2023;219(S8):S15-S18.

25. Clark K. Highlighting models of Indigenous leadership and self-governance for COVID-19 vaccination programmes. AlterNative: An International Journal of Indigenous Peoples. 2024;20(1):250–8.

26. Bourque Bearskin ML, Seymour MLC, Melnyk R, et al. Truth to Action: Lived Experiences of Indigenous Healthcare Professionals Redressing Indigenous-Specific Racism. Canadian Journal of Nursing Research. 2025;57(1):94–111. doi:10.1177/08445621241282784

27. Came H. Sites of institutional racism in public health policy making in New Zealand. Social Science and Medicine. 2014;106:214–220.

28. Ray L. Shapeshifters, systems thinking and settler colonial logic: Expanding the framework of analysis of Indigenous health equity. Social Science and Medicine. 2022.

29. da Silva MM. A moral economy of care: How clinical discourses perpetuate Indigenous-specific discrimination and racism in western Canadian emergency departments. Medical Anthropology Quarterly. 2024.

30. Long RC. A rapid systematized review of evaluated health care programmes for Indigenous peoples in Canada with First Nations authentication of cultural safety domains. AlterNative: An International Journal of Indigenous Peoples. 2025;21(2):429–39.

31. ANZSOG. Healing from the Centre: integrating Aboriginal healing into the health system. Melbourne: Australia and New Zealand School of Government (ANZSOG); 2021.

32. Lacey C. The Hui Process: a framework to enhance the doctor-patient relationship with Māori. New Zealand Medical Journal. 2011;124(1347):72–8.

33. Komene E. Whakawhanaungatanga – Building trust and connections: A qualitative study indigenous Māori patients and whānau (extended family network) hospital experiences. Journal of Advanced Nursing. 2024;80(4):1545–58.

34. Goodman A, Etowa J, Hamelin KP, Kaseje N. "They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal peoples living in Vancouver's inner city. Int Indig Policy J. 2017;8(2).

35. McLardie-Hore FE, McLachlan HL, Newton MS, et al. Accurate identification and documentation of First Nations women and babies attending maternity services: How can we 'close the gap' if we can't get this right? Australian & New Zealand Journal of Obstetrics & Gynaecology. 2023;63(2):234–240. doi:10.1111/ajo.13641

36. Johnson J, Hasan L. Paddling Together for Culturally Safe Emergency Care for Elders. International Journal of Indigenous Health. 2021;16(1):146–164.

37. Kerrigan V, McGrath SY, Majoni SW, et al. From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital. BMC Health Services Research. 2021;21(1):548. doi:10.1186/s12913-021-06564-4

38. Fraser SL. Dissecting systemic racism: policies, practices and epistemologies creating racialized systems of care for Indigenous peoples. International Journal for Equity in Health. 2021;20(1):164.

39. Morgan DJ, Harris T, Gidgup R, et al. Identifying the cultural heritage of patients during clinical handover and in hospital medical records. Med J Aust. 2019;210(5):220–226.

40. Fitzpatrick K. Understanding Indigenous peoples experiences to inform recommendations for improving cultural safety and care in radiation therapy centres in Alberta, Canada. Journal of Medical Imaging and Radiation Sciences. 2024;55(3):101722.

41. Sivertsen N, Johnson T, Mehus G, et al. What is known about Indigenous women's dissatisfaction of Birthing experiences in mainstream maternity hospitals in Australia, Aotearoa, Canada, US, Kalaallit Nunaat and Sapmi? A systematic scoping review. Frontiers in Public Health. 2025;13:1495197. doi:10.3389/fpubh.2025.1495197

42. Nash D. Indigenous Preferences for Inpatient Rooms in Australian Hospitals: A Mixed-Methods Study in Cross-Cultural Design. Health Environments Research and Design Journal. 2021;14(1):174–89.

43. Monchalin R. "I would prefer to have my health care provided over a cup of tea any day": Recommendations by urban metis women to improve access to health and social services in toronto for the metis community. AlterNative. 2019;15(3):217–25.

44. Doyle H. Ceremony, Respect, and Understanding: Storytelling as Method for Indigenous Patient Experience Measurement to Inform Culturally Safe Care. International Journal of Indigenous Health. 2025.

45. Gerard C, O'Brien I, Shuker C, et al. Patient experience surveys are vital in the twenty-first century: let's put some myths to rest. N Z Med J. 2024;137(1588):80–89.

46. Elvidge E, Paradies Y, Aldrich R, Holder C. Cultural safety in hospitals: Validating an empirical measurement tool to capture the Aboriginal patient experience. Aust Health Rev. 2020;44(2):205–11.

47. Roach P, Ody M, Campbell P, et al. Access, relationships, quality and safety (ARQS): A qualitative study to develop an Indigenous-centred understanding of virtual care quality. BMJ Open Quality. 2022;11(4).

48. Latimer M. Co-creating better healthcare experiences for First Nations children and youth: The FIRST approach emerges from Two-Eyed seeing. Paediatric and neonatal Pain. 2020;2(4):104–12.

49. Bradley P, Lowell A, Daiyi C, Macklin K, Nagel T, Dunn S. It's a little bit like prison, but not that much: Aboriginal women's experiences of an acute mental health inpatient unit. International Journal of Mental Health Nursing. 2021;30(4):917–30. doi:10.1111/inm.12843

50. Willing E. Indigenous voices on measuring and valuing health states. AlterNative. 2020;16(1):3–9.

51. Brumpton K. Assessing cultural safety in general practice consultations for Indigenous patients: protocol for a mixed methods sequential embedded design study. BMC Medical Education. 2023.

52. Cormick A, Graham A, Stevenson T, et al. Co-designing a Health Journey Mapping resource for culturally safe health care with and for First Nations people. Australian Journal of Primary Health. 2024;30. doi:10.1071/PY23172

53. Fraser S, Grant J, Mackean T, et al. Considering difference: clinician insights into providing equal and equitable burns care for Aboriginal and Torres Strait Islander children. Australian & New Zealand Journal of Public Health. 2021;45(3):220–226. doi:10.1111/1753-6405.13110

54. Anderson K. Development of Key Principles and Best Practices for Co-Design in Health with First Nations Australians. International Journal of Environmental Research and Public Health. 2023.

55. Muller J, Devine S, Geia L, et al. Audit tools for culturally safe and responsive healthcare practices with Aboriginal and Torres Strait Islander people: a scoping review. BMJ Global Health. 2024;9(1):29. doi:10.1136/bmjgh-2023-014194

56. Marrie A, Marrie H. A matrix for identifying, measuring and monitoring institutional racism within public hospitals and health services. Gordonvale (QLD): Bukal Consultancy Services; 2014.

57. Mackean T, Fisher M, Friel S, et al. A framework to assess cultural safety in Australian public policy. Health Promotion International. 2020;35(2):340–351. doi:10.1093/heapro/daz011

58. Hardy BJ, Filipenko S, Smylie D, et al. Systematic review of Indigenous cultural safety training interventions for healthcare professionals in Australia, Canada, New Zealand and the United States. BMJ Open. 2023;13(10):e073320. doi:10.1136/bmjopen-2023-073320

59. Smylie J. Randomized controlled trial demonstrates novel tools to assess patient outcomes of Indigenous cultural safety training. BMC Medicine. 2024.

60. Australian Government Department of Health. National Preventive Health Strategy 2021–2030. Canberra: Commonwealth of Australia; 2021. Available from: https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030

61. Veasey AE. An opportunity to transform Australia's neo-colonial health system. Australian Health Review. 2024;48(2):116–118.

62. Stefanon BM. Effective health and wellness systems for rural and remote Indigenous communities: a rapid review. International Journal of Circumpolar Health. 2023;82(1):2215553.

63. Topp SM. Rhetoric, Reality and Racism: The Governance of Aboriginal and Torres Strait Islander Health Workers in a State Government Health Service in Australia. 2022.

64. Coombes J. Discharge interventions for First Nations people with a chronic condition or injury: a systematic review. BMC Health Services Research. 2023.

65. Maar M. Developing Relationships on a Shared Path to Reconciliation: The Core of Health Transformation and Safe Care for Indigenous People. Healthcare Quarterly. 2022;25(2):16–24.

66. Wood L. Beyond the rhetoric: How can non-government organisations contribute to reducing health disparities for Aboriginal and Torres Strait Islander people? Aust J Prim Health. Australian Journal of Primary Health. 2011;17(4):384–94.

67. Sheldon C. Creation of the Indigenous Support Line for health system navigation and culturally safe access to care: a quality improvement project. BMJ Open Quality. 2024.

68. Tremblay MC. Cultural safety involves new professional roles: a rapid review of interventions in Australia, the United States, Canada and New Zealand. AlterNative. 2023;19(1):166–75.

69. Chatwood S. Indigenous values and health systems stewardship in circumpolar countries. International Journal of Environmental Research and Public Health. 2017.

70. Harfield S, Purcell T, Schioldann E, et al. Enablers and barriers to primary health care access for Indigenous adolescents: a systematic review and meta-aggregation of studies across Australia, Canada, New Zealand, and USA. BMC Health Services Research. 2024;24(1):553. doi:10.1186/s12913-024-10796-5

71. Monchalin R. Digging up the medicines: Urban Metis women's identity and experiences with health and social services in Toronto, Ontario. Dissertation Abstracts International: Section B: The Sciences and Engineering. 2020;81(6-B):No Pagination Specified.

72. Ahuriri-Driscoll A, Lovell S, Te Kawa D, et al. The future of Māori health is here – The 2022 Aotearoa New Zealand health reforms. The Lancet Regional Health - Western Pacific. 2022;28:100589.

73. Came H, Aspin C, Coupe N, et al. Pae Ora (Disestablishment of Māori Health Authority) Amendment Act 2024: further Crown breaches of Te Tiriti o Waitangi. N Z Med J. 2024;137(1595):94–98.

74. Nathan S. An Australian National Survey of First Nations Careers in Health Services. Health & Social Care in the Community. 2023.

75. Terrill K, Woodall H, Evans R, Sen Gupta T, Ward R, Brumpton K. Cultural safety in telehealth consultations with Indigenous people: A scoping review of global literature. Journal of Telemedicine and Telecare. 2025;31(4):515–22. doi:10.1177/1357633X231203874

76. McPhail R, Avery MJ, Fisher R, Fitzgerald A, Fulop L. The changing face of healthcare accreditation in Australia. Asia Pacific Journal of Health Management. 2015;10(2):58–64.

77. Arnold-Ujvari M, Rix E, Kelly J. The emergence of cultural safety within kidney care for Indigenous Peoples in Australia. Nurs Inq. 2024;31(3):e12626.

78. Health Practitioner Regulation National Law (Queensland) Act 2023 (Qld).

79. Anderson I, Paradies Y, Langton M, Lovett R, Calma T. Racism and the 2023 Australian constitutional referendum. The Lancet. 2023;402(10411):1400–1403. doi:10.1016/S0140-6736(23)01954-2

Part B: Environmental scan

Introduction

This section presents the findings of an environmental scan. An environmental scan is not a literature review. Where a literature review analyses peer-reviewed research, an environmental scan maps the real-world policy landscape. It documents what has actually been enacted, built, and implemented. It seeks to capture what academic research cannot: enacted standards, binding obligations, implemented programs, inquiry findings, and governance structures.

This scan covers cultural safety policy, regulatory instruments, governance structures, and implementation models in Aboriginal and Torres Strait Islander health care. It covers Australia and three comparable international jurisdictions. Together with Part A, it provides the Australian Commission on Safety and Quality in Health Care (the Commission) with a dual-lens evidence base. Part A established what the evidence says should exist. Part B maps what has actually been built.

The scan is organised around four policy functions. These correspond to the stages through which cultural safety moves from concept to consequence in health systems.

- Function 1 examines definitional and conceptual frameworks. It asks how cultural safety has been translated into policy language and whose definition has been adopted.
- Function 2 examines regulatory and standards instruments. It asks what has been mandated, by whom, and with what statutory authority.
- Function 3 examines governance and accountability structures. It asks who is responsible, to whom they report, and how compliance is assessed and enforced.
- Function 4 examines implementation models and measurement. It asks what has actually been built, and what outcomes it has produced.

These four functions are not separate stages. They are interdependent policy dimensions. The quality of a definitional framework shapes the strength of regulatory instruments. The architecture of accountability structures determines whether implementation produces measurable outcomes or merely documentation.

The domestic scan covers the Australian national, state and territory policy landscape. It gives particular attention to the National Standards and the accreditation systems in which they operate.

The international scan examines three settler-colonial jurisdictions selected for their comparability with Australia's regulatory context. Aotearoa, New Zealand, is included because the concept of cultural safety originated there. It also has the most sustained regulatory implementation of any comparable jurisdiction. Canada is included because recent binding provincial standards and a national data framework have advanced the accountability architecture. The United States of America is included because it has the most developed model of indigenous self-governance in health service delivery. It also demonstrates what happens when self-governance operates without a regulatory framework for cultural safety.

These comparisons are not offered as models for direct adoption. They are offered to make visible what may be possible, what has been tried, what has worked, and what has been

dismantled. They allow this scan to identify, with precision, the distance between those international experiences and the architecture Australia has built to date.

A note on the argument this scan makes. The gap between what the evidence supports (Part A) and what the policy landscape shows (Part B) is not an ordinary policy design failure. The Australian regulatory environment contains well-designed definitions, nationally endorsed monitoring frameworks, and jurisdictional strategies. These reflect genuine engagement with the evidence. What is absent is not knowledge of what is needed.

While resource constraints and legacy infrastructure play a role, the comparative evidence in this scan consistently identifies political will as the decisive barrier.[1-2] Jurisdictions that have made progress did so when governments mandated, funded, and enforced accountability mechanisms.

That gap is named explicitly in this scan. It should be named in any honest analysis of why the system produces the outcomes it does. Naming it is not intended to foreclose action. It clarifies what action the Commission could take within its existing mandate. It also clarifies what action would require political conditions that do not currently exist.

Methodology

The environmental scan used a purposive search strategy. This means sources were deliberately selected because they were relevant to the four policy functions. Sources were not identified through a comprehensive database search. These sources are described as 'grey literature.' Grey literature includes government strategies, regulatory frameworks, accreditation standards, inquiry reports, peak body statements, and implementation toolkits. Unlike peer-reviewed research, grey literature is not comprehensively indexed in academic databases. Finding it requires targeted source searching and following references from identified documents to new ones – a method known as snowball sampling.

Inclusion and exclusion criteria

The scan targeted sources published between 2011 and 2026, consistent with the review's overall timeframe. All sources are in English. The domestic search covered Commonwealth, state and territory health department websites, health professional regulatory body websites, accreditation organisations, and peak Aboriginal and Torres Strait Islander community-controlled health organisations. The international search targeted equivalent bodies in Aotearoa, Canada, and the United States of America. This included health professional regulatory councils, national quality and patient safety agencies, and Indigenous health governance organisations. Legislation identified during the scan is referenced as contextual material rather than as a screened source.

Assessment framework

Sources were screened against five research questions corresponding to the policy functions.

- The first research question (RQ A) asks whether the community rather than health practitioners define cultural safety.
- The second (RQ B) asks whether a measurement framework centred on community experience exists.
- The third (RQ C) asks whether governance and accountability mechanisms are in place.

- The fourth (RQ D) asks what structural conditions enable or impede culturally safe care in Aotearoa and Canada.
- The fifth (RQ E) asks how existing regulatory frameworks – including the National Standards – compare to the evidence and to international practice.

Each source was assessed against several dimensions. These included the level of government at which it operates – national, state/territory, or organisational. They also included whether requirements are binding, voluntary, or advisory. Accountability requirements were assessed, including consequence structures, public reporting, and community oversight. Evidence of effectiveness was noted where available. Transferability to the Australian accreditation context was also assessed. 74 sources were screened and included across the domestic and international components of the scan. The comparative findings are summarised in Tables 2 and 5.

Results

Domestic scan – Australia

Table 2: Comparative summary – Australian cultural safety models and frameworks

Source/model	Jurisdiction	Setting	Key features	Evidence of effectiveness
National Standards (Standard 1: Clinical Governance; Standard 2: Partnering with Consumers)[3]	National	Hospitals and health services	The second edition of the Standards includes six defined Aboriginal and Torres Strait Islander-specific actions. Action 1.21 addresses cultural competency (language to be reviewed in the third edition in partnership with Aboriginal and Torres Strait Islander communities). Standard 2 requires consumer partnership structures. The National Standards are a framework for safety and quality with cultural safety and equity requirements embedded throughout – not a standalone cultural safety model or standard. No defined benchmark or threshold for compliance with cultural safety-specific requirements.	No published national outcome data against cultural safety-specific indicators. AIHW monitoring framework under development. Limited facility-level reporting.
National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025[4] Australian Health Practitioner Regulation Agency	National	Health practitioner regulation (all registered professions)	Defines cultural safety as a responsibility of health practitioners rather than patients. Aboriginal and Torres Strait Islander Health Strategy Group advises on implementation.	No published outcome data against cultural safety indicators. No national dataset of complaints or notifications with cultural safety classification.
NACCHO/RACGP Joint Commitment to Cultural Safety[5]	National	Primary care; general practice	Joint framework defining cultural safety as community-controlled and requiring acknowledgement of power imbalance between practitioner and patient. No binding accreditation consequence; no enforcement pathway.	Not evaluated against quantitative outcomes. Cited as a definitional reference in subsequent policy documents.

Quality Improvement Council (QIC) Health and Community Services Standards[6]	National	Aboriginal Community Controlled Health Organisations (ACCHOs)	A sector-specific accreditation framework is applied across the ACCHO sector. Culturally grounded quality standards with a strong Aboriginal and Torres Strait Islander community governance model. Distinct from National Standards.	ACCHOs consistently outperform mainstream services on Aboriginal and Torres Strait Islander patient experience indicators. Strongest Australian evidence base for Aboriginal and Torres Strait Islander-governed culturally safe services.[7]
State and territory frameworks	State / Territory	State health systems; community services	Co-designed frameworks embedding cultural safety across state health strategy. Vary significantly in governance architecture and accountability mechanisms. Queensland's Making Tracks Together is co-governed with the Queensland Aboriginal and Islander Health Council (QAIHC).	Inconsistent reporting across jurisdictions. Queensland publishes outcome data against framework indicators. Thirteen of 19 frameworks examined have no publicly available progress reports (see Table 4).

Function 1: Definitional and conceptual frameworks

Several related terms are used in the health system alongside cultural safety – including cultural awareness, cultural competency, and cultural capability. Health services have adopted all at various points. This scan focuses on cultural safety, as it is the term adopted by Australia's national regulatory/accreditation frameworks.

The concept of cultural safety was developed in Aotearoa by Ngāi Tahu nurse-academic Dr Irihapeti Ramsden. Her definition established that cultural safety is an outcome of education – it 'enables safe service to be defined by those who receive the service.'[8-9]

The author of this report managed the consultation process that produced Ahpra's cultural safety definition.[4] The Australian Health Practitioner Regulation Agency (Ahpra) administers the National Registration and Accreditation Scheme (NRAS). NRAS covers Ahpra, 15 National Boards, and their accrediting authorities.[4] The NRAS cultural safety definition was heavily influenced by Ramsden's work and Australian nurses and midwives.[8]

The term 'cultural safety' is well-suited for adoption by health regulators and accrediting bodies. It connects to the established understanding of 'safety' and 'safe health care' because both locate the test of safety with the person receiving care, not the provider. Cultural safety extends the existing patient-safety paradigm – already core to the National Standards – to include freedom from racism and care that the patient experiences as respectful.

Several definitions of cultural safety have been adopted globally by health regulators and health services. These span government-led and community-controlled organisations. Despite this variation, there is a strong consensus on their core components.

The core components include:

- Recipient determines;
- Acknowledgment of and need to address power differentials;
- Anti-racism;
- Ongoing practice;
- Critical self-reflection.[10]

These components collectively reflect a decolonising praxis.[10] Cultural safety, as Ramsden conceived it, was not a technique to be applied within existing colonial structures – it was a challenge to those structures.

The Commission's definition of cultural safety is a modified version of the NRAS definition.

The definition is as follows:

> Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.
>
> In health care, culturally safe practise is the ongoing critical reflection of knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.
>
> Essential features of cultural safety are individuals and organisations:
>
> • Acknowledging colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health

> • Acknowledging and addressing individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism
>
> • Recognising the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community
>
> • Fostering a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.[11]

The National Scheme's full definition is as follows:

> **Principles:**
>
> The following principles inform the definition of cultural safety:
>
> • Prioritising COAG's goal to deliver healthcare free of racism supported by the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*
>
> • Improved health service provision supported by the *Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health*
>
> • Provision of a rights-based approach to healthcare supported by the *United Nations Declaration on the Rights of Indigenous Peoples*
>
> • Ongoing commitment to learning, education and training
>
> **Definition:**
>
> Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.
>
> Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.
>
> **How to:**
>
> To ensure culturally safe and respectful practice, health practitioners must:
>
> a. Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health;
>
> b. Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism;
>
> c. Recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community;
>
> d. Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.[4]

The NRAS definition is Aboriginal and Torres Strait Islander-determined and features in the codes of conduct and registration standards for all 16 regulated health professions. This grounding in the Health Practitioner Regulation National Law (the National Law) gives it statutory authority. Most health practitioners' employment (regulated under NRAS) is conditional on meeting registration and code of conduct requirements. These requirements are based on the National Scheme's definition of cultural safety. That definition applies to regulated health practitioners across every state and territory under the National Law.

IRP's assessment is that all state and territory health departments, hospitals, and health services should adopt the same definition. Without this, accountability mechanisms cannot function consistently across the system. For accountability to function at the local level,

institutions responsible for delivering care must share a common definition. Systemic, structural, and individual accountability all depend on this. Without definitional alignment, an accountability vacuum emerges. That vacuum can be exploited by those who caused harm. It allows them to invoke whichever framework offers the least scrutiny of their conduct.

The consequences of definitional misalignment are not theoretical. In 2023, a Coroner's inquest examined the deaths of three Aboriginal women in Doomadgee, a remote community in north-west Queensland.[12-13] These women died from rheumatic heart disease – a serious and largely preventable condition. It is the most comprehensively documented case of its kind in Queensland. The inquest found that 'systems failed' these three women.[12-13] Confusion about 'which service was responsible' was identified as a direct barrier to care.[12-13] Critically, the Coroner did not attribute this to individual clinical failure.[13] The failure was structural and foreseeable. The *2016 Case for Change* paper, cited in the inquest, had already identified this problem.[14] It found 'no common frame of reference between key health organisations' as a root cause of dysfunction.[12] The tripartite agreement, intended to govern relationships between relevant services, was found to be 'not legally binding' and 'not adequately executed.'[12] The inquest and the *2016 Case for Change* identify the absence of a 'common frame of reference' as a root cause. This review specifically draws a link to definitional misalignment.[12-13]

Under *Queensland's Health Practitioner Regulation National Law 2023*, every registered health practitioner at Doomadgee Hospital carries a legal obligation. That obligation included contributing to the elimination of racism in health services. It was shaped by landmark amendments to the National Law in 2022.[15]

Adding a new objective:

- to build the capacity of the Australian health workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander Peoples.

And a new guiding principle:

- The Scheme is to ensure the development of a culturally safe and respectful health workforce that:
  - is responsive to Aboriginal and Torres Strait Islander Peoples and their health; and
  - contributes to the elimination of racism in the provision of health services.[16]

Yet the institution itself operated without a shared definition of cultural safety or the governance mechanisms to enforce it. When the gap between practitioners' obligations and the institutional framework is this wide, accountability diffuses. No single actor is clearly responsible. No single framework governs.

Adopting the Commission's definition across all health departments, hospitals, and health services would do more than harmonise language. It would close the structural gap that allowed these three preventable deaths to occur. It would ensure that no institution can avoid accountability by pointing to definitional ambiguity.

Function 2: Regulatory and standards instruments

The regulatory and standards instruments in Australia that drive culturally safe health practice derive their authority from two primary sources. The first is NRAS, operating through

the National Law as in effect in every state and territory. That legislation covers all registered health practitioners across 15 profession-specific National Boards, administered by Ahpra.[16]

These two instruments create parallel but distinct compliance obligations. For a health service to maintain accreditation, it must meet the requirements set out in the National Standards. For an individual practitioner to practise in a health service, they must meet the National Board's registration conditions and code of conduct. The National Boards also impose continuing professional development (CPD) requirements for each profession regulated under the National Scheme.

The second is the Australian Commission on Safety and Quality in Health Care (the Commission). Under the National Health Reform Act 2011, the Commission is responsible for formulating the National Safety and Quality Standards and coordinating the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme).

The Commission is not itself a regulator: state and territory health departments are responsible for licensing health services and for determining which standards a health service organisation must be accredited to. The Commission approves accrediting agencies to assess health service organisations against the National Standards and monitors their performance and compliance with the requirements of the Scheme.[3,17]

The National Standards are currently in their second edition, which sets the existing compliance baseline.[3] A third edition is currently under consultation and development.[18] Its final form will be shaped by the outcomes of that consultation process, including stakeholder and community feedback.[18] The third edition builds upon the second. It represents a significant opportunity to strengthen accountability for culturally safe practice at both the practitioner and institutional levels. Critically, the third edition provides an opportunity to align the Commission's definition of cultural safety with that used in the National Law.[18] This includes adopting a common definition shared with the National Scheme. Definitional alignment across these two instruments would address part of the accountability vacuum identified in Function 1. Whether the third edition consultation delivers that outcome may depend on the policy choices made during its development.[18]

This work also sits within a broader program of First Nations health reform being progressed under the National Health Reform Agreement extension and in advance of Schedule B of the 2026–2031 Addendum. The rapid literature review and environmental scan form part of the Commission’s preliminary work, undertaken alongside separate projects led by the National Aboriginal Community Controlled Health Organisation (NACCHO), focused on monitoring and accountability, and the Australian Institute of Health and Welfare (AIHW), focused on measurement and data. The Commission has advised that it will draw on the findings of this report, together with the work of the AIHW and NACCHO, to inform the direction of the standards for cultural safety review and, ultimately, its approach to implementation under the National Health Reform Agreement.

It is worth noting the current disparity in statutory authority between these two instruments. The National Law carries stronger powers to sanction health practitioners. It can impose conditions on those found to be practising in a culturally unsafe manner. Published data on how often these stronger powers are exercised specifically for culturally unsafe practice is limited. Both instruments' enforcement arrangements are publicly documented – the National Law through Ahpra's published regulatory framework and registers, and the National Standards settings through the Commission's accreditation scheme materials.

The Commission's National Standards operate through accreditation rather than professional registration. Non-accreditation carries real consequences for health services,

but the current Standards do not require cultural safety to be assessed as a specific, standalone outcome. The enforcement mechanism exists; the cultural safety obligation within it does not.

This comparison requires qualification. The National Law and the National Standards operate on different regulatory logics: the former governs individual practitioners through registration and professional conduct mechanisms; the latter governs health service organisations through accreditation cycles. Strengthening cultural safety accountability within the National Standards would require adaptation to that organisational logic, not simple equivalence with the National Law's enforcement model.

Weenthunga Health Network developed an unpublished *Cultural Safety Accreditation and CPD Upskilling Framework and Strategy 2026–2031*, a key deliverable of the *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025 (the Strategy).*[4,19] The framework was developed with an expert working group convened by Ahpra. The working group comprised a majority of Aboriginal and Torres Strait Islander health leaders and allies, including the Commission. The framework recommends a mandatory annual cultural safety training requirement for all health practitioners regulated under NRAS.[19] It further recommends establishing an independent Aboriginal and Torres Strait Islander led body to accredit cultural safety practice and training. This would consolidate that function into a single body, rather than across 15 separate profession-specific accrediting bodies. That arrangement has been identified as ineffective and inefficient in delivering culturally safe care to Aboriginal and Torres Strait Islander peoples.[7,19]

Complex health complaint body architecture

Further complicating the consistent application of standards and statutory authority is the fragmented architecture for health practitioner complaints across Australian jurisdictions. Not all states and territories have Ahpra as their primary complaints body for complaints about health practitioners.

In Queensland, health practitioner complaints are managed by the Office of the Health Ombudsman. In Victoria, they are managed by the Health Complaints Commissioner. In New South Wales, they are managed by the Health Care Complaints Commission. For an Aboriginal or Torres Strait Islander health consumer experiencing culturally unsafe care, this complexity is an additional barrier. It creates an unnecessary burden in identifying the appropriate avenue for redress.

The principles and objectives of the National Law bind each of these complaint bodies. Each is also bound by the codes of conduct established by the 15 National Boards. Despite this, the way complaints are administratively managed and the outcomes produced differ across bodies. This produces differential outcomes for complaints of culturally unsafe care and adds further fragmentation to an already complex system.

It is recommended that a uniform approach to managing complaints be adopted across all health complaints bodies in Australia. This approach should apply to complaints relating to Aboriginal and Torres Strait Islander health consumers and practitioners. Alternatively, such complaints could be primarily managed by Ahpra. Ahpra has an existing Aboriginal and Torres Strait Islander-chaired complaints committee architecture, including the National Special Issues Committees on Indigenous-Specific Racism. This mechanism applies to complaints about individual registered health practitioners in medical, nursing, and midwifery practice. The establishment of these committees is publicly documented.[20-21]

Function 3: Governance and accountability structures

As noted in Function 2, formal obligations to deliver culturally safe health practice are set out across multiple instruments. These include the National Law, the codes of conduct established by the 15 National Boards, and the National Standards. However, obligations and enforcement infrastructure are not the same thing. This function finds that while those obligations exist on paper, the accountability architecture for cultural safety is thin, fragmented, and largely advisory rather than binding.

Aboriginal and Torres Strait Islander oversight bodies and advisory structures exist within the Australian health regulatory system. However, they are not empowered to make binding decisions or to hold institutions to account independently.

Ahpra convenes the National Scheme's Aboriginal and Torres Strait Islander Health Strategy Group to advise on the Strategy's implementation. State and territory hospital and health services maintain Aboriginal and Torres Strait Islander health advisory bodies at various levels. The Commission also has advisory input from Aboriginal and Torres Strait Islander representatives. None of these bodies, however, holds independent enforcement powers. Each advises the accountable institution rather than holding it to account from outside. This is a structural arrangement that places authority to respond to cultural safety concerns within the very institutions that raise those concerns.

According to the evidence, what is measured against cultural safety obligations is very limited. Accreditation processes assess process compliance: whether a health service has a cultural safety policy, whether staff have completed training. They do not assess outcome compliance – that is, whether Aboriginal and Torres Strait Islander patients actually experienced care as culturally safe. Accreditation is also a point-in-time process conducted every few years; it is not an ongoing or continual assessment.

The AIHW tracks accreditation coverage through its *Indigenous Health Performance Framework Measure 3.19*, which records the proportion of Aboriginal and Torres Strait Islander hospitalisations occurring in accredited hospitals.[7,22,77] That figure is 99.2% – making accreditation coverage effectively universal.[22] Yet this near-universal coverage is not a measure of cultural safety. It establishes that First Nations patients are overwhelmingly admitted to accredited hospitals; it cannot tell us whether care in those hospitals was culturally safe. The absence of a community-reported cultural safety outcome measure is, itself, a structural finding. This is corroborated by the Lowitja Institute and by Elvidge and Haddock, both of whom identify the current compliance architecture as insufficient to drive meaningful change in culturally safe practice.[23-24]

The fragmentation of accreditation body processes compounds this accountability deficit. This scan addresses the three primary accreditation streams. Additional arrangements apply to other primary care settings, allied health, and aged care; these are noted but are beyond the scope of this review.

Hospitals are assessed against the National Standards by one of six accrediting agencies approved by the Commission. The Australian Council on Healthcare Standards (ACHS) is the best known, but five others are also approved under the Australian Health Service Safety and Quality Accreditation Scheme.[25] General practices are assessed by one of five Commission-approved agencies against the *Royal Australian College of General Practitioners (RACGP) Standards.*[26]

Aboriginal Community Controlled Health Organisations (ACCHOs) are assessed by Quality Innovation Performance (QIP) against the *Quality Innovation Performance Health and Community Services Standards (QIC)*.[6]

Each accreditor applies different cultural safety requirements. None mandates a standalone cultural safety standard. Table 3 illustrates these three parallel streams and the bodies that govern them.

As shown in Table 3, the Commission sets the National Standards but authorises six independent accrediting agencies to assess hospital compliance. Separating the standard-setter from the accreditors manages conflicts of interest, but it also distances policy from enforcement.

Accrediting agencies assess hospitals against Standard 2 (Partnering with Consumers), which does not require governance specific to cultural safety.[25] AGPAL's cultural safety requirements for general practices are weaker than the *QIC Standards* developed by and for the community-controlled sector.[6,26] No accrediting body has adopted a consistent definition of cultural safety. None mandates a standalone cultural safety standard. This reflects and reproduces the accountability vacuum identified in Function 1.

Table 3 sets out the three accreditation streams, their standards, accrediting bodies, and how each addresses cultural safety, alongside enforcement consequences and key gaps.

Table 3: Accreditation streams for cultural safety in Australian health services

Stream (setting)	Standard	Standard-setting body	Accrediting agencies	How cultural safety is addressed	Enforcement/consequence	Binding/voluntary	Key gap
Public and private hospitals and day procedure services	*National Safety and Quality Health Service (NSQHS) Standards (2nd edition; 3rd edition under development)*	Australian Commission on Safety and Quality in Health Care (the Commission)	Six Commission-approved agencies under the Australian Health Service Safety and Quality Accreditation Scheme	Embedded within Standard 1 (Clinical Governance), Aboriginal and Torres Strait Islander-specific actions, and Standard 2 (Partnering with Consumers), are assessed as process compliance, not as a standalone outcome.	Accreditation is mandatory; loss of accreditation has real funding and operational consequences.	Binding (accreditation mandatory)	No standalone cultural safety standard; cultural safety is assessed as a process, not a patient-determined outcome
General practices	*RACGP Standards for general practices (5th edition)*	Royal Australian College of General Practitioners (RACGP); scheme administered by the Commission (National General Practice Accreditation Scheme)[78]	Five Commission-approved agencies	Cultural safety requirements are weaker than the QIC Standards and contain limited Aboriginal and Torres Strait Islander-specific criteria.	Accreditation is required to access some funding (for example, the Practice Incentives Program)	Binding for practices seeking accreditation/incentives	Weaker cultural safety criteria than the community-controlled sector standard
Aboriginal Community Controlled Health Organisations (ACCHOs)	*QIC Health and Community Services Standards (8th edition)*	Quality Innovation Performance (QIP)	Quality Innovation Performance (QIP)	Stronger, community-defined cultural safety; Standard 5 requires community-centred engagement and co-design, with patient and community feedback embedded in the accreditation cycle	Accreditation against a sector-specific standard developed by and for the community-controlled sector	Sector standard (community-governed)	Some ACCHOs carry a dual NSQHS and QIC accreditation burden; the model is not adopted as the mainstream standard.

The absence of findings for Australia is most clearly evident when compared with peer jurisdictions. Australia does not have an independent Aboriginal and Torres Strait Islander-led complaints pathway for cultural safety. The closest equivalent is Ahpra's National Special Issues Committees on Indigenous-Specific Racism.[20-21] These committees remain housed within a non-Indigenous-led regulatory body. This means complaints about culturally unsafe care are assessed by the same institutional system that delivered that care. In British Columbia, the British Columbia College of Nurses and Midwives (BCCNM) has had a binding practice standard in place since 2022.[27] The *Indigenous Cultural Safety, Cultural Humility and Anti-Racism standard* creates enforceable obligations against which complaints can be assessed.[28]

While Australia lacks an independent Aboriginal and Torres Strait Islander-led complaints pathway, an emerging domestic example shows that culturally governed accountability is achievable within the system. A *Better Culture's 2025 report, Cultural Safety: From Compliance to Commitment,* documents the Hunter New England Local Health District's Aboriginal-led shared governance model, in which Aboriginal and Torres Strait Islander decision-making was embedded directly into the Public Health Unit's COVID-19 emergency response, enabling real-time cultural oversight of clinical operations, policy and public communications. [29]

The same report frames the recurring weakness of advisory structures as an 'illusion of inclusion' – institutions invite Aboriginal, and Torres Strait Islander participation but act to marginalise it once genuine power-sharing is at stake – naming the mechanism behind the advisory-rather-than-binding pattern this scan documents.[29]

Institutions must hold themselves to the standards they set

The accountability deficit documented in this scan is not confined to health service organisations. It extends to the regulatory and standards-setting institutions that sit above them. The Commission, accrediting agencies, and professional registration bodies all operate within a system that asks Aboriginal and Torres Strait Islander Peoples to trust in the cultural safety of its institutions. That trust cannot be established through standards documentation alone; it requires institutions to demonstrate, through their own internal practices, that cultural safety is not a requirement applied outward while exempting those who set it.

This principle extends to the workforce itself. A *Better Culture's 2025 report* argues that culturally safe care for patients cannot be achieved unless Aboriginal and Torres Strait Islander staff and trainees are themselves culturally safe in their workplaces – a precondition underscored by evidence that Aboriginal and Torres Strait Islander medical trainees report experiencing or witnessing racism at more than double the rate of their colleagues.[29]

Ahpra's Aboriginal and Torres Strait Islander Anti-Racism Policy: an institutional accountability model

The most developed instrument of institutional accountability in the Australian regulatory landscape is *Ahpra's Aboriginal and Torres Strait Islander Anti-Racism Policy*.[30] Developed by Wakaya race scholar Professor Yin Paradies – whose foundational synthesis of the empirical evidence on racism and health established the evidence base for understanding racism as a systemic health determinant[31] – the policy adopts a systemic definition of racism that encompasses institutional racism. It applies not only to Ahpra's interactions with regulated practitioners but to its own workforce, governance structures, and internal culture.

The policy established the Racism-related Aboriginal and Torres Strait Islander Special Issues Committee (RATSISIC) – a five-person, Aboriginal and Torres Strait Islander-only body with authority to assess reports of racism directed at Aboriginal and Torres Strait Islander staff or Board members within Ahpra itself. Critically, RATSISIC was designed to operate entirely outside Ahpra's human resources (HR) processes, with authority to recommend sanctions, including termination of employment. This design addressed a structural conflict of interest that any accountability architecture must confront. Internal HR processes within an institution are structurally compromised when the harm being assessed is one the institution may itself have perpetrated. RATSISIC placed accountability authority in Aboriginal and Torres Strait Islander hands, outside the standard institutional chain.

The gap between the policy's design and its implementation is itself a finding of this scan. Despite being approved by the Ahpra Board in December 2024, the RATSISIC has not been established to date. This gap – between a formally approved accountability mechanism and its non-implementation – reflects a pattern identified in structural analyses of institutional racism: what has been described as 'procedural containment,' in which institutions manage accountability obligations through policy processes that satisfy the appearance of structural change without producing it.[32]

The patterns documented in that analysis – including the elevation of institutional reputation over accountability, and the management of community-derived accountability instruments through administrative channels – are not jurisdiction-specific. They describe the structural logic through which institutional harm is sustained across diverse regulatory contexts.

What institutional accountability requires

The *Ahpra Aboriginal and Torres Strait Islander Anti-Racism Policy* – and the gap between its commitments and their realisation – establishes a clear evidentiary standard.[30] An institution that requires cultural safety of others must be held to an equivalent standard in its own structure, governance, and workforce practices. Accreditation assesses whether a health service organisation has the required policies and processes in place; it cannot, by design, assess whether the institution's internal culture and power arrangements are themselves safe for Aboriginal and Torres Strait Islander Peoples working within them.

This limitation applies equally across the system: to hospitals, to accrediting agencies, and to the standards-setting bodies whose frameworks define what accreditation measures. The accountability gap this scan identifies is therefore not only a gap in what health service organisations are required to demonstrate – it is a gap in what regulatory and standard-setting institutions are required to demonstrate about themselves.

A national cultural safety standard has an opportunity to address this gap. Explicit requirements for the accountability structures of standards-setting bodies and accrediting agencies – not only the health service organisations that those standards regulate – would represent a structurally coherent application of the principle that cultural safety is determined by those receiving care. This applies to Aboriginal and Torres Strait Islander peoples navigating health services, and to Aboriginal and Torres Strait Islander staff and communities navigating the regulatory institutions above them.

Australia also lacks mandatory practice standards with enforcement consequences – the *BCCNM standard* provides a comparative model. There is also no national measurement framework for cultural safety outcomes. In Canada, the Canadian Institute for Health Information (CIHI) – an independent, not-for-profit organisation – has developed a four-domain measurement framework for indigenous health outcomes.[33] This work was directly shaped by the death of Joyce Echaquan at a Quebec hospital in 2020. She was an

Atikamekw woman who died after staff made racist comments while she sought care. Finally, no jurisdiction in Australia has established First Nations authority over health service design equivalent to the First Nations Health Authority in British Columbia.[34]

A partial domestic response to these gaps is proposed in the Weenthunga Health Network's unpublished *Cultural Safety Accreditation and CPD Upskilling Framework and Strategy 2026–2031.* The framework recommends establishing an independent Aboriginal and Torres Strait Islander-led body to oversee cultural safety accreditation across Australia. This would consolidate that function into a single body, rather than the current fragmented multi-body arrangement. The recommendation directly addresses the accountability deficit identified in this function. It also aligns with international evidence that indigenous-led governance of cultural safety standards enables meaningful accountability.[19]

Function 4: Implementation models and measurement

The dominant response to cultural safety obligations in Australia has been individual workforce training. Across the health system, the primary mechanism has been training. Institutions have delivered training in cultural awareness, cultural competency, and cultural safety to individual practitioners.

This is the case across multiple settings. Hospitals and health services deliver it in accordance with their National Standards obligations. General practices regulated through the *RACGP Standards* and AGPAL accreditation do so as well. It is also embedded in the National Scheme CPD requirements for registered health practitioners. The training-first approach reflects a systems logic. It frames cultural safety as a knowledge and skills problem, solvable at the individual practitioner level. The evidence does not support that framing.[23-24,35]

Workforce training frameworks

The Australian workforce training landscape lacks both consistency and a common evidential foundation. This fragmentation is one expression of a broader, system-wide problem: the absence of any consistent national standard for cultural safety training and education across the health workforce. There is no national, mandatory cultural safety training standard across all health settings. CPD requirements for cultural safety vary by profession. They are set at the discretion of each of the 15 National Boards. Specialist medical colleges similarly set their own cultural safety CPD requirements, adding a further layer of variation beyond the 15 National Boards. This results in a fragmented, uneven training architecture across the health workforce.

Cultural safety training programs exist across hospital and health service networks. However, content, delivery modalities, frequency, and quality-assurance mechanisms differ substantially across jurisdictions and settings. There is no centralised oversight or standardised outcomes framework. Weenthunga Health Network's *Cultural Safety Accreditation and CPD Upskilling Framework and Strategy 2026–2031* is the most substantive domestic proposal identified in this scan.[19] It proposes a mandatory annual cultural safety training requirement for all practitioners regulated under NRAS. It also recommends an independent Aboriginal and Torres Strait Islander-led body to accredit that training.[19] As with CPD requirements, the absence of centralised oversight means training consistency depends entirely on individual jurisdictions and providers – the same structural gap the Weenthunga proposal seeks to close.

The evidence base underpinning the Weenthunga framework reinforces these findings. Weenthunga's accompanying literature review, *Evaluating the Research Base of Cultural*

Safety in Health Outcomes Relative to Accreditation and Continuing Professional Development (2024), documents a notable absence of cultural safety within Australia's accreditation and continuing professional development (ACPD) regulatory mechanisms, and identifies why embedding it is difficult.[36] It groups the barriers into three: efforts to protect privilege and power, including white fragility and the weaponising of bullying, harassment and psychological-safety policies to deflect accountability for racism; organisational barriers, particularly tokenism – appointing few Aboriginal and Torres Strait Islander staff and none to senior roles, or establishing advisory bodies that lack decision-making authority; and the distinctive demand of cultural safety education, which requires practitioners to unlearn and relearn rather than add to existing knowledge, and so requires more time and investment than conventional CPD.[36]

The review also names the absence of longitudinal research into cultural safety training as a critical gap: without it, the durability of attitudinal and behavioural change, the effect on organisational culture, and the relationship between training and Aboriginal and Torres Strait Islander patient outcomes cannot be established. This corroborates the conclusion drawn across Parts A and B – that the thinness of outcome evidence is a function of voluntary, unconsequenced policy design rather than a reason to defer stronger action. Weenthunga's central finding aligns with this scan's: change is required at individual, organisational and systemic levels concurrently, and cultural safety must be embedded in mandatory accreditation standards and CPD rather than left to discretionary training.[36]

The central problem, however, is not the absence of training. This evidence shows that training, in the absence of systemic and organisational change, does not produce culturally safe care. The Lowitja Institute identifies this as the critical finding. Individual training initiatives have minimal impact on cultural safety outcomes. This is especially so when training is not accompanied by structural change – to organisational culture, governance, and leadership accountability. The limited impact also reflects the lack of quality assurance and consistency in the training itself: there is no national standard governing content, delivery or assessment.[23]

Education is not ineffective; education without consistency, quality assurance and structural accountability is insufficient. Elvidge and Haddock reach the same conclusion in their AHHA analysis of *NSQHS Standard 2*, finding that the current architecture lacks a uniform cultural safety framework, performance indicators, and guidance on engagement.[24] The current compliance architecture produces training activity. It does not, however, produce measurable improvements in the cultural safety experiences of Aboriginal and Torres Strait Islander patients.[23-24]

A Better Culture's 2025 review reaches the same conclusion from the workforce perspective: cultural safety training fails when delivered as a one-off, generic exercise disconnected from organisational accountability. It calls instead for a programmatic model, led or co-facilitated by Aboriginal and Torres Strait Islander experts, tailored to professional roles and tied directly to governance and consequences.[29]

Together, these findings reframe the question for policymakers. It is not whether practitioners are trained. It is whether the systems within which they practise are structurally capable of delivering culturally safe care. The evidence examined in this scan suggests that, at a systemic level, they are not currently.

Patient identification and data infrastructure

The most foundational requirement for culturally safe health care is reliable patient identification – knowing which patients are Aboriginal and/or Torres Strait Islander. This requirement is inconsistently met across the Australian health system.

The causes are dual. At the system level, identification processes are inconsistently applied – staff do not always ask, recording mechanisms vary across settings, and the question is not always asked in a culturally safe way. At the individual level, some Aboriginal and Torres Strait Islander People choose not to identify, a pattern the evidence links to experiences of racism and institutional mistrust rather than to disengagement. Both causes are addressable through system design. Consistent, sensitive asking – embedded in accreditation requirements – improves identification rates. This is a system responsibility, not a population characteristic.

Without accurate and consistent patient identification, outcome measurement for cultural safety is impossible. If Aboriginal and Torres Strait Islander patients cannot be identified in the data, it is not possible to assess whether their care was culturally safe.

The AIHW has developed a *Monitoring Framework for Cultural Safety in Health Care for Indigenous Australians.*[7] It operationalises measurement across three domains: culturally respectful services, patient experience, and access to services. The framework's utility, however, is contingent on the quality of patient identification data. The AIHW's *Indigenous Health Performance Framework* shows persistent identification gaps across public and private health settings, particularly in primary care and specialist services.[7,22]

Until identification is consistently and accurately recorded across all health settings, outcome-level measurement of cultural safety will remain structurally incomplete.

Australia also has its own Indigenous data sovereignty framework – the *Maiam nayri Wingara Indigenous Data Sovereignty Principles* and the NIAA's *Framework for Governance of Indigenous Data (GID)* – which, alongside the *National Agreement on Closing the Gap*, should govern any cultural safety measurement infrastructure so that data about Aboriginal and Torres Strait Islander people is owned and controlled by their communities.[29,37]

Community-controlled implementation models

The most substantive domestic proof of concept for Aboriginal and Torres Strait Islander led culturally safe care is the Aboriginal Community Controlled Health Organisation (ACCHO) sector. ACCHOs operate nationally through the National Aboriginal Community Controlled Health Organisation (NACCHO) network. They also operate in each state and territory through peak bodies and member services. ACCHOs are, by design and governance, Aboriginal and Torres Strait Islander led organisations delivering care to Aboriginal and Torres Strait Islander communities. ACCHOs work to a community-defined understanding of cultural safety, consistent with the NACCHO comprehensive primary health care model and the National Scheme's patient-determined definition. Cultural safety is not an add-on to their service model – it is foundational to it.

ACCHOs are assessed against the *Quality Innovation Performance (QIC) Health and Community Services Standards, 8th edition*. This framework was developed independently of the Commission and incorporates stronger cultural safety requirements.[6] Some ACCHOs face a dual accreditation burden, required to meet both *QIC* and National Standards. This represents a significant compliance impost on smaller services. More substantively, it reflects a regulatory architecture that treats the community-controlled sector as a subset of

the mainstream system. This framing inverts the appropriate relationship: the mainstream system should look to the community-controlled sector as the model.

The ACCHO sector demonstrates that culturally safe implementation is not aspirational in the Australian context; it exists, it operates, and it has been evaluated. Its accreditation against the *QIC Standards* embeds what the National Standards do not: Standard 5 (8th edition) requires community-centred engagement and cultural safety, with services co-designed with communities, and patient and community feedback built into the accreditation cycle.[6]

The relevant question for the Commission is therefore not whether a working domestic model exists, but why the ACCHO sector's governance, accountability, and definition of cultural safety have not been adopted as the standard for mainstream health services. The consultation process may be the most direct route to closing it.

State and territory programs

Australia has produced a substantial body of jurisdictional frameworks, plans and strategies. Together, these embed cultural safety as a policy principle across federal, state and territory health systems. At the federal level, the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* sets the overarching ten-year policy direction.[38] It embeds cultural safety, self-determination, and equity as core principles across the health system.

The *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025* governs implementation across the National Scheme. Progress is reported through Ahpra's annual reporting cycle.[4]

The *AIHW's Cultural Safety Monitoring Framework* provides a three-module structure for measuring progress.[7] It covers culturally respectful services, patient experience, and access to care. At the state and territory level, all jurisdictions have produced at least one framework, plan or strategy. Each nominally addresses cultural safety or cultural respect in the delivery of health services.

The existence of these frameworks, however, is not the same as accountable implementation. The question for this review is not whether frameworks have been produced – they have – but whether they produce measurable, publicly visible, community-accessible progress. Table 4 presents the 19 federal, state and territory frameworks identified in this scan. It focuses on whether progress reporting is publicly available.

Table 4: State, territory and federal cultural safety health frameworks – progress reporting status

Jurisdiction	Organisation	Document title	Year	Document type	Cultural safety focus	Progress reports published	Binding/voluntary
Federal	Australian Government Dept of Health and Aged Care	*National Aboriginal and Torres Strait Islander Health Plan 2021–2031* [38]	2021	Health Plan	Ten-year plan guiding all Aboriginal and Torres Strait Islander health policies. Embeds cultural safety, self-determination, equity and prevention as core principles across the health system.	**Partial –** Implementation Plan published. Progress is reported through the federal health department's annual reporting; no standalone annual progress report.	Voluntary – strategic policy document; no legislative mandate
Federal	Australian Health Practitioner Regulation Agency (Ahpra)	*National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025* [4]	2020	Strategy	Governs the National Health Practitioner Regulation Scheme. Embeds cultural safety across all regulated health professions; includes accountability and reporting mechanisms.	**Yes –** Progress reported in Ahpra Annual Reports. The 2023–24 Annual Report includes a substantive feature on strategy implementation and Aboriginal and Torres Strait Islander health workforce growth.	Binding – mandated under Health Practitioner Regulation National Law Act 2009 (Cth)
Federal	Australian Institute of Health and Welfare (AIHW)	*Cultural Safety in Health Care for Indigenous Australians: Monitoring Framework* [7]	2023	Monitoring Framework	Three-module framework measuring progress toward cultural safety in the Australian health system: (1) culturally respectful services, (2) patient experience, (3) access to services.	**Yes –** The framework itself is a living monitoring tool. Modules are updated periodically as new data becomes available; last updated in 2023 with new measures across all three modules.	Voluntary – data monitoring tool; no legislative mandate
Federal	Australian Commission on Safety and Quality in Health Care (ACSQHC)	*National Standards User Guide for Aboriginal and Torres Strait Islander Health (2nd ed.)* [17]	2017	Standards User Guide	Guides health service organisations to implement the 6 National Standards actions specific to Aboriginal and Torres Strait Islander health. Addresses cultural safety, partnership and welcoming environments.	**Not found –** No standalone progress report. Implementation is assessed through the national health service accreditation process against the relevant Standards' actions, rather than through separate published progress reporting.	Binding – National Standards are mandatory for hospital accreditation under the *National Health Reform Agreement 2011* and state/territory health legislation.

Jurisdiction	Organisation	Document title	Year	Document type	Cultural safety focus	Progress reports published	Binding/voluntary
Federal	Australian Government Department of Health	*National Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health* [39]	2016	Framework	Defines cultural respect across six domains underpinning culturally respectful health service delivery nationally. Endorsed by all Health Ministers.	**Not found –** No dedicated progress or evaluation report found. Superseded in part by the National Aboriginal and Torres Strait Islander Health Plan 2021–2031.	Voluntary – endorsed by all Health Ministers; no legislative mandate.
NSW	NSW Health	*NSW Aboriginal Health Plan 2024–2034* [40]	2024	Health Plan	Ten-year strategic plan for Aboriginal health in NSW. Positions cultural safety, self-determination, and shared decision-making as central to improved health outcomes.	**Not found -** Formal measurement framework in development; reporting was expected to commence in December 2025.	Voluntary – strategic health plan; no legislative mandate
NSW	NSW Health	*NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework* [41]	2022	Governance Framework	Establishes shared decision-making and accountability structures. Embeds Aboriginal voices and leadership in design, delivery, monitoring and evaluation of NSW Health programs.	**Not found –** No standalone progress report found. Accountability is embedded in the NSW Health system governance reporting.	Voluntary – administrative governance framework; no legislative mandate
NSW	NSW Health	*NSW Aboriginal Mental Health and Wellbeing Strategy 2020–2025* [42]	2020	Strategy	Addresses mental health and social and emotional wellbeing for Aboriginal people in NSW. Cultural safety is a foundational principle throughout.	**Yes –** Monitoring and Evaluation Framework published on the NSW Health website. Independent evaluation commissioned to Yulang Indigenous Evaluation (Aboriginal-run), running to June 2025.	Voluntary – strategic policy; no legislative mandate
VIC	Dept of Health Victoria / Dept of Families, Fairness and	*Aboriginal and Torres Strait Islander Cultural Safety*	2021	Framework	Provides a continuous quality improvement model for mainstream Victorian health, human and community services to create culturally	**Not found –** No dedicated public progress report found. Implementation progress embedded in organisational reporting for funded services.	Voluntary – quality improvement framework; no legislative mandate

Jurisdiction	Organisation	Document title	Year	Document type	Cultural safety focus	Progress reports published	Binding/voluntary
	Housing (DFFH)	*Framework (Part 1)* [43]			safe environments, services and workplaces.		
VIC	Department of Health Victoria	*Aboriginal and Torres Strait Islander Cultural Safety Framework Guidelines* [44]	2021	Guidelines	Accompanying implementation guidelines for the Cultural Safety Framework. Provides practical tools for health service organisations to embed cultural safety.	**Not found –** No dedicated public progress report found. See Framework Part 1 above.	Voluntary – implementation guidance; no legislative mandate
QLD	Queensland Health / QAIHC	*Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework* [45]	2021	Framework	Co-designed with QAIHC. Requires HHSs to partner with Aboriginal and Torres Strait Islander peoples to design, deliver and monitor health care. Prioritises the elimination of racism and institutional discrimination.	**Yes –** Annual progress reports are required from each Hospital and Health Service (HHS) and are published publicly. HHS Health Equity Strategies 2025–2028 are now in place; individual HHS annual reports are available on each HHS website.	Voluntary – departmental policy; annual progress reporting required of all QLD HHSs
SA	SA Health	*SA Health Aboriginal Cultural Learning Framework* [46]	2019	Framework	Provides a consistent approach to improving cultural competency within SA Health. Addresses workforce capability and cultural responsiveness to meet the needs of Aboriginal consumers.	**Not found –** No dedicated public progress or evaluation report found.	Voluntary – quality improvement framework; no legislative mandate
SA	Preventive Health SA / SA Health	*South Australian Aboriginal Health Promotion Strategy 2022–2030* [47]	2022	Strategy	Focuses on strengthening and promoting cultural determinants of health and wellbeing for Aboriginal peoples in SA. Cultural identity is central to the health promotion approach.	**Not found –** No dedicated public progress report found. Strategy includes Action Plan 2022–2026; evaluation mechanisms are described, but no published progress reports were located.	Voluntary – strategic policy; no legislative mandate

Jurisdiction	Organisation	Document title	Year	Document type	Cultural safety focus	Progress reports published	Binding/voluntary
WA	WA Department of Health	*WA Aboriginal Health and Wellbeing Framework 2015–2030* [48]	2015	Framework	High-level 15-year policy document setting strategic directions for Aboriginal health in WA. Identifies cultural security as a key guiding principle and foundational determinant of health.	**Not found –** No dedicated public progress report found. A notable gap, given that the framework spans 2015–2030, is that implementation progress does not appear to be publicly reported.	Voluntary – strategic policy document; no legislative mandate
TAS	Tasmanian Dept of Health / Dept of Communities Tasmania	*Improving Aboriginal Cultural Respect Across Tasmania's Health System Action Plan 2020–2026* [49]	2020	Action Plan	Joint action plan for improving Aboriginal cultural respect across Tasmania's health system. Includes evaluation and annual reporting as core accountability mechanisms.	**Yes –** Annual progress reports are published on the Department of Health website. Most recent: Annual Report 2023–24 (published June 2025). Earlier years are also available – the most transparent reporting of any jurisdiction in this table.	Voluntary – action plan; annual reporting required, but no legislative mandate
NT	NT Health	*NT Health Aboriginal Cultural Security Framework 2016–2026* [50]	2016	Framework	Guides culturally secure services across six priority areas: workforce, communication, whole-of-organisation approach, leadership, consumer/community participation, and quality improvement.	**Not found –** No dedicated public progress or evaluation report found. A significant accountability gap exists, given that the framework is now in its final decade.	Voluntary – quality improvement framework; no legislative mandate
NT	NT Health	*NT Health Aboriginal Health Plan 2021–2031* [51]	2021	Health Plan	Ten-year evidence-based policy framework for improving the health and well-being of Aboriginal Territorians. Builds on the previous NT Aboriginal Health Plan 2015–2018.	**Not found –** No standalone public progress report found. Progress is likely reported through NT Health's annual reporting, but no dedicated plan evaluation is publicly available.	Voluntary – strategic health plan; no legislative mandate
ACT	ACT Government	*ACT Aboriginal and Torres Strait Islander*	2019	Agreement / Strategy	Whole-of-government 10-year strategy including health outcomes. Supports the	**Not found –** No dedicated public health-specific progress report found.	Voluntary – whole-of-government

Jurisdiction	Organisation	Document title	Year	Document type	Cultural safety focus	Progress reports published	Binding/voluntary
		Agreement 2019–2028 [52]			development of culturally safe and accessible health services; guides Indigenous Health Partnerships in the ACT.	Broader Closing the Gap reporting covers ACT, but a standalone health-focused evaluation is not publicly available.	agreement; no legislative mandate
ACT	ACT Health	*ACT Health Workforce Strategy 2023–2032* [53]	2023	Workforce Strategy	Includes a strategic priority for culturally safe environments and growing the Aboriginal and Torres Strait Islander health and wellbeing workforce in the ACT. Co-designed with an Aboriginal-owned consulting firm.	**Not found –** Too recent. Action Plan 1 (2025–2026) is the first implementation phase; no progress report is available.	Voluntary – workforce strategy; no legislative mandate

The pattern across Table 4 is unambiguous. Of the 19 frameworks examined, 13 have no publicly accessible progress report. The absence of a standalone progress report does not always mean a lack of monitoring. When a framework serves as implementation guidance, progress may be tracked indirectly through accreditation against the associated standard rather than through a public-facing report. The accountability gap identified here is the absence of a community-facing record, not necessarily of any oversight. There is no standalone evaluation, no annual accountability document, and no community-facing record of what has been implemented, what has changed, or what has not.

The binding/voluntary column sharpens this picture. Of the 19 frameworks, only two carry any binding force – and both are national regulatory instruments (the National Law, through the National Scheme, and the National Standards, through accreditation) rather than dedicated cultural safety frameworks. Every state and territory framework is voluntary. Cultural safety in Australia is therefore articulate d almost entirely through instruments that cannot compel the outcomes they describe; binding force attaches only where cultural safety rides on a pre-existing national regulatory mechanism, not on the cultural safety frameworks themselves.

Western Australia's *Aboriginal Health and Wellbeing Framework* has been in place since 2015. It is now in its eleventh year of a 15-year term, with no public reporting against it.[48] Victoria's *Aboriginal and Torres Strait Islander Cultural Safety Framework*, introduced in 2021, tracks implementation progress through internal organisational reporting that is not publicly available.[43] The Northern Territory has two active plans and frameworks with no dedicated public accountability mechanism for either.[50-51] The Australian Capital Territory and South Australia each have multiple frameworks with no published progress or evaluation reports. [46-47,52-53] New South Wales' flagship *Aboriginal Health Plan 2024–2034* had no formal reporting at the time this scan was conducted.[40] Its measurement framework was described as being in development.

The exceptions are instructive. *Queensland's Making Tracks Together*[45] framework was co-designed with the Queensland Aboriginal and Islander Health Council (QAIHC). It requires each Hospital and Health Service (HHS) to publish an annual *Health Equity Strategy* progress report. Individual HHS reports are publicly available on each service's website. Tasmania's *Improving Aboriginal Cultural Respect Across Tasmania's Health System Action Plan 2020–2026* publishes annual reports, the most recent covering 2023–24.[49] The *NSW Aboriginal Mental Health and Wellbeing Strategy 2020–2025* commissioned an independent evaluation through Yulang Indigenous Evaluation, an Aboriginal-run evaluation firm.[42] This provides a model for both independence and Aboriginal and Torres Strait Islander leadership in monitoring. These three examples demonstrate that publicly accessible, community-facing accountability is achievable and has been operationalised within existing system architecture.

The critical limitation, however, is that even in jurisdictions with published reporting, accountability runs through institutions rather than to communities. Health departments and health services produce progress reports, which are assessed against frameworks designed by those same departments and published at the government's discretion. Aboriginal and Torres Strait Islander communities have no systematic mechanism to scrutinise, challenge or independently verify institutional claims of progress. These are the communities whose lived experience determines whether care is truly culturally safe.

Queensland's model[45] is the closest to genuine community oversight. Its co-design with QAIHC and the granularity of HHS-level public reporting are notable. It does not, however, establish community governance over the evaluation process itself. Across Australian

jurisdictions, the dominant pattern is consistent. Cultural safety frameworks are designed with community input, implemented by institutions, and reported on by governments. In this structure, community oversight of progress is incidental rather than foundational.

The evidence in this scan supports an accountability model with a fundamentally different design. Aboriginal and Torres Strait Islander communities should have an independent, formal role in monitoring, evaluating, and publicly reporting progress against cultural safety obligations, and in employing Indigenous data sovereignty and governance principles over their data. This is not as recipients of institutional reporting, but as governing authorities over it.

International Scan

The international jurisdictions examined – Aotearoa, Canada, and the United States – were selected as settler-colonial comparators sharing structural features with Australia. Those features are: federal or quasi-federal governance; significant indigenous populations whose health outcomes reflect the legacy of dispossession; and health systems in which indigenous peoples have historically received care designed by and for non-indigenous majorities.

The same four-function analytical lens applied to the domestic scan is applied here, organised by jurisdiction rather than by function. The focus throughout is on enacted instruments – regulatory frameworks, governance structures, and implementation models – rather than on academic evidence about their effects, which is addressed in Part A.

Table 5 carries the comparative summary across all three jurisdictions.

Table 5: Comparative summary – international cultural safety models and frameworks

Country	Model/framework	Sector	Key features	Evidence of effectiveness	Transferability to the AU context	Binding/voluntary
Aotearoa	*Te Tiriti-based cultural safety framework;* 54-56 *Pae Ora (Healthy Futures) Act 2022* 57	Health professional regulation; national health system	• Māori patients and whānau define cultural safety (not practitioners). • Mandatory for professional registration across nursing and medicine. Three-part framework: critical consciousness, ongoing self-reflection, structural change. • *Te Tiriti o Waitangi* provides the Treaty grounding.	• HQSC patient experience survey data demonstrates measurable disparities and tracks cultural safety over time. • Waitangi Tribunal confirmed Treaty breaches in health system disestablishment. Nursing Council standard subject to judicial review (2026) – political resistance documented.	High. Closest jurisdictional comparator to Australia: regulator-led mandatory framework, indigenous-defined cultural safety, equity-centred measurement. Key limitation: *Te Tiriti* provides a constitutional grounding not replicated in Australia.	Binding – mandatory for professional registration under *the Pae Ora (Healthy Futures) Act 2022 (NZ)*

Canada	*Health Standards Organization HSO 75000:2022 (Cultural Safety and Humility Standard – BC);*[28] *BC College of Nurses and Midwives (BCCNM) Binding Practice Standard (2022);*[27] *CIHI Framework for Measuring Indigenous-Specific Racism;*[33] *Joyce's Principle (2020)* [59]	Health professional regulation (BC); national quality and patient safety standards; national health data governance	• British Columbia is the first Canadian province with a binding mandatory cultural safety and humility practice standard for nurses and midwives (in force 25 February 2022). • *HSO 75000:2022* is a voluntary national standard. • *CIHI framework* adopted nationally for indigenous health performance reporting. • *Joyce's Principle* (submitted November 2020) calls for universal access to cultural safety and the right to be accompanied by a support person.	• BCCNM binding standard enforceable through professional conduct mechanisms. • *CIHI framework* adopted nationally for indigenous health performance reporting. • Inquiry into Joyce Echaquan's death (2021) confirmed systemic racism as a structural, not individual, failure. • *2019 Tripartite evaluation*: the voluntary Declaration phase increased awareness but produced no measurable reduction in racism or gain in trust (avg 3.5/5; no baseline data).[60] • *In Plain Sight (2020)*: 84% of 2,780 indigenous respondents reported discrimination – evidence that precipitated the binding 2022 standards.[61]	High. The Canadian colonial health system legacies and regulatory architecture share significant parallels with Australia. *HSO standard* and *CIHI framework* offer direct institutional precedent for an ACSQHC-led measurement framework.	Mixed – BCCNM practice standard: Binding (enforceable through professional conduct mechanisms); *HSO 75000:2022:* Voluntary national standard; *Joyce's Principle:* political commitment, no enforcement mechanism.
United States	Indian Health Service (federal trust responsibility model)*;*	Federal health service for American Indian and	• IHS serves approximately 2.6 million American Indian and Alaska Native (AIAN)	Chronic funding disparity: IHS per capita expenditure is US$4,078 compared with US$8,873 for Medicaid and	Moderate-low. The USA does not operate a cultural safety regulatory framework.	Mixed – IHS: Binding under federal trust responsibility (*Indian Self-Determination*

	National CLAS Standards (HHS Office of Minority Health, 2013);[62] *Indian Self-Determination and Education Assistance Act 1975 (ISDEAA) – Title V self-governance compacts* [63]	Alaska Native peoples; national voluntary cultural competency standards	people across 574 federally recognised tribes under a federal trust responsibility. • Title V ISDEAA self-governance compacts allow tribes to assume full control of IHS programs. • CLAS Standards provide voluntary national guidance on culturally and linguistically appropriate services – not indigenous-specific.	US$13,493 for overall US health spending (2023), reflecting structural underfunding of the federal trust responsibility.[74] Self-governance compacts demonstrate the feasibility of full tribal control of the health system.	*CLAS Standards* are voluntary, non-indigenous-specific, and without enforcement mechanisms. The self-governance model provides a partial analogue to community-controlled health in Australia.	*and Education Assistance Act 1975)*; *CLAS Standards:* Voluntary (no enforcement mechanism)

The binding/voluntary column shows the same fault line internationally. The instruments associated with measurable traction – Aotearoa's registration mandate under *Pae Ora* and British Columbia's *BCCNM practice standard* – are the binding ones; the voluntary instruments (the United States' *CLAS Standards*, the *HSO national standard*, and the rejected *Joyce's Principle*) are those without demonstrated enforcement. Binding status, not the sophistication of a framework, is what tracks with outcomes.

Aotearoa (New Zealand)

Cultural safety as a concept originates in Aotearoa. Its development by Irihapeti Ramsden in the late 1980s and early 1990s was an explicit response to the health consequences of colonisation for Māori, grounded in the obligations of *Te Tiriti o Waitangi* and the principle that the safety of a health encounter is determined not by the practitioner but by the person receiving care.[64] What distinguishes the Aotearoa context from Australia is that this foundational definition was developed within a jurisdiction that has a constitutive Treaty relationship between the Crown and Māori – one that carries legal and policy weight, however inconsistently realised, across the health system. The *Health Practitioners Competence Assurance Act 2003* requires all health regulatory authorities to set standards that enable practitioners to recognise their obligations under Te Tiriti o Waitangi. Cultural safety is therefore not a discretionary policy commitment in Aotearoa; it is a Treaty obligation.[8-9,64-65]

The regulatory framework reflects this grounding. The Medical Council of New Zealand (MCNZ) defines cultural safety as a multi-dimensional obligation encompassing critical consciousness, ongoing self-reflection, accountability to patients and communities, and the recognition that the patient, not the practitioner, defines cultural safety.[54]

The Nursing Council of New Zealand updated its cultural safety guidance in early 2026.[55] The update integrates Māori health, kawa whakaruruhau and cultural safety into a single framework explicitly grounded in *Te Tiriti.* It emphasises power-sharing, accountability, and addressing structural inequities within the health system. The Health Quality and Safety Commission (HQSC) has developed tools for measuring culturally safe care through patient experience surveys, operationalising the principle that the patient determines safety into a measurement framework applicable across hospitals and health services.[54,66-67,55-56]

Te Aka Whai Ora – Maori Health Authority

The most significant governance development in Aotearoa's recent history is also its most significant cautionary finding. *The Pae Ora (Healthy Futures) Act 2022* restructured the health system. It established Health New Zealand (Te Whatu Ora) as the single national health entity. Crucially, it also established Te Aka Whai Ora – the Māori Health Authority – as an independent statutory body. Te Aka Whai Ora held commissioning powers over kaupapa Māori health services and a mandate to hold the wider health system accountable for Māori health outcomes.[57] Te Aka Whai Ora represented the first time an independent statutory authority had formal governance power over Māori health in New Zealand's history.

In 2024, the *Pae Ora (Disestablishment of Māori Health Authority) Amendment Act 2024* was introduced on 27 February and passed under parliamentary urgency in approximately 24 hours, coming into force on 30 June 2024.[57] Te Aka Whai Ora's functions were absorbed into Health New Zealand, and its independent commissioning authority was dissolved. The Waitangi Tribunal subsequently released an urgent report finding that the disestablishment constituted further Crown breaches of *Te Tiriti o Waitangi.*[57,68]

The lesson for Australia is precise: Treaty-grounded regulatory standards and community-controlled governance architecture were built in Aotearoa – and were reversed by a single electoral cycle. Without constitutional protection or legislative entrenchment that survives a change of government, indigenous health governance authority is structurally precarious regardless of how carefully it is designed. Anti-racism systems change frameworks developed by the Ministry of Health during this period now sit within an institutional architecture that has lost the independent Māori authority intended to drive their

implementation. A further structural contrast is that New Zealand's unitary system regulates hospitals at a single level of government. In contrast, Australia's federated structure distributes that authority across the Commonwealth, states and territories.

Regulator independence and political interference

In June 2026, New Zealand Health Minister Simeon Brown declined to reappoint Dr Rachelle Love – the first wāhine Māori chair of the MCNZ – and deputy chair Simon Watt, publicly stating that the Council had become 'distracted by politics' and an 'ideological agenda.' The basis for that characterisation was the Council's recent consultation on cultural competence, cultural safety and Māori health and wellbeing.[69]

The finding this presents for the scan is structural rather than biographical. The MCNZ is an independent regulator responsible for practitioner registration, professional standards and fitness to practise. Its consultation on cultural safety was not an exercise in discretionary policy preference; it was a discharge of its statutory function.

The *Health Practitioners Competence Assurance Act 2003 (HPCA Act)*, as amended in 2019, expressly defines cultural competence to include competencies that enable effective and respectful interaction with Māori. The Council, in consulting on cultural safety, was performing the work the law required of it.[70]

The Minister's characterisation of that function as 'ideology' inverts the statutory basis of the Council's authority. It reframes legally mandated regulatory activity as political excess – a framing that, if institutionally embedded, operates to delegitimise cultural safety obligations without repealing them. The proposed amendments to the *HPCA Act* would amplify this structural risk: they would allow ministers to direct independent regulators to implement government policy, removing the institutional firewall between political priorities and professional standards. The Association of Salaried Medical Specialists described this mechanism as capable of leaving medical standards subject to change with every change of government.[69]

Taken together with the disestablishment of Te Aka Whai Ora, this case illustrates a pattern in the Aotearoa evidence that is directly relevant to Australian regulatory design. indigenous health governance bodies can be dismantled by parliamentary urgency. Regulatory leaders can be removed by declining reappointment. The statutory provisions that embed cultural safety obligations can be proposed for repeal. Each of these mechanisms is individually legal. Cumulatively, they demonstrate that cultural safety in health regulation is vulnerable to political reversal at every point in the institutional architecture – standard-setting, governance, leadership, and the statutory foundations themselves – unless each is specifically protected.

The Australian regulatory context is not insulated from equivalent pressures. The lesson from Aotearoa in 2024–2026 is not that these risks materialised because of poor regulatory design. It is that architecture alone is insufficient. The independence of regulatory institutions from political interference is itself a structural condition for the durability of cultural safety frameworks – and one that cannot be assumed to persist across electoral cycles.

Turtle Island (Canada)

Two converging forces have shaped Canada's engagement with cultural safety in health regulation. The first is the *Truth and Reconciliation Commission's (TRC) 2015 Calls to Action,* which established a national accountability framework for indigenous health equity.[71]

The second is a series of deaths of indigenous people in healthcare settings, which converted inquiry findings into binding governance instruments. Together, these forces have produced a regulatory landscape that is, in some jurisdictions, meaningfully ahead of Australia – and that demonstrates, concretely, what binding obligations and indigenous led governance produce.[71]

The durability of these instruments varies. Those embedded in legislation or professional regulation are harder to reverse. Policy-based measures remain vulnerable to government change – as the disestablishment of Te Aka Whai Ora in Aotearoa demonstrates.

Truth and Reconciliation Commission 2015 Calls to Action

TRC's health-related *Calls to Action* (#18–#24) addressed federal, provincial, territorial, and Aboriginal governments. They called on these governments to close the First Nations health gap, acknowledge the health consequences of residential schools and colonial policies, and establish measurable goals to eliminate indigenous health disparities. What has been operationalised in response to these *Calls to Action* is uneven across jurisdictions: some commitments remain aspirational, while others have been translated into specific regulatory and governance instruments. The distinction between aspirational and binding is the central analytical question for this scan, and the answer varies significantly between provinces.[71]

The First Nations Health Authority (FNHA)

The First Nations Health Authority (FNHA) in British Columbia is the most comprehensive model of indigenous-controlled health governance identified in this scan. It is also the closest international equivalent to what Weenthunga Health Network's *Cultural Safety Accreditation and CPD Upskilling Framework and Strategy 2026–2031* recommends for Australia. [19,34,72]

Established in 2013 through a *Tripartite Agreement* between the FNHA, the federal government, and the Province of BC, the FNHA assumed control of federal health programs previously administered by Health Canada for BC First Nations.[72] It has its own health plan, cultural safety framework, data infrastructure, and accountability mechanisms. The FNHA's foundational framework, *Creating a Climate for Change (2016)*, defines cultural safety as an outcome: "an environment free of racism and discrimination, where people feel safe when receiving health care." Health Canada's Chief Public Health Officer Forum subsequently adopted this as the national reference definition.[34,73]

The FNHA funds and coordinates First Nations primary and community health programs. Mainstream hospital services remain under the control of BC's regional health authorities. Cultural safety is embedded there through partnership agreements and the provincial *Cultural Safety and Humility standard,*[72] rather than through FNHA control of hospitals.

British Columbia also offers the most developed evidence-based evaluation of any jurisdiction in this scan, and that evidence is instructive precisely because it is candid. The 2019 evaluation of the *Tripartite Framework Agreement* found that, under the voluntary *Declaration of Commitment* adopted from 2015, cultural safety work had measurably increased awareness, dialogue and program activity, but that key informants reported no significant reduction in racism or increase in indigenous patients' trust at the system level; partners rated improvement at an average of 3.5 out of 5, and the evaluation noted the absence of baseline data or any system-wide measure of how indigenous clients experience care.[60]

In 2020, the *In Plain Sight* review – drawing on nearly 9,000 participants, including 2,780 indigenous respondents – found that 84% of indigenous people had experienced

discrimination in BC health care, confirming that voluntary commitment had not displaced widespread indigenous-specific racism.[61] These findings precipitated the binding instruments that followed: the *BCCNM practice standard* (in force 2022) and the *HSO Cultural Safety and Humility Standard*, developed as the deliverable for Recommendation 8 of *In Plain Sight.*[27-28,61]

The evaluative throughline most relevant to the Commission is therefore not that British Columbia's approach succeeded, but that its voluntary phase produced activity without measurable safety – and that the province's response was to move from voluntary commitment to binding standards.

Indigenous Cultural Safety, Cultural Humility and Anti-Racism Practice Standard

The BC College of Nurses and Midwives (BCCNM) *Indigenous Cultural Safety, Cultural Humility and Anti-Racism Practice Standard* came into force on 25 February 2022.[27] Like Ahpra's registration standards, this is a practitioner-level instrument regulating individual professionals; its organisational counterpart is the companion *BC Cultural Safety and Humility Standard (HSO 75000:2022)*.[28]

It is the most significant regulatory instrument in the Canadian landscape for Australia's purposes. This is a mandatory, binding practice standard: it is not a guideline, an aspiration, or a CPD recommendation. All nurses and midwives registered with BCCNM are required to practise in accordance with it, and complaints about culturally unsafe practice are assessed against it. A standalone cultural safety standard, against which practitioner conduct is specifically assessed, is conspicuously absent from Australia's regulatory architecture, as identified in Function 3.

The codes of conduct and registration standards under NRAS carry real enforcement power, including removal of registration. However, cultural safety obligations are embedded in broader conduct frameworks rather than constituted as a discrete, enforceable standard. The companion *BC Cultural Safety and Humility Standard (HSO 75000:2022)*, developed through the Health Standards Organization, provides a parallel framework applicable at the organisational level.[28]

Joyce's principle

Joyce Echaquan was an Atikamekw woman who died on 28 September 2020 at Joliette hospital in Quebec, having filmed herself receiving racist treatment from hospital staff in the final hours of her life. Her death led the Atikamekw Nation to develop *Joyce's Principle*, co-submitted on 16 November 2020 by Chief Paul-Émile Ottawa and Grand Chief Constant Awashish. The principle affirms the right of all indigenous peoples to equitable, discrimination-free access to all social and health services, with the right to oversee their own health.

Joyce's Principle is a community-developed policy instrument rather than legislation or regulation; it was submitted to both the Quebec and federal governments for adoption. The Quebec government rejected *Joyce's Principle.* That rejection is itself a governance finding: community-derived accountability instruments can be created, formally submitted, and refused by the state. Despite the Quebec government's rejection, *Joyce's Principle* has since been referenced in federal parliamentary committee reports and health institution commitments across Canada. It functions as a governance touchstone – in a way, the Doomadgee coronial inquest findings have not yet functioned in Australia.[59]

The difference is not in the severity of the deaths or the quality of the findings; it is in whether a community-derived accountability instrument was created and institutionally recognised in response.[59]

Indigenous data sovereignty – OCAP principles

The Canadian Institute for Health Information (CIHI) responded directly to Joyce Echaquan's death and the *In Plain Sight* report on indigenous-specific racism in BC health care. In 2021, it published a four-category measurement framework for cultural safety. The four categories are Health System Interventions, Experience of Health System, Health System Performance, and Health and Wellness Outcomes.[33] The CIHI document explicitly states that it was developed in response to these events, providing the data governance architecture that Australia lacks for outcome-level cultural safety accountability.[33,58] The First Nations Information Governance Centre's *OCAP® principles – Ownership, Control, Access, and Possession* – establish the data sovereignty framework within which culturally safe measurement operates in Canada, affirming that First Nations communities own and control data about their peoples and communities.[58]

Turtle Island (United States of America)

The United States occupies a distinct position in the comparative landscape. It has the most developed federal architecture for indigenous-controlled health service delivery of any jurisdiction examined. At the same time, it has the least developed regulatory framework for cultural safety as a concept.

Indian Health Service (IHS)

The Indian Health Service (IHS) is a federal agency within the Department of Health and Human Services. It was established under the *Snyder Act of 1921* and strengthened by the *Indian Health Care Improvement Act of 1976*.[63] It provides health care to approximately 2.6 million American Indians and Alaska Natives across 574 federally recognised tribes. Per capita IHS spending in 2023 was $4,078. That is less than half the Medicaid per-capita rate ($8,873) and under a third of the overall USA health spending per person ($13,493).[74] This chronic underfunding gap directly constrains the quality and comprehensiveness of services available through tribal health programs.

The *Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA)* represents the foundational governance instrument for indigenous control of health services in the USA. Under Title V of ISDEAA, tribes can enter into self-governance compacts with the federal government, receive IHS funding, and operate their own health programs with significant autonomy from federal oversight.[63] This model – tribal control of federally funded health services – demonstrates that indigenous-led health governance at scale is operationally achievable within a federal system.

The limitations of the model are equally instructive: self-determination without adequate resourcing and without a cultural safety regulatory framework produces indigenous-controlled but resource-constrained services, with quality and comprehensiveness varying significantly across tribal health programs.

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards)

The USA does not use the term "cultural safety" in health regulation. The primary framework governing culturally appropriate care is the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards)*.[62] It applies to all population groups, not to indigenous peoples specifically. The HHS Office of Minority Health developed it and updated it in 2013. The *CLAS Standards* comprise 15 voluntary guidelines addressing cultural responsiveness and language access.[62] They are not binding obligations. They do not incorporate the power analysis, self-determination framing, or indigenous rights grounding that characterise cultural safety definitions in Australia, Aotearoa and Canada. The Joint Commission – an independent, not-for-profit accreditor rather than a government agency – sets accreditation standards that address patient-centred communication and language services, but again without the structural analysis that the cultural safety framework demands.[62]

The key comparative finding from the USA is this. The most developed model of indigenous-controlled health service delivery in any jurisdiction examined does not use cultural safety as an organising concept. It has no binding regulatory standard for culturally safe practice and no indigenous-governed accountability mechanism for outcome measurement. What the USA demonstrates is that indigenous control of health service delivery – the structural condition – can exist without the definitional and regulatory architecture needed to name and enforce cultural safety as an obligation. The ISDEAA compacting model shows what self-determination looks like in health governance; the absence of a cultural safety regulatory framework shows what is missing within it.[63]

Analysis

Across the four jurisdictions, cultural safety definitions adopted by regulatory bodies are a consistent upstream predictor of instrument strength downstream. Where these definitions are grounded in First Nations-led frameworks, the instruments that follow tend to contain binding obligations, measurable outcomes, and explicit accountability mechanisms. These frameworks centre the experience of those receiving care as the measure of safety.

The *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025 (the Strategy)* defines cultural safety as a patient-determined outcome. The Strategy describes it as requiring ongoing critical reflection of practitioner knowledge, skills, attitudes, behaviours and power differentials in healthcare delivery.[4]

The MCNZ defines cultural safety similarly – as a practice determined by Māori patients and whānau, not by medical practitioners.[54] This makes ongoing critical consciousness a professional requirement.

By contrast, the current framing of the National Standards emphasises the acquisition of practitioner competency and the appropriateness of service delivery.[3] The instruments that follow tend toward process compliance rather than outcome accountability. This chain is not incidental: it reflects whose epistemology is privileged in the regulatory design and who is the authoritative arbiter of safety.

The environmental scan reveals a consistent, cross-jurisdictional pattern. Whether a cultural safety framework is binding or voluntary is the single strongest predictor of its outcomes. Binding frameworks produce measurable implementation results; voluntary ones tend to produce documented compliance processes without corresponding culture change.

British Columbia's *BCCNM practice standard* is the clearest example: binding and enforceable through professional conduct and complaints mechanisms, with formal consequences for registered nurses and midwives.[27] The National Scheme's enforceable mechanism, established through the 2022 National Law amendments, is its closest comparator in the Australian regulatory environment.[15]

In the United States of America, the 15 National *CLAS Standards* have remained voluntary since their development. They are the closest federal analogue to a cultural competency regulatory framework, but are not specific to indigenous peoples.[62] Their variable, unenforced uptake reflects a combination of factors: they are voluntary, they are broad and not indigenous-specific, and they carry no consequence for non-adoption – illustrating that breadth without binding force tends to produce inconsistent implementation.

Within Australia, 13 of 19 state and territory Aboriginal and Torres Strait Islander health frameworks published between 2015 and 2024 lack publicly accessible progress reporting. This means neither governments nor communities can assess whether these frameworks are producing change in line with their stated objectives. This pattern is not unique to any single jurisdiction or government; it is the modal outcome of voluntary frameworks operating without consequence structures.

The international evidence in this scan shows that effective, durable cultural safety frameworks result from deliberate political choices, not from technical capacity or resource availability.

In Aotearoa, *Te Tiriti o Waitangi* provides a constitutional foundation for Māori health rights, giving the Waitangi Tribunal jurisdiction to assess Treaty compliance.[68] This foundation enabled Māori-led health governance innovation, culminating in the *Pae Ora (Healthy Futures) Act 2022* and the Māori Health Authority, Te Aka Whai Ora. *The Pae Ora (Disestablishment of Māori Health Authority) Amendment Act 2024* reversed this, passing under urgency in approximately 24 hours. [57] The Waitangi Tribunal found this to constitute Treaty breaches.[68] The disestablishment shows both the power of Treaty-grounded frameworks and their fragility when not insulated by deeper legislative protection.[57]

In Canada, the death of Joyce Echaquan generated the political mandate for CIHI's national framework for measuring the performance of the Indigenous health system.[33,59] The Aotearoa and Canadian cases illustrate that effective structural frameworks emerge not from policy readiness but from political obligation, whether constitutionally grounded or crisis-generated.

Australia has neither an equivalent Treaty basis nor a nationally mandated accountability framework generated by a comparable sentinel event. The National Scheme's codes of conduct and registration standards carry enforcement power, including removal of registration.[4,75] However, these powers are not consistently operationalised for cultural safety. Countless documented coronial records warrant precisely such a nationally mandated response. The National Scheme's definitional framework is internationally comparable in its rigour; the gap is not knowledge but the authority and enforcement architecture to operationalise it.[4,75]

The domestic scan reveals that the gap in Australia's cultural safety policy landscape is not only definitional – though definitional inconsistency persists even within a single agency's own materials. The Commission's website uses a variation of the jointly-agreed Ahpra definition of cultural safety. However, the Commission's Glossary has not been updated to reflect it. The *User Guide* still describes cultural safety as 'defined by the person,' rather than 'by the Aboriginal and/or Torres Strait Islander person and/or their community.'[17] These

resources can be updated to reflect the current definition. The deeper gap is structural: the absence of consequence-bearing accountability mechanisms at every level of the system.

The *AIHW Cultural Safety in Health Care for Indigenous Australians Monitoring Framework* provides a nationally endorsed measurement architecture encompassing system-level inputs and outcomes. Yet its adoption by state and territory health departments and accreditation bodies as a mandatory reporting instrument remains discretionary.[7] This discretionary uptake is itself a function of Australia's federated structure: with powers distributed across the Commonwealth, states and territories, no single authority can mandate uniform adoption.

The Health Quality and Safety Commission's New Zealand patient experience survey shows what equity-centred, community-reported measurement looks like within a national accreditation architecture.[56] The *CIHI framework* links system performance measurement to indigenous-defined health and wellness outcomes.[33] The National Standards require organisations to show compliance with culturally safe practices.[3] They do not specify what community-determined evidence of cultural safety must look like, nor do they require its public disclosure.

Consequently, organisations can satisfy accreditation requirements by documenting processes – training completed, policies in place, and user guides consulted. No external assessment is required to determine whether Aboriginal and Torres Strait Islander patients' experience has actually changed. The evidence consistently identifies community accountability as central to producing genuine cultural safety. This condition is structurally absent from the dominant compliance model. The result is a landscape of well-intentioned policy instruments operating without the consequence structures that would compel implementation.

The combined findings of the rapid literature review (Part A) and the environmental scan (Part B) converge on a single conclusion. Voluntary, non-binding frameworks without community oversight and consequence structures do not produce culturally safe care for Aboriginal and Torres Strait Islander peoples. Part A established this from the academic evidence. It showed that cultural safety is a structural concept, that measurement must be community-led, and that accountability to the community, rather than to the institution, produces safe care. Part B maps the policy landscape against this evidence. The frameworks actually built do not meet these conditions, with exceptions in British Columbia and the Health Standards Organization national standard.[28]

One important complication moderates the combined argument. Part A’s evidence base is stronger on what should produce cultural safety than on what demonstrably has produced it in practice. The academic outcomes literature is thin, both in Australia and internationally. This is because implementation environments have rarely created the conditions the evidence assumes.

Part B clarifies why: systems built on voluntary compliance without consequences cannot create the implementation environments that produce robust evidence of outcomes. The evidentiary gap is therefore not a reason to withhold action – it is, itself, a consequence of inadequate policy design. Taken together, Parts A and B establish a case sufficient to support mandatory, binding and community-accountable standards. The remaining question is not evidentiary. It is whether the Commission’s instruments carry sufficient specificity and consequence to produce the outcomes the evidence says are achievable.

Discussion

This environmental scan makes a distinct contribution to the Commission's evidence base that the rapid literature review alone could not provide. Where Part A mapped what the academic evidence says should produce culturally safe care, Part B maps what has actually been built. In doing so, it makes visible a structural rather than an informational gap.

The jurisdictions examined in this scan share access to the same international evidence base. Variation in regulatory outcomes is not a function of knowledge asymmetry. It is a function of what each jurisdiction has chosen to mandate, to whom accountability is directed, and what consequences attach to non-compliance.

The Commission occupies a unique position in the Australian standards landscape. The National Standards are a single instrument with national reach, binding application across accredited health services, and authority to specify what cultural safety requires. The environmental scan's most important finding for the Commission is therefore not comparative; it is diagnostic. The National Standards are the lever currently set to produce compliance. They are among the instruments that could be used to promote accountability. Whether they are the most appropriate vehicle for a standalone national cultural safety standard, or for another model, is a question for the analysis and stakeholder engagement that should follow this review.

The scan identifies a graduated transferability of international models to the Australian hospital accreditation context. The frameworks with the highest transferability share three features. They define cultural safety as determined by those receiving care. They embed binding obligations with enforceable consequences. And they include community-reported measurement mechanisms. The definitions from MCNZ and the Nursing Council of New Zealand meet these criteria.[54-55] They are directly adaptable as definitional language for revised Standards, given the National Scheme's own definition already reflects comparable principles.

The *BCCNM practice standard* offers a direct precedent for Australia. It is binding, companion-guided and complaint-enforceable – features that define what a mandatory cultural safety instrument could require of health practitioners.[4,27,54-55] These are practitioner-level instruments – they regulate individual registered professionals rather than health-service organisations. Their definitions and consequence mechanisms are directly transferable as definitional and accountability language, but adapting them to organisational (hospital) accreditation requires translating practitioner obligations into institutional ones.

The *CIHI four-category framework* and the *AIHW Monitoring Framework* are measurement and performance-reporting architectures rather than standards. [7,33] They do not, by themselves, drive change; they make change visible and enable accountability – but only when linked to a binding standard that attaches consequences to the results. Frameworks with lower transferability include the *National CLAS Standards.*[62] They are voluntary, not indigenous-specific, and operate without enforcement mechanisms. The constitutional dimensions of Aotearoa's Te Tiriti framework have no direct Australian parallel. Transferability is not automatic. The frameworks most relevant to Australia's context are those the Commission would need to mandate, not adopt voluntarily, for their structural features to translate.

The opportunity to close the accountability gap

The National Standards are a primary lever – among the options to be considered – for closing the accountability gap the scan identifies. The scan supports four specific design directions.

First, the definitional language of the National Standards should move toward community-defined cultural safety. This aligns with the National Scheme's own binding definition, already operative in the regulatory environment. Where the Commission's *Standards* and the National Scheme's framework use different definitional logics, the system sends conflicting signals to health services about what is required.[4]

Second, the *Standards* should shift from the acquisition of practitioner competencies to organisational accountability. The question shifts: from what practitioners must complete, to what the organisation must show has changed for Aboriginal and Torres Strait Islander patients and communities.

Third, the measurement requirements should specify community-reported outcome evidence aligned with the *AIHW Cultural Safety Monitoring Framework*, alongside process measures (not in place of them).[19]

Fourth, the accountability architecture should include mandatory public reporting of progress against cultural safety outcomes. This enables communities, not only accreditation bodies, to assess organisational performance. These directions are not novel proposals; they are the features that distinguish effective frameworks from compliance frameworks across every jurisdiction examined in this scan.

The political will imperative and interim pathways

This scan establishes that the structural conditions for genuinely accountable cultural safety frameworks are not absent due to governments' lack of knowledge. Binding mandates, consequence structures, and First Nations authority are absent because their implementation requires a genuine transfer of power to Aboriginal and Torres Strait Islander peoples. That transfer has not occurred.

This is the political will gap, and it should be named as such. It manifests in concrete structural forms: federated governance arrangements that distribute accountability rather than concentrate it; constitutional limitations that require intergovernmental agreement for national reform; and institutional architectures built for process compliance rather than outcome accountability. These are not independent barriers – they are the policy expression of political choices that have not yet prioritised genuine power transfer to Aboriginal and Torres Strait Islander peoples.

The disestablishment of Te Aka Whai Ora in Aotearoa, New Zealand shows this clearly. Structural reforms not anchored in genuine power transfer are not structural reforms – they are conditional concessions.

Exactly this conditionality characterises the Australian regulatory and health standards landscape. Frameworks exist at the discretion of governments. Advisory bodies lack authority. Reporting requirements lack consequences. Standards may be revised – and requirements potentially weakened – at successive review cycles.

The *AHRC National Anti-Racism Framework* calls on the Australian Government to recognise racism as a public health crisis. It recommends mandating cultural safety through professional registration requirements. If adopted, this would shift the Commission's obligations from voluntary quality improvement to mandated human rights compliance. Those recommendations have not been adopted.[1] It was developed through two years of national consultation, and the *Voices of First Nations peoples Report* that underpinned it was explicit that genuine accountability requires not only cultural safety standards but genuine First Nations authority over the systems that produce and enforce them.[2]

The Commission's interim pathways operate through a different lever: the National Standards and the accreditation framework. These are distinct from professional registration requirements. Alignment between the two instruments is achievable through a collaborative arrangement. The *National Scheme's Aboriginal and Torres Strait Islander Cultural Safety Strategy* demonstrates this is possible.[4] But alignment requires intergovernmental agreement – the Commission cannot effect it unilaterally. As an agency funded and governed across jurisdictions, however, it can advise and recommend such alignment.

The Commission must therefore operate in an environment where political conditions for full structural reform do not currently exist. It must simultaneously build the architecture that would make genuine reform possible when those conditions change. The scan supports four interim approaches within the Commission's existing authority.

First, cultural safety requirements in any national cultural safety standard should be precise, outcome-referenced, and explicitly linked to community-determined evidence. These features make them harder to compliance-wash than broad, process-oriented requirements.

Second, any national standard needs to align with the *AHRC National Anti-Racism Framework.* This establishes a documented regulatory basis for treating cultural safety as a human rights obligation rather than a service-quality preference.[1-2]

Third, a national cultural safety measurement infrastructure should be established and mandated as a condition of accreditation. No nationally scaled, Aboriginal and Torres Strait Islander-governed measurement framework for cultural safety in health care currently exists in Australia. That absence is itself a structural finding. The *AIHW Cultural Safety Monitoring Framework* provides the most comprehensive available starting point. However, any mandated framework must be co-designed and co-governed with Aboriginal and Torres Strait Islander communities and organisations.

The cultural domains identified through the Mayi Kuwayu longitudinal research measures, including Connection to Country, Language and Self-determination, provide a model for what First Nations-grounded measurement looks like.[76] Measurement sovereignty and governance sovereignty are the same problem. This infrastructure would create a national database through which the accountability gap becomes publicly documented. The gap would become progressively harder to ignore, regardless of the political environment.[7]

Fourth, the community-controlled health sector already shows what genuine First Nations authority over health systems looks like in practice. Any national standard framework should explicitly recognise the sector as a proof of concept for the accountability architecture that the broader system is yet to build.

Risks

The scan also identifies risks that must be considered in designing any national cultural safety standard.

The first risk is replicating the modal international outcome. Where cultural safety standards retain competency framing without binding consequence structures, the documented result across multiple jurisdictions is compliance without culture change.[3] Where any national standard strengthens cultural safety language without strengthening accountability and consequence architecture, organisations will update their documentation rather than change their practice. This is the same outcome produced by the current *Standards.*[3]

The second risk is structural fragility. Te Aka Whai Ora – a structurally significant Māori health governance body – was dismantled within 24 hours of a change in government in Aotearoa. This shows that frameworks not anchored in specific, enforceable legislative language are subject to administrative reversal. The specificity of any national standard's cultural safety requirements will determine their durability.[57,68]

The third risk is the persistence of the accountability void identified in the domestic scan. Without mandatory public reporting built into the National Standards, this pattern will extend to health services operating under them. Currently, 13 of 19 state and territory frameworks operate without public accountability. Community oversight of progress is the feature the evidence most consistently associates with genuine cultural safety outcomes. It will remain absent from the system unless specifically required.

Conclusions

The environmental scan documented in Part B finds that the absence of frameworks does not characterise Australia's cultural safety policy architecture. The absence of consequences characterises it. Definitional frameworks exist at every level of the Australian system, from the National Scheme's binding definition to state and territory health strategies.

Regulatory instruments reference cultural safety across accreditation, professional registration and health service delivery. What the scan consistently fails to find, across 19 domestic frameworks and four international jurisdictions, is a consequence structure capable of compelling accountability. The evidence identifies accountability to Aboriginal and Torres Strait Islander communities, not to institutions, as the necessary condition for safe care. The exception that makes the pattern visible is British Columbia's binding practice standard for nurses and midwives.[27] It is the one instrument in the comparative landscape that is enforceable, specific and directed at outcomes rather than processes.

Australia has not built a directly equivalent standalone standard. The National Scheme's codes of conduct and registration standards carry enforcement power, including removal of registration.[4] However, cultural safety obligations remain embedded within broader conduct frameworks rather than constituted as a discrete, enforceable standard.

Part B's findings directly extend and complicate Part A's evidence base. Where Part A established what culturally safe care requires, Part B maps the gap between that evidence and what has been built. Part A identified three requirements: community-led definition, community-centred measurement and accountability to the community rather than to institutions. The gap is not ignorance.

The Australian regulatory environment reflects genuine engagement with the evidence, as shown by the National Scheme's definition and the *AIHW Monitoring Framework*.[4,7] The gap is architectural: translating sound definitions into binding instruments, monitoring frameworks into mandatory reporting, and advisory engagement into genuine community authority. Together, Parts A and B identify the revision of the National Standards and the consultation process as the site where that architectural gap can be most directly addressed.[4,7,18]

These findings will also feed into a broader program of reform. The Commission has advised that it will draw on this report, together with parallel measurement and data work led by the AIHW and monitoring and accountability work led by NACCHO, to inform the standards for cultural safety review and its approach to implementation under the National Health Reform Agreement extension and Schedule B of the 2026–2031 Addendum.

This report set out to answer five research questions. These addressed the meaning of cultural safety in First Nations health care and how to measure it. It also examined governance and accountability mechanisms, structural conditions for realisation, and how the National Standards compare to the evidence and to international practice.

The rapid literature review (Part A) and the environmental scan (Part B) approach these questions from complementary directions. Part A examines what the evidence says should exist; Part B examines what has actually been built. The convergence of their findings is unambiguous. Training requirements do not produce cultural safety for Aboriginal and Torres Strait Islander peoples in health care, definitional statements or policy frameworks, however well designed. It is produced when those frameworks are binding, when accountability runs to the community rather than to the institution, and when consequences attach to non-compliance. The evidence supporting this conclusion is consistent across jurisdictions, study designs and timeframes.

The combined evidence base reveals a second, more uncomfortable finding. The evidentiary gap – the relative thinness of evidence on outcomes in the academic literature – is not a reason to delay stronger regulatory action. It is a consequence of the policy architecture that has operated to date. Voluntary frameworks without consequences do not generate the implementation environments in which robust outcome evidence can be produced and evaluated. Australia's documented coronial records constitute a body of evidence sufficient to establish that the current architecture is not working. These records include the deaths of Yvette Booth, Adele Sandy, Shakaya George and others whose care was found to have failed them. The burden of proof does not lie with those arguing for stronger action. It lies with any position that would maintain the status quo in the face of that record.[12]

The Australian Commission on Safety and Quality in Health Care occupies a singular position in this landscape. The National Standards are the only instrument in the Australian health system with national reach, institutional authority and binding application across accredited health services.

This combination is what a national cultural safety standard would require to produce system-level change. This scan has not directly compared variations on that model or assessed alternative instruments against each other – that determination appropriately follows stakeholder consultation and engagement.

The National Standards and consultation process represent the Commission's most immediate opportunity to redesign the accountability architecture. The redesign should be consistent with the evidence and comparable with best international practice. It must be responsive to the experience of Aboriginal and Torres Strait Islander peoples in the health system. The conclusions that follow identify the specific design features that the combined

evidence of this review supports, regardless of which model the Commission ultimately determines is most appropriate.

Design features for consultation

The design features that follow translate the architectural gap identified in this scan into the specific elements the combined evidence supports. They are offered as inputs to the Commission's options analysis and stakeholder engagement, not as a determination of which instrument should carry them.

As established throughout this review, whether the review of the National Standards, a standalone national cultural safety standard or another model is the most appropriate vehicle is a question for the consultation to follow.[4] What the evidence does determine is the set of features any such instrument would need to share to close the accountability gap rather than reproduce it. Each feature below should therefore be read as a design direction for consultation: evidence-supported in substance, with its final form, sequencing and implementation appropriately shaped by Aboriginal and Torres Strait Islander communities and the stakeholders the Commission engages.

1. The evidence supports aligning the definitional language of any national standard with the National Scheme's binding definition of cultural safety. The National Scheme defines cultural safety as a patient-determined outcome, shaped by ongoing practitioner reflection on knowledge, skills, attitudes and power differentials. This alignment would replace competency-based framing across all relevant Standard actions. It should be explicitly cross-referenced to the *National Scheme's Aboriginal and Torres Strait Islander Health Strategy 2026–2031* to ensure regulatory coherence.[4,75]

2. The evidence supports establishing binding, specific organisational requirements directed at demonstrable outcomes in the experience of Aboriginal and Torres Strait Islander patients and communities, rather than at process documentation. Such requirements would specify what organisations must show has changed, not what they must have completed, and would include explicit criteria for assessor judgment during accreditation surveys. The *BCCNM practice standard* and the *Health Standards Organization national standard* provide directly relevant architectural precedents.[27-28]

3. The evidence supports requiring community-reported cultural safety measurement as a condition of accreditation. No nationally scaled, Aboriginal and Torres Strait Islander-governed measurement framework for cultural safety in health care currently exists in Australia – itself a structural finding requiring remedy. Any measurement infrastructure would need to be co-designed and co-governed with Aboriginal and Torres Strait Islander communities and organisations, consistent with the *Maiam nayri Wingara Indigenous Data Sovereignty Principles* and *Ownership, Control, Access and Possession (OCAP) principles*.[79-80] The *AIHW Cultural Safety Monitoring Framework* offers a starting point, with its scope and governance subject to that co-design process; self-assessed compliance documentation would not satisfy this feature.[7]

4. The evidence supports requiring accredited health services to publicly report progress against cultural safety outcomes annually, using formats and channels accessible to the Aboriginal and Torres Strait Islander communities each service serves. Public reporting obligations would specify minimum content – including patient experience data, workforce cultural safety training outcomes, and progress against service-level improvement plans – with compliance serving as a condition of accreditation status.

5. The evidence supports establishing a First Nations community oversight mechanism with formal authority rather than advisory status, able to assess organisational cultural safety performance between accreditation cycles. Such a mechanism would be independently resourced and empowered to receive concerns from Aboriginal and Torres Strait Islander patients and communities outside formal complaints processes. It would be co-designed with the community-controlled health sector, including NACCHO and its affiliates, drawing on existing community-controlled governance models.

Taken together, these five features describe the accountability architecture the evidence associates with cultural safety that is realised rather than declared: a community-determined definition, binding organisational obligations, community-governed measurement, public reporting, and independent First Nations oversight. They are not a menu of alternatives but a set of interdependent components – each is weakened where the others are absent.

The Commission's task in the consultation that follows is not to determine whether these features matter, which the evidence settles, but to determine, with Aboriginal and Torres Strait Islander communities and stakeholders, the instrument that should carry them and the form each should take. Presenting them as design features for consultation, rather than fixed prescriptions, is itself consistent with the report's central finding: cultural safety is produced when authority is genuinely shared with the communities the system is meant to serve.

Reference list – Part B

1. Australian Human Rights Commission. National Anti-Racism Framework. Sydney: AHRC; 2024.
2. Australian Human Rights Commission. An Anti-Racism Framework: Voices of First Nations Peoples. Sydney: AHRC; 2023.
3. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. Sydney: ACSQHC; 2021.
4. Australian Health Practitioner Regulation Agency. The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025. Melbourne: Ahpra; 2020. Available from: https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx
5. National Aboriginal Community Controlled Health Organisation and Royal Australian College of General Practitioners. Joint Commitment to Cultural Safety. Melbourne: NACCHO and RACGP; 2019.
6. Quality Innovation Performance. QIC Health and Community Services Standards. Sydney: QIP; 2026.
7. Australian Institute of Health and Welfare. Cultural safety in health care for Indigenous Australians: monitoring framework. Canberra: AIHW; 2023.
8. Ramsden IM. Kawa Whakaruruhau: cultural safety in nursing education in Aotearoa. Wellington: Ministry of Education; 1990.
9. Ramsden IM. Cultural safety in nursing education in Aotearoa (New Zealand). Nursing Praxis in New Zealand. 1993;8(3):4–10.
10. Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine SJ, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. International Journal for Equity in Health. 2019;18(1):174. doi:10.1186/s12939-019-1082-3
11. Australian Commission on Safety and Quality in Health Care. ACSQHC Combined Glossary. February 2026. Sydney: Australian Commission on Safety and Quality in Health Care; 2026.
12. Wilson N. Inquest into the deaths of Yvette Booth, Adele Sandy and Shakaya George ('RHD Doomadgee Cluster'). Brisbane: Queensland Coroner's Court; 2023.
13. Tarrago A, Veit-Prince E, Brolan CE. 'Simply put: systems failed': lessons from the Coroner's inquest into the rheumatic heart disease Doomadgee cluster. Medical Journal of Australia. 2024;221(1).
14. Queensland Health. Case for Change: North West Hospital and Health Service. Brisbane: Queensland Health; 2016.
15. Joint statement: Aboriginal and Torres Strait Islander health and cultural safety at heart of National Law changes [press release]. Melbourne: Ahpra, 13 October 2022.
16. Health Practitioner Regulation National Law (Queensland) Act 2023 (Qld).
17. Australian Commission on Safety and Quality in Health Care. NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health. Sydney: ACSQHC; 2017.
18. Australian Commission on Safety and Quality in Health Care. Third edition engagement hub [Internet]. Sydney: ACSQHC; 2025 [cited 2025]. Available from: https://www.safetyandquality.gov.au

19. Weenthunga Health Network. Cultural Safety Accreditation and CPD Upskilling Framework and Strategy 2026–2031. Melbourne: Weenthunga Health Network; [unpublished] 2026.
20. Australian Health Practitioner Regulation Agency, National Boards. Ahpra and the National Boards annual report 2024/25: Highlights. Melbourne: AHPRA; 2025.
21. Lowitja Institute. Close the Gap: Agency, Leadership, Reform: Ensuring the survival, dignity and wellbeing of First Nations Peoples. Melbourne: Lowitja Institute; 2025.
22. Australian Institute of Health and Welfare. Indigenous Health Performance Framework: Measure 3.19 – Accreditation. Canberra: AIHW; 2019.
23. Lowitja Institute. Embedding Cultural Safety: National Cultural Safety Training Standards and Organisational Change. Melbourne: Lowitja Institute; 2024.
24. Elvidge E, Haddock R. Measuring what really matters for Aboriginal and Torres Strait Islander Peoples: racism and cultural safety in healthcare. Deeble Issues Brief. Canberra: Australian Healthcare and Hospitals Association (Deeble Institute for Health Policy Research); 2025.
25. Australian Council on Healthcare Standards. Accreditation and standards [Internet]. Sydney: ACHS; 2025 [cited 2025]. Available from: https://www.achs.org.au
26. Australian General Practice Accreditation Limited. General practice accreditation [Internet]. Sydney: AGPAL; 2025 [cited 2025]. Available from: https://www.agpal.com.au
27. BC College of Nurses and Midwives. Indigenous Cultural Safety, Cultural Humility and Anti-Racism Practice Standard. In force 25 February 2022. Vancouver: BCCNM; 2022.
28. Health Standards Organization. HSO 75000:2022 British Columbia Cultural Safety and Humility Standard. Ottawa: Health Standards Organization; 2022.
29. Springer, SJ. Cultural Safety: From Compliance to Commitment. A Better Culture; 2025.
30. Paradies Y. Aboriginal and Torres Strait Islander Anti-Racism Policy. Melbourne: Australian Health Practitioner Regulation Agency; December 2024.
31. Paradies YC. A systematic review of empirical research on self-reported racism and health. International Journal of Epidemiology. 2006;35(4):888–901.
32. Daniels S. 30 Patterns of Harm: A Structural Review of Systemic Racism within the London Metropolitan Police Service. London: Metropolitan Police Service; 2025.
33. Canadian Institute for Health Information. Measuring Cultural Safety in Health Systems. Ottawa: CIHI; 2021.
34. First Nations Health Authority, BC Ministry of Health, Health Canada. Creating a Climate for Change: Cultural Safety and Humility in Health Services for First Nations and Aboriginal Peoples in British Columbia. Vancouver: FNHA; 2016.
35. Mohamed J. Cultural Safety in Australia. Melbourne: Lowitja Institute; 2024.
36. Weenthunga Health Network. Evaluating the Research Base of Cultural Safety in Health Outcomes Relative to Accreditation and Continuing Professional Development. Melbourne: Weenthunga Health Network; [unpublished] 2024.
37. National Indigenous Australians Agency. Framework for Governance of Indigenous Data [Internet]. Canberra: NIAA; 2024 [cited 2026 Jul 6]. Available from: https://www.niaa.gov.au/our-work/data-evaluation-and-research/framework-governance-indigenous-data-gid

38. Australian Government Department of Health and Aged Care. National Aboriginal and Torres Strait Islander Health Plan 2021–2031. Canberra: Department of Health and Aged Care; 2021.

39. Australian Government Department of Health. National Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health. Canberra, ACT: Australian Government Department of Health; 2016.

40. NSW Health. NSW Aboriginal Health Plan 2024–2034. Sydney: NSW Ministry of Health; 2024.

41. NSW Health. NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework. Sydney: NSW Ministry of Health; 2022.

42. NSW Health. NSW Aboriginal Mental Health and Wellbeing Strategy 2020–2025. Sydney: NSW Ministry of Health; 2020.

43. Department of Health Victoria. Aboriginal and Torres Strait Islander Cultural Safety Framework. Melbourne: Department of Health Victoria; 2021.

44. Department of Health Victoria. Aboriginal and Torres Strait Islander Cultural Safety Framework Guidelines. Melbourne: Department of Health Victoria; 2021.

45. Queensland Health and Aboriginal and Torres Strait Islander Health Council. Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework. Brisbane: Queensland Health; 2021.

46. SA Health. SA Health Aboriginal Cultural Learning Framework. Adelaide: SA Health; 2019.

47. Preventive Health SA and SA Health. South Australian Aboriginal Health Promotion Strategy 2022–2030. Adelaide: Preventive Health SA; 2022.

48. Western Australian Department of Health. WA Aboriginal Health and Wellbeing Framework 2015–2030. Perth: WA Department of Health; 2015.

49. Tasmanian Department of Health and Department of Communities Tasmania. Improving Aboriginal Cultural Respect Across Tasmania's Health System Action Plan 2020–2026. Hobart: Tasmanian Department of Health; 2020.

50. NT Health. NT Health Aboriginal Cultural Security Framework 2016–2026. Darwin: NT Department of Health; 2016.

51. NT Health. NT Health Aboriginal Health Plan 2021–2031. Darwin: NT Department of Health; 2021.

52. ACT Government. ACT Aboriginal and Torres Strait Islander Agreement 2019–2028. Canberra: ACT Government; 2019.

53. ACT Health. ACT Health Workforce Strategy 2023–2032. Canberra: ACT Health; 2023.

54. Medical Council of New Zealand. Statement on cultural safety. Wellington: Medical Council of New Zealand; 2019.

55. Nursing Council of New Zealand. Cultural safety guidelines for the nursing sector. Wellington: Nursing Council of New Zealand; 2026.

56. Health Quality and Safety Commission New Zealand. Measuring culturally safe care through the patient experience surveys. Wellington: HQSC; 2021.

57. New Zealand Parliament. Pae Ora (Disestablishment of Māori Health Authority) Amendment Act 2024. Wellington: New Zealand Government; 2024.

58. First Nations Information Governance Centre. A First Nations Data Governance Strategy. Ottawa: FNIGC; 2020.

59. Council of the Atikamekw of Manawan and Council of the Atikamekw Nation. Joyce's Principle: Atikamekw Nehirowisiw. Brief presented to the Government of Canada and the Government of Quebec. Manawan: 2020. Available from: https://principedejoyce.com/sn_uploads/principe/Joyce_s_Principle_brief___Eng.pdf

60. Nickerson M. Cultural Safety and Humility Case Study Report: As Part of the Evaluation of the Tripartite Framework Agreement on First Nation Health Governance. First Nations Health Authority, Province of British Columbia, Indigenous Services Canada; 2019.

61. Turpel-Lafond ME (Aki-Kwe). In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care – Summary Report. Victoria (BC): Addressing Racism Review; 2020.

62. United States Department of Health and Human Services – Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards). Washington DC: US DHHS; 2013.

63. Indian Self-Determination and Education Assistance Act 1975, Title V (Tribal Self-Governance), (2000).

64. Te Tiriti o Waitangi [Treaty of Waitangi]. Wellington: Archives New Zealand | Puna Mātauranga o Aotearoa; 1840. Available from: https://www.archives.govt.nz/the-treaty-of-waitangi

65. Ramsden IM. Cultural safety and nursing education in Aotearoa and Te Waipounamu [doctoral thesis]. Wellington: Victoria University of Wellington; 2002.

66. Ministry of Health New Zealand. Ao Mai te Rā: the Anti-Racism Kaupapa Literature Review Summary Paper – Lessons for the Aotearoa New Zealand Health System. Wellington: Ministry of Health New Zealand; 2022.

67. Ministry of Health New Zealand. Whiria te Muka Tangata: Anti-Racism Systems Change – A Preliminary Model for the Aotearoa New Zealand Health System. Wellington: Ministry of Health New Zealand; 2023.

68. Waitangi Tribunal. Urgent report on the disestablishment of Te Aka Whai Ora – Māori Health Authority. Wellington: Waitangi Tribunal; 2024.

69. New Zealand Resident Doctors A. Minister's interference with Medical Council independence is the real political agenda: New Zealand Resident Doctors Association; 2026.

70. Health Practitioners Competence Assurance Act 2003 (as amended 2019), (2003).

71. Truth and Reconciliation Commission of Canada. Truth and Reconciliation Commission of Canada: Calls to Action. Winnipeg: TRC; 2015. Available from: https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf

72. Health Canada, Government of British Columbia, First Nations Health Society. British Columbia Tripartite Framework Agreement on First Nations Health Governance. Made 13 October 2011; FNHA assumed design, management and delivery of First Nations health programming in BC on 1 October 2013. Ottawa: Government of Canada (Indigenous Services Canada); 2011.

73. Public Health Agency of Canada. Common Definitions on Cultural Safety: Chief Public Health Officer Health Professional Forum. Ottawa: Public Health Agency of Canada; 2023.

74. Cornell AD. Indian Health Service (IHS) FY2022 Budget Request and Funding Issues [Internet]. Washington (DC): Congressional Research Service; 2022 Jan 6 [cited 2026 Jul 6]. Report No.: R47004. Available from: https://www.congress.gov/crs-product/R47004

75. Australian Health Practitioner Regulation Agency. National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2026–2031. Melbourne: Ahpra; 2026.

76. Bourke SC, Chapman J, Jones R, Brinckley MM, Thurber KA, Calabria B, et al. Developing Aboriginal and Torres Strait Islander cultural indicators: an overview from Mayi Kuwayu, the National Study of Aboriginal and Torres Strait Islander Wellbeing. International Journal for Equity in Health. 2022;21(1).

77. Australian Institute of Health and Welfare. Indigenous Health Performance Framework 2025 Summary Report. Canberra: AIHW; 2025.

78. Australian Commission on Safety and Quality in Health Care. National General Practice Accreditation Scheme. Sydney: ACSQHC; 2025.

79. Maiam nayri Wingara Indigenous Data Sovereignty Collective, Australian Indigenous Governance Institute. Indigenous Data Sovereignty Communique. Canberra, ACT: Maiam nayri Wingara; 2018.

80. First Nations Information Governance Centre. Ownership, Control, Access and Possession (OCAP): the path to First Nations information governance. Ottawa, ON: First Nations Information Governance Centre; 2014.

Appendices

Appendix A: Search strategy - Part A (Rapid Literature Review)

This appendix documents the search strategy executed for Part A of the Rapid Literature Review and Environmental Scan. The strategy was developed by Jayde Fuller, Director, Indigenous Regulatory Practice, and endorsed by the Australian Commission on Safety and Quality in Health Care (the Commission) as Milestone 1. Database searches were executed on 23 April 2026.

A.1 Summary search log

Database	Search terms / strings	Filters applied	Date searched	Results
MEDLINE (PubMed)	Cultural safety, cultural humility, cultural competency, Indigenous Peoples, health services - MeSH + free-text (see string A.1 below)	English language; 2011–2026 (with exceptions for foundational pre-2011 literature)	20 April 2026	998
Embase	Cultural safety, cultural humility, cultural competency, Indigenous Peoples, health services - Emtree + free-text (see string A.2 below)	English language; 2011–2026 (with exceptions for foundational pre-2011 literature)	21 April 2026	1,255
CINAHL (EBSCO)	Cultural safety, cultural humility, Indigenous Peoples, health services - CINAHL Subject Headings + free-text (see string A.3 below)	English language; 2011–2026 (with exceptions for foundational pre-2011 literature)	21 April 2026	16
PsycINFO (APA/EBSCO)	Cultural competence, Indigenous Peoples, health services - PsycINFO Descriptors + free-text (see string A.4 below)	English language; 2011–2026 (with exceptions for foundational pre-2011 literature)	21 April 2026	140
Scopus	Main + 4 supplementary searches: cultural safety, Indigenous Peoples, health systems; regulatory theory; NSQHS Standards; comparative regulatory trajectories; foundational Aotearoa literature (see strings A.5 below)	English language; 2011–2026 (with exceptions for foundational pre-2011 literature); supplemental searches: no date filter for	21 April 2026	2,288

Database	Search terms / strings	Filters applied	Date searched	Results
		pre-2011 exception		
Web of Science (Core Collection)	Main + 2 supplementary searches: cultural safety, Indigenous Peoples, health systems; regulatory theory; NSQHS Standards (see strings A.6 below)	English language; 2011–2026 (with exceptions for foundational pre-2011 literature)	21 April 2026	1,214
Indigenous Studies Portal (iPortal)	Cultural safety, cultural humility, Indigenous Peoples, health services - keyword + subject heading browse (see string A.7 below)	English language; 2011–2026 (with exceptions for foundational pre-2011 literature)	21 April 2026	175
Informit (ATSI Health Collection)	Cultural safety, cultural humility, racism, health services; supplementary: standards, accreditation, governance (see strings A.8 below)	English language; 2011–2026 (with exceptions for foundational pre-2011 literature)	21 April 2026	474
TOTAL				6,560

Note: Forward and backward citation chasing was applied to key papers identified through the database search, using Scopus (forward citations) and manual reference list review (backward citations). Additional records identified through citation chasing are recorded in the Part A report body.

A.2 Database-specific search strings

Full search strings are reproduced below as executed in each database interface, including controlled vocabulary terms, field qualifiers, and Boolean logic. Line numbers and set identifiers reflect the interface conventions of each database.

A.2.1 MEDLINE (PubMed) - Date searched: 20 April 2026

#	Search string	Records retrieved
1	"cultural safety"[tiab] OR "cultural humility"[tiab] OR "cultural competenc*"[tiab] OR "culturally safe"[tiab] OR "racism"[MeSH] OR "structural racism"[tiab] OR "anti-racism"[tiab]	
2	"Indigenous peoples"[MeSH] OR "Aboriginal"[tiab] OR "Torres Strait Islander"[tiab] OR "First Nations"[tiab] OR "Māori"[tiab] OR "Maori"[tiab] OR "American Indian"[MeSH] OR "Alaska Native"[tiab] OR "Native American"[tiab] OR "Métis"[tiab] OR "Inuit"[tiab]	

#	Search string	Records retrieved
3	"health services"[MeSH] OR "hospitals"[MeSH] OR "health care"[tiab] OR "health system*"[tiab] OR "primary health care"[MeSH] OR "community health services"[MeSH]	
4	#1 AND #2 AND #3	
5	#4 with filters: English language, 2011–2026	998

A.2.2 Embase - Date searched: 21 April 2026

Field qualifiers ti, ab, kw restrict searching to the title, abstract, and keyword fields. /exp = exploded Emtree term.

```
S1   'cultural safety ': ti, ab,kw OR 'cultural humility ': ti, ab,kw OR
'cultural competence'/exp OR 'racism'/exp OR 'structural racism ': ti, ab,kw
OR 'anti-racism ': ti,ab,kw OR 'culturally safe':ti, ab,kw OR 'cultural
responsiveness':ti,ab,kw
S2   'indigenous people'/exp OR 'aboriginal':ti,ab,kw OR 'Torres Strait
Islander':ti,ab,kw OR 'First Nations':ti,ab,kw OR 'Maori':ti,ab,kw OR
'Māori':ti,ab,kw OR 'Inuit':ti,ab,kw OR 'Métis':ti,ab,kw OR 'Alaska
Native':ti,ab,kw OR 'Native American':ti,ab,kw OR 'American Indian'/exp OR
'indigenous Australian':ti,ab,kw
S3   'health care'/exp OR 'hospital'/exp OR 'health system':ti, ab,kw OR
'primary health care'/exp OR 'community health service'/exp OR 'health
service':ti, ab,kw
S4   S1 AND S2 AND S3
S5   S4 AND [English]/lim AND [2011-2026]/py   →  1,255 records
```

A.2.3 CINAHL (EBSCO) - Date searched: 21 April 2026

MH = CINAHL Subject Heading (controlled vocabulary). TI, AB = title and abstract free-text.

```
S1   (MH "Transcultural Nursing") OR (MH "Cultural Competency") OR TI,AB
"cultural safety" OR TI,AB "cultural humility" OR TI,AB "culturally safe" OR
(MH "Racism") OR TI,AB "structural racism" OR TI,AB "anti-racism" OR TI,AB
"cultural responsiveness"
S2   (MH "Aboriginal Australians") OR (MH "Native Americans") OR TI,AB
"Aboriginal" OR TI,AB "Torres Strait Islander" OR TI,AB "First Nations" OR
TI,AB "Māori" OR TI,AB "Maori" OR TI,AB "Inuit" OR TI,AB "Métis" OR TI,AB
"Indigenous" OR TI,AB "Alaska Native" OR TI,AB "Native American"
S3   (MH "Health Services") OR (MH "Hospitals") OR (MH "Primary Health
Care") OR TI,AB "health system*" OR TI,AB "health service*" OR TI,AB
"hospital*" OR TI,AB "inpatient*"
S4   S1 AND S2 AND S3
S5   S4 Limiters: English language; Publication Date: 2011-2026   →  16
records
```

A.2.4 PsycINFO (APA/EBSCO) - Date searched: 21 April 2026

DE = PsycINFO Thesaurus Descriptor. TI, AB = title and abstract free-text.

```
S1   DE "Cultural Competence" OR DE "Multicultural Competence" OR TI,AB
"cultural safety" OR TI,AB "cultural humility" OR TI,AB "culturally safe" OR
DE "Racism" OR TI,AB "structural racism" OR TI,AB "anti-racism" OR TI,AB
"cultural responsiveness"
```

```
S2   DE "Indigenous Peoples" OR DE "American Indians" OR TI,AB "Aboriginal"
OR TI,AB "Torres Strait Islander" OR TI,AB "First Nations" OR TI,AB "Māori"
OR TI,AB "Maori" OR TI,AB "Inuit" OR TI,AB "Métis" OR TI,AB "Indigenous
Peoples"
S3   DE "Health Care Services" OR DE "Hospitals" OR TI,AB "health system*"
OR TI,AB "health service*" OR TI,AB "hospital*" OR DE "Community Health
Services"
S4   S1 AND S2 AND S3
S5   Limit to: English language; Publication Year: 2011–2026   →  140
records
```

A.2.5 Scopus - Date searched: 21 April 2026

All searches use the TITLE-ABS-KEY field. Five searches were run (one main, four supplementary).

Main search (all research questions):

```
TITLE-ABS-KEY(( "cultural safety" OR "cultural humility" OR "cultural
competenc*" OR "culturally safe" OR "structural racism" OR "anti-racism" OR
"cultural responsiveness" ) AND ( "Indigenous" OR "Aboriginal" OR "First
Nations" OR "Māori" OR "Maori" OR "Torres Strait Islander" OR "Inuit" OR
"Métis" OR "Native American" OR "Alaska Native" ) AND ( "health care" OR
"health system*" OR "hospital*" OR "primary health care" OR "health
service*" )) AND LANGUAGE(english) AND PUBYEAR > 2010
```

Supplemental search 1 - Regulatory theory and accountability mechanisms (RQs C and E):

```
TITLE-ABS-KEY(( "responsive regulation" OR "regulatory logic" OR
"accountability-based" OR "competency-based regulation" OR "regulatory
reform" OR "regulatory capitalism" OR "meta-regulation" ) AND ( "health
standard*" OR "accreditat*" OR "health system*" OR "Indigenous health" OR
"cultural safety" ))
```

Supplemental search 2 - NSQHS Standards (RQ E):

```
TITLE-ABS-KEY("NSQHS" OR "National Safety and Quality Health Service") AND
TITLE-ABS-KEY("cultural safety" OR "Indigenous" OR "Aboriginal" OR "First
Nations")
```

Supplemental search 3 - Comparative regulatory trajectories: Aotearoa and Canada (RQ D):

```
TITLE-ABS-KEY(( "cultural safety" OR "cultural humility" ) AND ( "standard*"
OR "regulat*" OR "professional regulation" OR "governance" OR
"accountability" ) AND ( "New Zealand" OR "Aotearoa" OR "Canada" OR "British
Columbia" )) AND LANGUAGE(english)
```

Supplemental search 4 - Foundational cultural safety literature, Aotearoa (pre-2011 exception; RQ D):

```
TITLE-ABS-KEY("cultural safety" AND ( "Ramsden" OR "Nursing Council" OR
"professional regulation" ) AND ( "New Zealand" OR "Aotearoa" )) [no date
filter applied – pre-2011 exception]
Combined total for all Scopus searches   →  2,288 records
```

A.2.6 Web of Science (Core Collection) - Date searched: 21 April 2026

TS = Topic field (title, abstract, author keywords, Keywords Plus). Three searches run (one main, two supplementary).

Main search (all research questions):

```
TS=("cultural safety" OR "cultural humility" OR "cultural competenc*" OR
"culturally safe" OR "structural racism" OR "anti-racism") AND
TS=("Indigenous" OR "Aboriginal" OR "First Nations" OR "Māori" OR "Maori" OR
"Torres Strait Islander" OR "Inuit" OR "Native American") AND TS=("health
```

```
care" OR "health system*" OR "hospital*" OR "health service*") Filters:
Language: English; Publication Years: 2011–2026
```

Supplemental search 1 - Regulatory theory (RQs C and E):

```
TS=("responsive regulation" OR "regulatory logic" OR "accountability-based
regulation" OR "regulatory reform" OR "meta-regulation") AND TS=("health
standard*" OR "accreditat*" OR "Indigenous health" OR "cultural safety")
```

Supplemental search 2 - NSQHS Standards (RQ E):

```
TS=("NSQHS" OR "National Safety and Quality Health Service Standards" OR
"ACSQHC") [No additional filters]
Combined total for all Web of Science searches   →  1,214 records
```

A.2.7 Indigenous Studies Portal (iPortal) - Date searched: 21 April 2026

Subject heading browsing for ‘Cultural safety’ and ‘Health services – Indigenous peoples’ was undertaken in addition to the keyword search below. Unique records not already captured in other database searches were carried forward to screening (n = 145).

Note: the iPortal row in the search log (v2, 23 April 2026) was labelled ‘Grey literature N/A’, but the PRISMA total of 6,560 confirms that these records were counted as bibliographic database records. This has been corrected here consistent with the PRISMA 2020 flow diagram.

```
("cultural safety" OR "cultural humility" OR "culturally safe" OR "cultural
competenc*" OR "structural racism") AND ("First Nations" OR "Aboriginal" OR
"Indigenous" OR "Māori" OR "Maori" OR "Inuit" OR "Métis") AND ("health care"
OR "health system*" OR "hospital*" OR "health service*")
Total records   →  175
```

A.2.8 Informit (Aboriginal and Torres Strait Islander Health Collection) - Date searched: 21 April 2026

Population terms are embedded in the collection's indexing. Two searches were run.

Main search:

```
("cultural safety" OR "cultural humility" OR "culturally safe" OR "cultural
competenc*" OR "racism" OR "structural racism" OR "anti-racism") AND
("hospital*" OR "health service*" OR "health system*" OR "primary health
care" OR "acute care")
```

Supplementary search - standards, governance, and policy:

```
("standard*" OR "accreditat*" OR "governance" OR "accountability" OR
"NSQHS") AND ("cultural safety" OR "Aboriginal" OR "First Nations")
Combined total for both Informit searches   →  474 records
```

Appendix B: Search strategy - Part B (Environmental Scan)

This appendix documents the search strategy for the Environmental Scan (Part B). The scan used a purposive search strategy. Sources were deliberately selected for their relevance to the four policy functions analysed in Part B: (1) definitional and conceptual frameworks; (2) regulatory and standards instruments; (3) governance and accountability structures; and (4) implementation models and measurement.

Unlike Part A, the environmental scan does not use comprehensive bibliographic database searching. Sources were identified through targeted website searches, snowball sampling from identified documents, and the Commission-provided First Nations Library (ACSQHC EndNote collection), which served as the baseline for the scan.

Inclusion criteria: sources published 2011–2026; English language; covering Australia, Aotearoa New Zealand, Canada, or the United States of America; addressing cultural safety policy, regulatory instruments, governance structures, or implementation models in Indigenous health care.

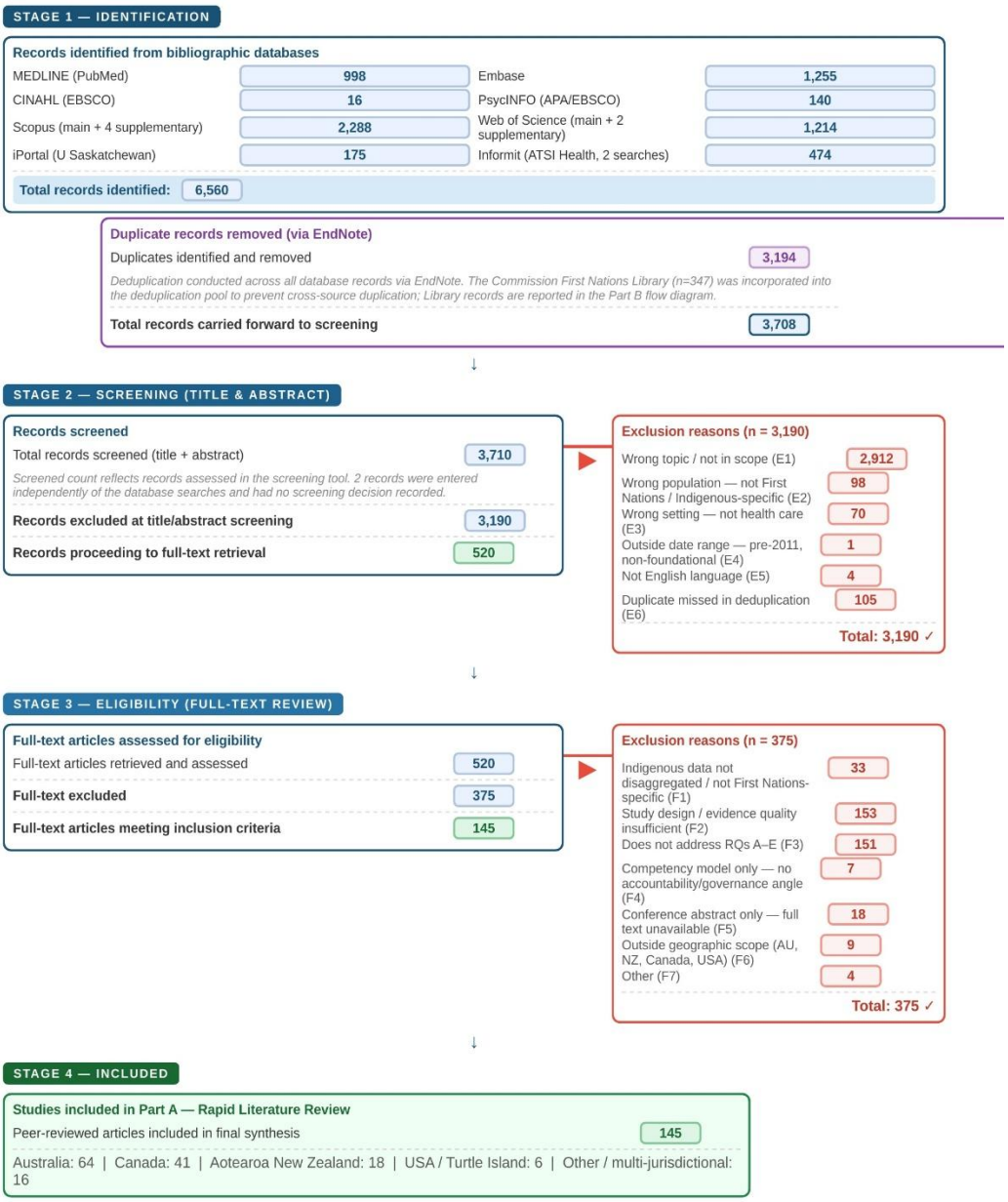
Source type	Jurisdictions covered	Search terms	Date	Results
Commission FN Library (ACSQHC EndNote collection)	Australia, Aotearoa New Zealand, Canada, United States of America	All core terms; collection pre-curated by the Commission	23 April 2026	347
National health regulatory and standards bodies (ACSQHC, Ahpra, HQSC NZ, HSO Canada, TJC USA)	Australia, Aotearoa New Zealand, Canada, United States of America	Cultural safety, cultural humility, standards, accreditation, Indigenous health, First Nations	23 April 2026	10
Government health departments (Australian Dept of Health and Aged Care, Ministry of Health NZ, Health Canada / CIHI, Indian Health Service USA)	Australia, Aotearoa New Zealand, Canada, United States of America	Cultural safety, Indigenous health, health plan, strategy, framework, First Nations	23-24 April 2026	7
Indigenous health peak bodies and research institutes (NACCHO, Lowitja Institute, Te Rau Ora, FNIGC, Urban	Australia, Aotearoa New Zealand, Canada, United States of America	Cultural safety, cultural humility, Indigenous data sovereignty, community-controlled health	24 April 2026	7

Source type	Jurisdictions covered	Search terms	Date	Results
Indian Health Institute)				
Research institutes and think tanks (AIHW, Grattan Institute, PHAC Canada)	Australia, Canada	Cultural safety, Indigenous health performance, accreditation, governance	24 April 2026	2
International health organisations (WHO, PAHO, OECD Health)	Global / multi-jurisdictional	Cultural safety, Indigenous health equity, health systems, standards	24 April 2026	5
Other sources - conference proceedings, preprints, AIATSIS catalogue, medRxiv	Australia, global	Cultural safety, First Nations health, Indigenous-authored research	24 April 2026	10
TOTAL				388

Note: The 347 records from the Commission FN Library (ACSQHC EndNote collection) were deduplicated alongside Part A database records (total duplicates removed: 3,194). The remaining Part B sources were assessed directly against the relevance criteria.

Appendix C: PRISMA flow diagram – Part A

The PRISMA 2020 flow diagram below documents the identification, screening, eligibility assessment, and inclusion of records for Part A of the Rapid Literature Review. The diagram was prepared in accordance with the PRISMA 2020 statement.



The figures underpinning the flow diagram are summarised in the table below for reference.

Stage	Detail
Stage 1 – Identification (Part A databases)	
MEDLINE (PubMed)	998 records
Embase	1,255 records
CINAHL (EBSCO)	16 records
PsycINFO (APA/EBSCO)	140 records
Scopus (main + 4 supplementary)	2,288 records
Web of Science (main + 2 supplementary)	1,214 records
Indigenous Studies Portal (iPortal)	175 records
Informit (ATSI Health Collection, 2 searches)	474 records
Total records identified (Part A)	6,560 records
Stage 1 – Identification (Part B grey literature sources)	
Commission FN Library (ACSQHC EndNote collection)	347 records
National regulatory bodies	10 records
Government health departments	7 records
Indigenous health peak bodies	7 records
Research institutes	2 records
WHO / PAHO / OECD Health	5 records
Other / conference/preprints	10 records
Total records identified (Part B)	388 records
Duplicates removed (via EndNote)	3,194 records removed
Total records carried forward to screening	3,708 records

Stage	Detail
Stage 2 – Screening (title and abstract)	
Records screened	3,710 records (incl. 2 entered independently of the database searches, no screening decision recorded)
Excluded at title/abstract screening	3,190 records
E1 – wrong topic / not in scope	2,912
E2 – wrong population (not Indigenous-specific)	98
E3 – wrong setting (not health care)	70
E4 – outside date range (pre-2011, non-foundational)	1
E5 – not English language	4
E6 – duplicate missed in deduplication	105
Records proceeding to full-text review	520 records
Stage 3 – Eligibility (full-text review)	
Full-text articles assessed for eligibility	520 records
Full-text excluded	375 records
F1 – Indigenous data not disaggregated / not First Nations-specific	33
F2 – study design or evidence quality insufficient	153
F3 – does not address the research questions (RQs A – E)	151
F4 – competency model only, no accountability or governance angle	7
F5 – conference abstract only, full text unavailable	18
F6 – outside geographic scope	9

Stage	Detail
(Australia, Canada, New Zealand, USA)	
F7 – other	4
Stage 4 – Included	
Studies included in final review (Part A – peer-reviewed literature)	145 records

Appendix D: Abbreviations and acronyms

All abbreviations and acronyms used in this report are listed below in alphabetical order. Per Commission style requirements, all abbreviations are spelled out at first mention in the body text.

Acronym/abbreviation	Full form
ACHS	Australian Council on Healthcare Standards
ACSQHC	Australian Commission on Safety and Quality in Health Care
ACT	Australian Capital Territory
AGPAL	Australian General Practice Accreditation Limited
AHPRA / Ahpra	Australian Health Practitioner Regulation Agency
AHRC	Australian Human Rights Commission
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIHW	Australian Institute of Health and Welfare
AU	Australia
BCCNM	BC College of Nurses and Midwives
CIHI	Canadian Institute for Health Information
CLAS	Culturally and Linguistically Appropriate Services
FNHA	First Nations Health Authority (British Columbia, Canada)
FNIGC	First Nations Information Governance Centre (Canada)
HQSC	Health Quality and Safety Commission (Aotearoa New Zealand)
HSO	Health Standards Organization (Canada)
IHS	Indian Health Service (United States of America)
IRP	Indigenous Regulatory Practice
M1	Milestone 1
MeSH	Medical Subject Headings
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHO	National Aboriginal Health Organization (Canada)
NSQHS	National Safety and Quality Health Service
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand (Aotearoa)
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organization
PAR	Participatory Action Research

Acronym/abbreviation	Full form
PHAC	Public Health Agency of Canada
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
QIC	Quality Health and Community Services (QIC) Standards
QIP	Quality Innovation Performance
RACGP	Royal Australian College of General Practitioners
RFQ	Request for Quotation
RQ	Research Question
SA	South Australia
TJC	The Joint Commission (United States of America)
TRC	Truth and Reconciliation Commission of Canada
UIHI	Urban Indian Health Institute (United States of America)
UN	United Nations
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
USA	United States of America
WA	Western Australia
WHO	World Health Organization

Glossary

Terms used with a specific meaning in this report are defined below in alphabetical order. Where a term appears in the ACSQHC Combined Glossary (February 2026), that definition is used, and the source is noted. Where a term is not in the Commission Glossary, the definition is provided with its source noted.

Term	Definition	Source
Aboriginal and Torres Strait Islander Peoples	The First Peoples of Australia, comprising Aboriginal peoples of the mainland and nearby islands and Torres Strait Islander peoples. Used in preference to 'ATSI', 'Aborigines', or 'Indigenous Australians' in accordance with Commission style. 'Peoples' (plural) refers to distinct nations and cultures; 'people' (singular collective) refers to individuals. See also: First Nations peoples.	Commission style guide; ACSQHC Combined Glossary, February 2026
Accreditation	A formal process by which an authorised body assesses whether a health service organisation meets defined standards. In the context of this report, accreditation refers specifically to assessment against the National Safety and Quality Health Service (NSQHS) Standards administered by the Australian Commission on Safety and Quality in Health Care.	ACSQHC Combined Glossary, February 2026
Accountability-based regulation	A regulatory model that holds health service organisations accountable for measurable outcomes - particularly outcomes determined by First Nations patients and communities - rather than for demonstrating compliance with process-based competency requirements. Contrasted with competency-based regulation in this report.	IRP analytical framework (Existing Material - Item 15)
Anti-racism	Active identification and elimination of racism - including structural and institutional racism - from policies, practices, systems, and cultures. Distinct from cultural competency approaches, which focus on individual practitioner skills rather than systemic change.	ACSQHC Combined Glossary, February 2026; Curtis et al. 2019
Competency-based regulation	A regulatory model that focuses on measuring and certifying individual practitioner knowledge and skills in relation to cultural safety, rather than on system-level accountability for outcomes experienced by First Nations patients. The current orientation of the NSQHS Standards Action 1.31.	IRP analytical framework (Existing Material - Item 15)
Cultural competency / competence	A model of intercultural practice focusing on the skills, knowledge, and attitudes of individual practitioners. Critiqued in this report and in the peer-reviewed literature as insufficient to achieve health equity for First Nations Peoples because it locates the problem of racism in individual practitioners rather than in institutional and systemic structures.	Curtis et al. 2019; ACSQHC Combined Glossary, February 2026

Term	Definition	Source
Cultural humility	A practice orientation emphasising ongoing self-reflection, openness to learning, and recognition of power imbalances in clinical relationships. Associated particularly with the Aotearoa, New Zealand and Canadian regulatory contexts. Related to but distinct from cultural safety.	First Nations Health Authority, BC 2016; Curtis et al. 2019
Cultural safety	An outcome defined by the patient or service user. Cultural safety is achieved when Aboriginal and Torres Strait Islander patients feel that their cultural identity, needs, rights, and experiences are respected and not threatened. It is determined by the recipient of care, not by the provider. Source: Commission Glossary (adapted from Ahpra, 2020). This definition is used throughout this report. Divergence from this definition, where it occurs in cited literature, is noted.	ACSQHC Combined Glossary, February 2026 (adapted from Ahpra 2020); Ramsden 1990, 2002
Aboriginal and Torres Strait Islander peoples / First Nations peoples / indigenous peoples:	All terms are used in this report. 'First Nations peoples' is used as the overarching term when referring to findings from across Canada and the United States of America. 'Aboriginal and Torres Strait Islander peoples' is used when referring specifically to Australia. 'Aboriginal' and 'Torres Strait Islander' are used separately where the evidence distinguishes between these groups. ‘Indigenous peoples’ with a lower case ‘i’ to refer to findings from across all four jurisdictions, as specified by the Commission’s style guide.	Commission style guide; ACSQHC Combined Glossary, February 2026
Grey literature	Literature produced by government, academia, business, and industry in print and electronic formats is not controlled by commercial publishing. In this report, grey literature includes government strategies, regulatory frameworks, accreditation standards, inquiry reports, peak body statements, and implementation toolkits identified through Part B (Environmental Scan).	IRP definition: consistent with PRISMA 2020 guidance
Health equity	The absence of avoidable, unfair, or remediable differences in health outcomes among population groups. In this report, health equity refers specifically to the elimination of disparities in health outcomes experienced by First Nations peoples in Australia and comparable settler-colonial jurisdictions.	WHO; ACSQHC Combined Glossary, February 2026
Indigenous data sovereignty	The right of Indigenous Peoples to govern the collection, ownership, and application of data about their communities, territories, and peoples. Relevant to the design of culturally safe measurement frameworks, patient experience surveys, and research methodologies discussed in this report.	FNIGC 2020; AIATSIS Code of Ethics
NSQHS Standards	National Safety and Quality Health Service Standards. The overarching national standards	ACSQHC 2021

Term	Definition	Source
	framework for safety and quality in Australian health service organisations is administered by the Australian Commission on Safety and Quality in Health Care. The second edition (2021) includes Action 1.31, which addresses cultural safety for Aboriginal and Torres Strait Islander peoples.	
Rapid literature review	A type of evidence synthesis that applies systematic and reproducible search methods within an accelerated timeframe. Appropriate for policy and regulatory contexts where evidence must inform decision-making within defined project parameters. Distinguished from a full systematic review by its accelerated timeframe and focused scope rather than by reduced methodological rigour.	IRP definition: Part A methodology
Responsive regulation	A regulatory theory (Ayres and Braithwaite 1992) holding that regulatory responses should be calibrated to the nature and severity of non-compliance, escalating from persuasion to sanction. Applied in this report to analyse the regulatory architecture of the NSQHS Standards' cultural safety requirements.	Ayres I, Braithwaite J. Responsive Regulation: Transcending the Deregulation Debate. Oxford: Oxford University Press; 1992.
Settler colonialism	A form of colonialism in which settlers occupy and establish permanent political authority over Indigenous territories, seeking to replace Indigenous peoples and systems rather than merely to extract resources. Used in this report to describe the shared structural context of Australia, Aotearoa, New Zealand, Canada, and the United States of America that shapes the health system conditions addressed by this review.	IRP analytical framework; peer-reviewed literature (Ray 2022; Fraser 2021)
Structural racism	The cumulative and compounding effects of policies, institutional practices, cultural representations, and other norms that work in concert to perpetuate racial group inequity. Distinguished from interpersonal racism. A key analytical concept in this report's examination of why cultural competency frameworks have not produced equitable health outcomes for First Nations Peoples.	ACSQHC Combined Glossary, February 2026; Curtis et al. 2019