



Healthcare Rights of Indigenous Australians with Kidney Disease: A Framework Analysis of Renal Policies and Strategic Plans for the Northern Territory Health Services

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Article abstract

This qualitative research, the first Australian study of its kind, constitutes an in-depth analysis of kidney disease care policies and strategic plans (n=11) to identify how they recognise and affirm the healthcare rights of the Northern Territory's (NT) Indigenous People. The Australian Charter of Healthcare Rights was used as a guiding document for the research. The study employed a thematic analysis method, specifically the framework analysis, due to its suitability for identifying and analysing patterns in qualitative data. The findings revealed that the Indigenous People's healthcare rights are not explicitly addressed in the policies and plans, even though they constitute 89% of the kidney disease patient population in the NT. A salient aspect of every policy and strategic plan was the lack of specific affirmative actions and targets to evaluate renal care processes and progress for Indigenous Peoples.





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Abstract

This qualitative research, the first Australian study of its kind, constitutes an in-depth analysis of kidney disease care policies and strategic plans (n=11) to identify how they recognise and affirm the healthcare rights of the Northern Territory's (NT) Indigenous People. The Australian Charter of Healthcare Rights was used as a guiding document for the research. The study employed a thematic analysis method, specifically the framework analysis, due to its suitability for identifying and analysing patterns in qualitative data. The findings revealed that the Indigenous People's healthcare rights are not explicitly addressed in the policies and plans, even though they constitute 89% of the kidney disease patient population in the NT. A salient aspect of every policy and strategic plan was the lack of specific affirmative actions and targets to evaluate renal care processes and progress for Indigenous Peoples.

Keywords

Healthcare rights, chronic kidney disease, Indigenous, Aboriginal and Torres Strait Islander, First Nations, renal care, health policies, framework analysis, kidney disease

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Healthcare Rights of Indigenous Australians with Kidney Disease: A Framework Analysis of Renal Policies and Strategic Plans for Northern Territory Health Services.

Australia has one of the best healthcare systems globally, yet Indigenous¹ Australians, also known as Aboriginal Torres Strait Islander peoples, do not experience health outcomes equivalent to those of other Australians. Kidney health² is one health area where the disparity between Indigenous and non-Indigenous Australians is alarmingly high. According to the Australian Institute of Health and Welfare (AIHW, 2022), the chronic kidney disease (CKD) burden is 7.3 times higher in Indigenous Australians than in non-Indigenous Australians, and their dialysis rates are 11 times higher than those of non-Indigenous Australians. On average, Indigenous patients present 20 years younger with kidney disease than non-Indigenous Australian CKD patients. Also, they are three times more likely to have Stage 1 CKD and are four times more likely to have Stage 4 and 5 CKD than non-Indigenous Australians (KHA, 2023).³ Despite consecutive renal care policies and strategic plans, the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA, 2024) shows that Northern Territory (NT) Aboriginal people requiring dialysis increased by a minimum of 7% every year over the previous three decades. The following adapted data (Figure 1) from the AIHW (2023) shows that the NT Aboriginal people have higher numbers of Kidney failure leading to dialysis than the rest of Australia.

¹ Indigenous Australians were the first inhabitants of Australia before the colonisation of Australia (from the late 18th century). They are also known as the Aboriginal and Torres Strait Islander Peoples, the First Nations Peoples, or the First Australians. The NT Indigenous people are respectfully called the Aboriginal people of the NT, and the term Indigenous people is used when there is a comparison required between them and non-Indigenous people.

² Kidney health is used synonymously with renal health.

³ Stages of CKD as per Kidney Health Australia is as follows:

No indicators of CKD: eGFR \geq 60 mL/min/1.73 m² and no presence of albuminuria

Stage 1: eGFR \geq 90 mL/min/1.73 m² and albuminuria

Stage 2: eGFR 60–89 mL/min/1.73 m² and albuminuria

Stage 3a: eGFR 45–59 mL/min/1.73 m²

Stage 3b: eGFR 30–44 mL/min/1.73 m²

Stage 4–5: eGFR < 30 mL/min/1.73 m² (KHA, 2023).

Table D1.10.15: Incidence of kidney failure with replacement therapy by Indigenous status, territory, 2006 to 2021^(a)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Northern Territory	71	67	76	59	53	67	85	80	102	106	68	107	109	112	91	98
Australia	221	242	253	197	211	261	257	286	307	294	320	365	332	390	322	351
Indigenous crude rate (per 100,000 population)																
Indigenous Australians age-standardised rate (per 100,000 population)^(d)																
Australia	66.5	66.9	65.8	47.9	53.3	58.7	58.4	61.8	64.1	62.2	64.2	69.7	61.7	71.5	56.7	60.6
Non-Indigenous Australians age-standardised rate (per 100,000 population)^(d)																
Australia	10.3	9.8	10.2	9.7	9.1	9.3	9.5	9.2	9.4	9.1	9.3	9.6	9.8	9.9	10.0	9.8

Figure 1. Incidence of kidney failure with replacement therapy for NT Aboriginal people compared to the whole of Australia (source: AIHW, 2023, Table D1.10.15)

In the international realm, the United Nations (UN) has commented in many human rights reviews and reports on the health disparities between Indigenous and non-Indigenous Australians. For example, the UN High Commissioner for Human Rights (2011, 2015, 2021a, 2021b) has commented in three consecutive UN Periodic Reviews on Indigenous Australians' health disparities and urged the Australian Government to take committed action.

This research constitutes the first Australian study analysing government renal care policies and strategic plans to identify how they recognise and affirm the healthcare rights of Aboriginal and Torres Strait Islander people in accordance with the Australian Charter of Healthcare Rights. The research is part of a larger qualitative study that explored the healthcare rights of Aboriginal people with CKD in the NT. This part of the study explored the policies and strategic plans addressing Aboriginal people with CKD in the publicly funded and provided Top End Health Service in the NT of Australia.

Background and Literature

Aboriginal people in the NT experience disproportionate kidney disease morbidity rates compared to the rest of Australia (AIHW, 2023) (see Figure 1). The impact of kidney disease and the subsequent health challenges for patients demand constant medical attention and regular use of healthcare facilities (Josif et al., 2017; Reilly et al., 2016; Rix et al., 2013), which challenge every domain of normalcy in their lives. The Australian Charter of Healthcare Rights (ACSQHC, 2008, 2019) applies to Indigenous Australians as it does to other Australians and affirms their right to receive healthcare on par with other Australians. According to the Māori political scholar O'Sullivan (2016):

Human rights standards codify the moral, legal and political principles of Indigenous peoples' reasonable health entitlement. They help explain policy failure and promote the values of equality and human dignity within the context of Indigenous peoples' reasonable public policy expectations. Also, human rights provide helpful analytical tools for assessing policy possibilities and limitations. (p. 747)

Therefore, this research used the Australian Charter of Healthcare Rights (ACSQHC, 2008, 2019) as the guiding document to examine current and recent NT renal care policies and strategic plans, and to explore the policy possibilities and limitations for renal care. The Australian Charter, which is inspired by the UN's Universal Declaration of Human Rights and the subsequent political, economic, social, and cultural rights covenants, outlines seven principles that should be the pillars of the healthcare experience in Australia. These principles are access to care, safety, communication, participation/partnership, respect, ability to comment, and privacy.

Despite the widespread interest in the inextricable link between health and human rights, there is little research globally on Indigenous Peoples' healthcare rights or health and human rights. Importantly, in the Australian context, the search did not retrieve any research that specifically examined the healthcare rights of Indigenous or non-Indigenous Australians. Australian health and human rights literature includes discussion papers, opinion papers, reviews, editorials, and government documents such as fact sheets (Anderson et al., 2006; Anderson & Loff, 2004; Calma, 2009; Gray & Oprescu, 2016; Gruskin et al., 2007; Mazel, 2018). There is no research evidence about the relationship between Aboriginal and

Torres Strait Islander Peoples' health and human rights, except for one case study by Freeman et al. (2016) that explored Aboriginal community-controlled primary healthcare services in Central Australia and their success in achieving universal health coverage (a UN initiative) based on the right to health. Freeman et al.'s study did not refer to the Australian Charter of Healthcare Rights.

Even though the literature search illustrated the dearth of research on healthcare rights nationally and internationally, there has been much research on Indigenous Australians' health disparities (Anderson et al., 2006; Angell et al., 2017; Hill et al., 2007; Kirmayer et al., 2014; Madden et al., 2016; Mohatt et al., 2014; Paradies, 2016; Taylor & Kukutai, 2015) and, more specifically, kidney health (Gorham et al., 2021; Hoy, 2014; Hoy et al., 2019; Hughes et al., 2019; Josif et al., 2017; Reilly et al., 2016; Rix et al., 2013, 2014, 2015). However, none of the research has had an explicit human rights focus. Therefore, it is important to examine how various policies and frameworks provide scope for or limit the realisation of the human rights of Aboriginal and Torres Strait Islander people in healthcare.

The following question guided this research: How do national and territory renal care policies recognise and affirm the Australian Charter of Healthcare Rights principles for NT Aboriginal people? The research objectives were to identify whether the NT and Australian governments' current and recent policies that relate to renal care recognise the principles of the Australian Charter of Healthcare Rights and to analyse how the NT Department of Health's renal care policies and strategic plans affirm the seven principles of the Australian Charter of Healthcare Rights: access to care, safety, communication, participation, respect, right to comment, and privacy.

Methodology

Policy and framework documents related to NT renal care were analysed using a thematic analysis method with framework analysis (Bowen, 2009; Braun & Clarke, 2019, 2022; Gale et al., 2013; R. C. Gale et al., 2019). Ritchie and Spencer (1994) developed the framework analysis method for applied policy research to enable researchers to explore data with potential actionable outcomes (Carroll et al., 2011; Dixon-Woods, 2011; N. K. Gale et al., 2013; R. C. Gale et al., 2019; Parkinson et al., 2016; Srivastava & Thomson, 2009). Framework analysis is a flexible tool and an appropriate mode of thematic analysis for policy research when the researcher has already determined *a priori* concepts to be used in the analysis (Braun & Clarke, 2022; Carroll et al., 2011; Dixon-Woods, 2011; N. K. Gale et al., 2013; R. C. Gale et al., 2019; Kiernan & Hill, 2018; Parkinson et al., 2016; Srivastava & Thomson, 2009; Vermunt et al., 2019; Zolnoori et al., 2020). This research used a framework developed from the seven guiding principles of the Australian Charter for Healthcare Rights—access, safety, respect, communication, participation, privacy, and comment—as *a priori* concepts.

Sample

The sample included policies and strategic plans at the national and territory levels that guide publicly funded and provided health care in NT health services. Clinical directives, such as dialysis procedure guidelines, care protocols, and policy documents unrelated to NT renal care, were excluded. The 11 selected documents are publicly available on the NT Department of Health website and the Australian

Department of Health website with Creative Commons licences. They are listed in the findings section (Table 1).

Data Collection

The NT Renal Services Strategy 2017–2022 (NT Health, 2017), the NT’s guiding document for renal care, was identified from the NT Department of Health website. The current NT Health Kidney Plan 2024–2029 was released in mid-2024 (NT Health, 2024) after this research was initiated. The NT Renal Services Strategy 2017–2022 (NT Health, 2017) and the Renal Services Framework 2012–2017 (NT Health, 2012) were added to the documents list as the documents that preceded the current Kidney Plan. These consecutive renal care strategies and plans were selected because they serve as the guiding documents for care, and to analyse how the last three guiding documents addressed renal care. The reference lists in the plan, strategy, and framework were reviewed to identify additional documents supporting NT renal care. The framework’s reference list identified documents guiding renal care policies for the NT’s Aboriginal people, such as the NT Aboriginal Health Plan 2015–2018 (NT Health, 2015) and the Aboriginal Cultural Security Policy (NT Health, 2016b).

Framework for Document Analysis

This research employed an “analytical framework” to guide the analysis (Carroll et al., 2011; Dixon-Woods, 2011; N. K. Gale et al., 2013; R. C. Gale et al., 2019; Parkinson et al., 2016; Srivastava & Thomson, 2009; Zolnoori et al., 2020). The original framework analysis method, developed by Ritchie and Spencer (1994), utilised a “thematic framework” to analyse data and was established during the initial stage of data examination. Ritchie and Spencer’s (1994) framework analysis approach has become widely adopted in qualitative data analysis over the past decade. Several qualitative researchers have adapted the technique to “best fit” their research questions (Carroll et al., 2011; Dixon-Woods, 2011; N. K. Gale et al., 2013; R. C. Gale et al., 2019). Likewise, this study adapted the original method and employed a “best fit” approach to analyse the documents.

The framework was developed using three steps: clarifying and refining the concepts, creating a concept matrix, and finalising the framework (see Figure 2). It was developed as part of the main study that explored healthcare rights. The seven principles of the charter were used as *a priori* concepts in this process.

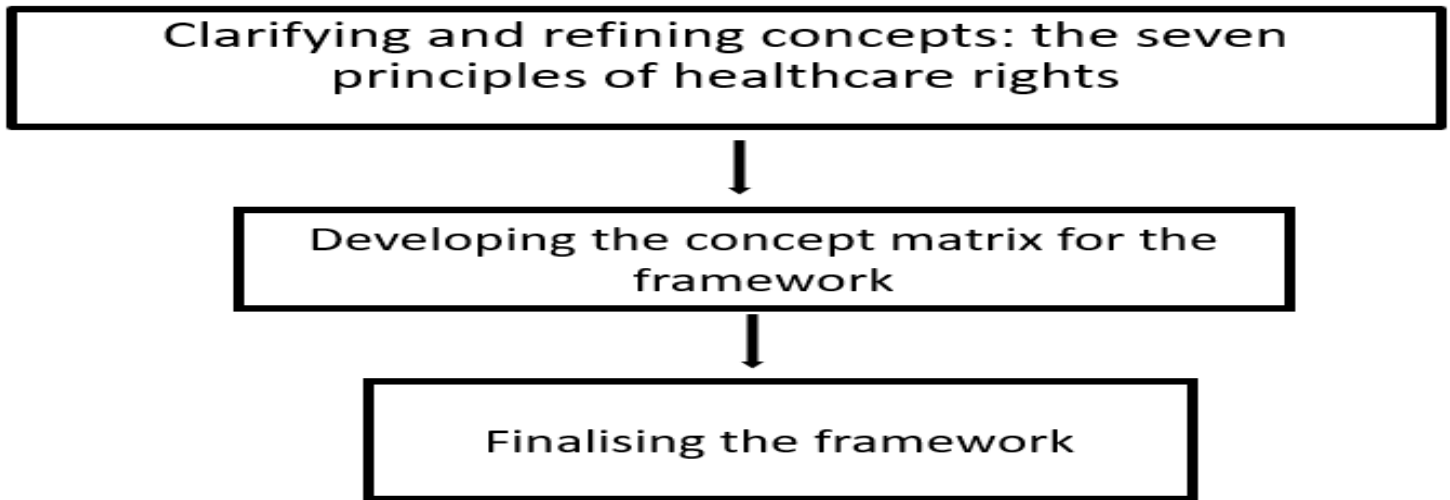


Figure 2. Steps of developing the analytical framework from Ritchie and Spencer's (1994) framework analysis

Clarifying and Refining the Concepts/Principles. The seven principles or concepts⁴ were further clarified during the literature review conducted for the main study. The concepts, their forms, associations, and interrelationships were further evaluated to refine them.

Developing a Concept Matrix. The identified literature was examined to create a list of related themes, with the antecedents, attributes and consequences of each of the seven principles. These concepts, along with related themes, were transferred to a spreadsheet to form the framework.

Finalising the Framework. The final version of the concept matrix was transformed into an analytical framework with the seven principles serving as its pillars. Figure 3 sets out the framework diagrammatically.

⁴The word "concepts" is used interchangeably with the seven principles of the Australian Charter in this context.

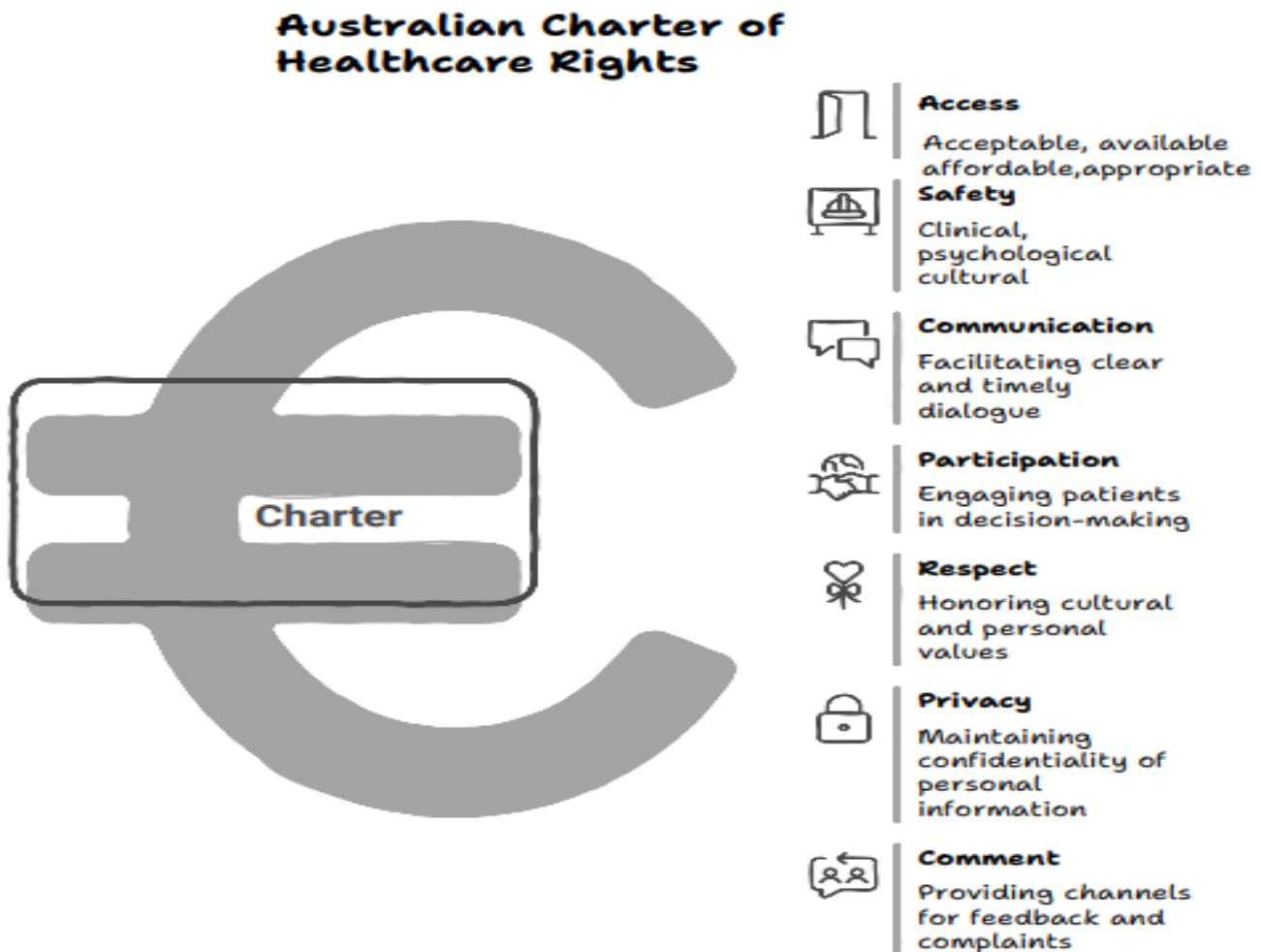


Figure 3. The analytical framework

Data Analysis

The above-described analytical framework and the qualitative analysis software NVivo were used to manage the data. The data analysis used an adapted version of Ritchie and Spencer's (1994) original five-step framework analysis, as set out below.

Transcribing the Data. This step was omitted because the policies and framework documents for analysis were readily available in text form. The policy and framework documents were downloaded from the respective NT and Australian government websites. PDF copies of the selected documents were uploaded to NVivo as case nodes⁵ for data analysis.

⁵ A case node in NVivo denotes a single unit of data. In this case, each policy document and each transcribed nurse or patient interview is a case node.

Familiarising with the Data. The selected documents are read multiple times to ensure understanding. This process helps to develop a comprehensive grasp of potential codes, offering clearer insight during the analytical stage.

Applying the Analytical Framework and Coding. The analytical framework was applied by indexing the transcripts and coding using the nodes⁶ and sub-nodes⁷ functions in NVivo. As shown in the analytical framework, the preselected themes for each principle were coded as sub-nodes under the respective nodes. The documents were read line by line and coded electronically into individual nodes and sub-nodes. Electronic notes or memos⁸ connected to each node during the coding process to capture preliminary thoughts on data analysis.

Charting the Data into a Framework Matrix. The coded data were summarised and charted in an electronic spreadsheet within NVivo, referred to as the framework matrix.⁹ At this stage, the original textual data were summarised, extracted from the source, and placed on the matrix (Srivastava & Thomson, 2009). The unique NVivo software can generate the matrix as a spreadsheet, allowing visual data analysis. Charting data on the matrix provides a clear audit trail of how the data were moved from the original form to nodes and sub-nodes (N. K. Gale et al., 2013; R. C. Gale et al., 2019). The audit trail is an advantage of the framework analysis method. The original data are not submerged during the coding and interpreting stage; they can be accessed at any time during the analysis process (N. K. Gale et al., 2013; R. C. Gale et al., 2019; Srivastava & Thomson, 2009).

Mapping and Interpretation. The first step in mapping and interpretation was downloading the framework matrix into an Excel spreadsheet. The second step was to download the electronic memos associated with each node from NVivo into separate Microsoft Word files. The final stage of the analysis involved mapping related nodes and sub-nodes, identifying interconnections, interpreting concepts, and documenting the findings (N. K. Gale et al., 2013; R. C. Gale et al., 2019). This stage required multiple re-readings of the dataset and drafting and revising the findings.

Findings

The analysis showed that policies and renal strategies relevant to Aboriginal people in the NT have existed for the past three decades; however, they have not significantly improved patients' renal care experiences. This was clear from the repeated, similar targets set in successive policies and plans, with almost every strategy emphasising the increasing number of CKD patients among NT Aboriginal people. The policies and frameworks do not explicitly acknowledge healthcare rights, except for the current Kidney Plan (2024-2029) and Cultural Respect Framework (2016-2026). Nonetheless, they indirectly

⁶ The term nodes in NVivo refers to the major analytical units derived during qualitative analysis; in this analysis, the seven principles were coded as concept nodes with corresponding case nodes (a document or an interview transcript).

⁷ Sub-nodes in this analysis denotes the themes under each node/one of the principles of the charter. For example, the node safety carried sub-nodes of cultural safety, clinical safety and psychological safety.

⁸ Memos are electronic notes that can be created and added to each category or node in NVivo, which allows the researcher to write notes and preliminary ideas for analysis during the coding process.

⁹ A framework matrix is a feature in the NVivo software that summarises the coded data in a grid that has columns for theme nodes and rows for case nodes.

address principles of healthcare rights, including access to care, communication, participation, safety, and cultural respect (see Table 1). Apart from the Cultural Respect Framework (2016-2026), these policies do not emphasise patients' rights to provide feedback on their care or to voice concerns about the services they received. The privacy principle from the charter was not recognised in any of the 11 documents.

Table 1. Details of policies and frameworks analysed

No	Policy/plan	Year	Author	Explicit focus on healthcare rights	Healthcare rights principles that are acknowledged indirectly
1	Kidney Plan 2024–2029	2024	NT Department of Health	Yes	Access to care, safety, participation and respect for culture
2	NT Renal Services Strategy 2017–2022	2017	NT Department of Health	No	Access to care, safety, participation and respect for culture
3	Renal Services Framework 2012–2017	2012	NT Department of Health	No	Access to care, safety, participation and respect for culture
4	Aboriginal Health Plan 2021–2031	2021	NT Department of Health	No	
5	NT Aboriginal Health Plan 2015–2018	2015	NT Department of Health	No	Access, participation, respect and safety
6	Aboriginal Cultural Security Policy	2016	NT Department of Health	No	Safety, communication, participation and respect
7	Aboriginal Cultural Security Framework 2016–2026	2016	NT Department of Health	No	Safety, communication, participation and respect
8	Language Services Policy	2012	NT Government	No	Communication, participation and respect
9	NT Chronic Conditions Prevention and Management Strategy 2010–2020	2010	NT Department of Health and Families	No	Access, safety, communication, participation and respect
10	Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health	2016	Australian Health Ministers' Advisory Council	Yes	Access, participation, communication, safety, feedback and respect
11	National Aboriginal and Torres Strait Islander Health Plan 2013–2023	2013	Commonwealth of Australia 2013	No	Access, participation, communication, safety and respect

Renal Services Framework 2012–2017 and NT Renal Services Strategy 2017–2022

This research examined both the framework and strategy, as they outline the history of renal care directives over the past 15 years. The primary goal of the framework was to bring treatment closer to home for patients or, when this was not feasible, to source accommodation for patients and families near treatment facilities to improve access to care and provide patient support services that encourage self-management. Similarly, the strategy also highlighted renal care access as a key priority, particularly in rural and remote areas, by establishing satellite services to deliver renal care (NT Health, 2017). However, comparing the latest ANZDATA registry (2024) reveals that the increasing number of CKD patients and the inadequate number of CKD treatment facilities in the NT raise questions about the effectiveness of renal care policies and plans.

The strategy and the framework identified community participation in care by addressing and acknowledging cultural practices and involving community support groups. This goal addresses the principle of participation in care and acknowledges the importance of respect for culture. Both documents targeted the development of a safe and sustainable workforce to support safe home dialysis services and timely referral services. However, home dialysis uptake in the NT is the lowest in Australia (ANZDATA, 2024). Neither document explicitly mentioned a human rights-based approach nor discussed patients' healthcare rights.

Even though the strategy suggested developing a master plan for renal infrastructure investments to improve services, the NT Health website does not provide evidence of such a plan. The last accessible plan was released in 2015 and implemented between 2015 and 2017. The current NT Health Kidney Plan 2024–2029 (NT Health, 2024) replaced the strategy; however, it does not serve as a comprehensive master plan as promised.

Kidney Plan 2024–2029

Similar to the framework and strategy discussed above, the Kidney Plan also highlights the disproportionate and rising renal morbidity and mortality among NT Aboriginal people. Nearly 50% of Indigenous adults over 50 have CKD or CKD markers, with 89% of NT CKD patients being Aboriginal people (NT Health, 2024). Although the plan promotes prevention, screening, and the development of support and workforce capacity for kidney care, the steps to evaluate and achieve these goals are not specifically targeted or clear for NT Aboriginal people, who comprise 89% of the patient group. The plan acknowledges that “it is evident that the incidence of ESKD [end-stage kidney disease] in NT Aboriginal populations will continue to grow” (NT Health, 2024, p. 13). Multiple NT-based research studies have assessed the economic viability of expanding dialysis access in Aboriginal communities, with Gorham et al. (2021) being the most recent. However, the plan falls short in outlining practical measures to accomplish this and does not guarantee improved access to care in remote regions. The NT's dialysis capacity is the lowest nationally, at 4.5 patients per dialysis chair, increasing to 6 patients per chair in remote areas (Sabanayagam et al., 2025). The national average stands at 3.33 patients per chair, as reported by Sabanayagam et al. (2025), yet the Kidney Plan lacks the framework and processes needed to reach that benchmark.

National Aboriginal and Torres Strait Islander Health Plan 2013–2023

The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (Australian Government, 2013) was a national-level guiding document for planning and implementing renal care in the NT. The initial drive for a National Aboriginal and Torres Strait Islander Health Plan started from the 1967 referendum, an initiative that gave Indigenous people the right to be included in national health planning. However, there was little strategic progress in national Aboriginal and Torres Strait Islander issues until 1996 (Australian Government, 2013). The first national document of the National Aboriginal and Torres Strait Islander Health Policy was the Health Strategy, released in 1989. The strategy evaluation report showed deficiencies in the implementation and few changes in national Aboriginal and Torres Strait Islander health indices (Australian Government, 2013). The National Aboriginal and Torres Strait Islander Health Framework Agreements took effect in 1996 following consultations with Indigenous health forums to engage and collaborate with the community in planning, resourcing, and evaluating the health (Australian Government, 2013). The 2013–2023 ten-year health plan's prototype was the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 (National Aboriginal and Torres Strait Islander Health Council, 2004), which aimed to address the inequalities in the health indices of Indigenous people with an evidence-based, multisectoral approach acknowledging the effects of the social determinants of health (Australian Government, 2013).

The five principles of the Australian Charter of Healthcare Rights—access, participation, communication, safety, and respect—were covered in this ten-year health plan for Aboriginal and Torres Strait Islander Peoples. However, the approach to addressing inequalities and health disparities has not fundamentally engaged with core human rights principles. For instance, the plan offers a statistical overview of the causes of health disparities and lists factors such as hypercholesterolemia, smoking, alcohol consumption, and inadequate fruit and vegetable intake. Unfortunately, it fails to acknowledge or address the underlying reasons for hypercholesterolemia or poor eating habits. Social, political, and economic strategies, along with coordinated actions by territorial and federal departments, are needed to ensure access to healthy food. Unless the fundamental issue of access to healthy food is addressed, the plan will not achieve its desired outcomes.

The National Aboriginal and Torres Strait Islander Health Plan (2013-2023) was replaced by a new 10-year plan in 2021. The National Aboriginal and Torres Strait Islander Health Plan (2021-2031) was launched in 2021, with the first phase of implementation scheduled from 2022 to 2026. According to the plan, Aboriginal and Torres Strait Islander culture will be the core focus and will influence social and cultural determinants of health. The plan states that new governance arrangements will be established within six months of the plan's release to collaborate with Aboriginal and Torres Strait Islander leaders and communities. However, the first communique from the First Nations Health Governance Group (FNHGG) was issued two years later, in December 2024, indicating slow progress.

Aboriginal Health Plan 2021–2031 and NT Aboriginal Health Plan 2015–2018

Like the national plan, the NT Aboriginal Health Plan 2015–2018 (NT Health, 2015) and the Aboriginal Health Plan 2021–2031 (NT Health, 2021) are the Northern Territory's responses to Indigenous health disparities. The plans highlight the over-representation of Aboriginal and Torres Strait

Islander people in NT's morbidity and mortality statistics. Over 10% of Australia's Aboriginal people live in the NT, accounting for 30% of the NT's population. However, they represent 70% of public hospitals and 89% of CKD patients (NT Health, 2021). Over 70% of Aboriginal people in the NT live in very remote areas. As per the 2021-2031 plan, these challenges affect health care, especially access to care, and prevention and early interventions for renal diseases (NT Health, 2021).

Even though a rights-based approach to healthcare is not explicitly stated, the plans acknowledge the importance of the following principles: access, safety, communication, participation, and respect. However, there are no targeted processes to address these principles other than the strategic directives listed to improve access, partnership, culturally safe care, workforce capacity, and health promotion (NT Health, 2021). Evaluation of the 2021-2031 plan is mentioned. However, there are no explicit targets to achieve or affirmative actions for the intended outcomes.

Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health

The National Cultural Respect Framework 2016–2026 (Australian Health Ministers' Advisory Council, 2016) follows on from the first Cultural Respect Framework 2004–2009. The framework's primary audience is the Australian public health system, including primary, secondary and tertiary-level healthcare providers. The Cultural Respect Framework 2016–2026 is formulated with the vision that "the Australian health system is accessible, responsive and safe for Aboriginal and Torres Strait Islander people where cultural values, strengths, and differences are recognised and incorporated into the governance, management, and delivery of health services" (Australian Health Minister's Advisory Council, 2016, p. 4).

The framework acknowledges that every Australian has the right to access safe, effective, responsive and appropriate health care. It clarifies that health is a fundamental right of every Australian; however, it recognises that Aboriginal and Torres Strait Islander people do not always exercise this right (Australian Health Minister's Advisory Council, 2016). The framework is a step towards addressing this inequality in the realisation of health rights. The human rights approach adopted in the framework acknowledges the importance of providing timely, accessible, affordable and appropriate quality care to Australia's Aboriginal and Torres Strait Islander people (Australian Health Minister's Advisory Council, 2016). The Cultural Respect Framework 2016–2026 recommends that cultural awareness may not initiate a positive change in healthcare settings. Other dimensions of cultural respect, such as cultural competency, safety and security, must be realised to ignite change (Australian Health Minister's Advisory Council, 2016).

One of the main barriers to accessing care identified in the framework is the mismatch between Aboriginal and Torres Strait Islander cultural values and norms and the Australian healthcare system. For Indigenous people, health is connected to spirituality, cultural values, and nature. The framework explains that, to provide safe and accessible care, the mainstream health system must recognise the impacts of colonisation on Indigenous health, cultures, and their health beliefs (Australian Health Minister's Advisory Council, 2016). The framework also highlights racism as another barrier to accessing care. It emphasises the need for culturally safe and responsive care to improve health outcomes for Aboriginal and Torres Strait Islander people (Australian Health Minister's Advisory Council, 2016).

The framework proposes pathways to achieve cultural respect for Indigenous people by monitoring and assessing cultural respect through the Aboriginal and Torres Strait Islander Health Performance Framework and providing professional training to staff (Australian Health Minister's Advisory Council, 2016). Healthcare organisations are urged to model cultural safety and responsiveness at all levels to achieve cultural respect. An important observation in the framework is the relationship between cultural safety and patient safety:

For Aboriginal and Torres Strait Islander people who do not speak English as a first language or who feel culturally unsafe and mistrust the system, this journey is particularly difficult. Also, it poses a great risk to the safety and quality of health care. (Australian Health Minister's Advisory Council, 2016, p. 7)

However, the language barrier in the mainstream health system makes it difficult for Aboriginal and Torres Strait Islander people to navigate the complex system, compromising healthcare safety and quality (Australian Health Minister's Advisory Council, 2016). The framework recognises the need to identify and implement mechanisms to address the linguistic diversity of Aboriginal and Torres Strait Islander people in mainstream healthcare services. The health system should ensure systematic two-way communication with communities and support groups to support culturally safe, responsive, and accessible care. The framework set out to create and implement processes to improve informed decision-making and active participation of First Nations people in planning, implementing and evaluating their care (Australian Health Minister's Advisory Council, 2016). Partnership in care is another vital suggestion; the framework advocates creating partnerships in healthcare planning, implementation and evaluation with communities and health consumers. Further, it states that research activities involving Aboriginal and Torres Strait Islander health delivery and planning should follow cultural respect and responsiveness to Indigenous consumers. The framework acknowledges the principle of comment by proposing pathways to seek feedback from Aboriginal and Torres Strait Islander people about their care. It directs healthcare organisations to arrange resources to seek input from patients and consumers and to make the complaints process explicit to Aboriginal and Torres Strait Islander people.

In conclusion, although the framework acknowledges six of the seven principles of the Australian Charter of Healthcare Rights and recognises the importance of cultural respect in achieving healthcare rights, the latest research evidence (Waugh et al., 2025) indicates that systemic racism and discrimination persist in the NT health services.

Aboriginal Cultural Security Framework 2016–2026

The Aboriginal Cultural Security Framework (NT Health, 2016a) is the NT Department of Health's guide to developing capacity to deliver culturally safe care. It provides pragmatic recommendations for implementing the Aboriginal Cultural Security Policy (NT Health, 2016b).

The policy addresses the Australian Charter of Healthcare Rights principle of respect. It acknowledges the significance of culturally responsive mediation in increasing the effectiveness of healthcare interventions and health promotion strategies (NT Health, 2016b). Notably, the policy identifies the link between culture and access to care, stating that respect for Indigenous cultures and values fosters

greater acceptance, equity, and the effectiveness of healthcare utilisation. The policy states that NT health services can support equity and improved access to health care by supporting communication, consumer empowerment, engagement, and Aboriginal people's participation. The policy focuses on identifying aspects of Aboriginal cultures that affect their interactions with healthcare services, reviewing current healthcare practices that affect Aboriginal cultural traditions, and initiating actions to modify the practices and evaluating the efforts (NT Health, 2016b).

The framework provides strategies for cultural security focused on six domains: workforce, communication, organisational approach, leadership, consumer and community participation, and quality improvement measures, including research and evaluation. The principle of access is linked to the cultural security experiences of Aboriginal patients and consumers. The framework explicates that adhering to cultural security measures and acknowledging Aboriginal culture will enable self-determination and empowerment of health consumers, leading to better access to health care and a more positive consumer experience (NT Health, 2016a). As an enabler of access to care, cultural security is "a viable strategy to improve the links between access, equity, quality and safety, better health outcomes for Aboriginal people and to enhance the cost-effectiveness of health service delivery" (NT Health, 2016a, p. 39).

The principle of safety is incorporated as cultural safety; the framework defines it as consumers' experience of care, where they can access care and raise concerns in the best possible way. However, this process requires healthcare professionals to recognise Aboriginal values, beliefs and realities (NT Health, 2016a). The policy does not mention other dimensions of safety, such as physical and psychological safety.

The framework acknowledges that communication is essential to access to health care. It points out that health information must be available to Aboriginal people so that they can make informed choices (NT Health, 2016a). Moreover, patients' access to interpreter services, Aboriginal liaison officers and Aboriginal health practitioners is part of cultural respect and the key to cultural security measures. Timely, two-way communication leads to shared decision making, and informed consent is central to cultural security strategies for Aboriginal people (NT Health, 2016a).

The framework urges staff training and cross-cultural development to enable cultural security measures. Hence, it encourages Aboriginal patients and consumers to be active participants in the healthcare experience, making informed choices and providing feedback on the service. Although the framework acknowledges most of the Australian Charter of Healthcare Rights principles, no targeted processes or evaluation plans exist to assess the outcomes.

Language Services Policy 2012

The Language Services Policy aims to ensure that interpreting and translating services are available to all NT consumers who do not speak English as their first language (NT Government, 2012). The Translating and Interpreter Service is a national language service provided by the Australian Government to people who cannot communicate in English and need translation or interpretation. The NT division of this national service, the Interpreting and Translating Service NT, provides translation services in

foreign languages. An NT Interpreter card is issued to people requiring services in foreign languages (NT Government, 2012). The Aboriginal Interpreter Service is the Northern Territory Government-funded provider of interpreting services to the NT's Aboriginal patients and healthcare consumers.

The policy explains that the following legislation reinforces the need for interpreter services for patients and consumers: the *Racial Discrimination Act 1975* (Cth), the *Disability Discrimination Act 1992* (Cth), the *Anti-Discrimination Act 1992* (NT), and the *Health and Community Services Complaints Act 1998* (NT) (NT Government, 2012). These legal directives require organisations to implement equitable access to services for people from culturally and linguistically diverse backgrounds and prohibit agencies from discriminating against people based on their language ability (NT Government, 2012). The policy proposes that healthcare organisations provide language support to patients and consumers by ensuring staff are aware of the Language Services Policy and acknowledge patients' and consumers' right to access language services (NT Government, 2012).

In conclusion, the Language Services Policy aligns with the principle of communication from the Australian Charter of Healthcare Rights. It emphasises that patients and consumers should receive help from an accredited interpreter and translation service. The policy urges organisations to provide healthcare information in patients' or consumers' first language, enhancing safe, high-quality care for Aboriginal people. However, consistent research indicates that interpreter support for Aboriginal people is underused in the NT Health system (Devitt et al., 2017, 2008; Kerrigan, 2022; Kerrigan et al., 2020a, 2020b, 2021). Also, the analysis revealed that the policy lacks structured processes and guidelines to support its aims. Although the policy notes that informed care is a legal requirement, it is not legally enforced in the NT, as many patients are unaware of their right to informed care (Kerrigan, 2022; Kerrigan et al., 2020a, 2020b, 2021).

Northern Territory Chronic Conditions Prevention and Management Strategy 2010–2020

The strategy recognised Australia's rapidly increasing risk of chronic disease, particularly the much higher risk among Aboriginal people in the NT (Department of Health and Families, 2010). It aimed to prevent, detect early, and manage chronic conditions in the NT, including CKD. Of particular importance to this study are measures designed to prevent unnecessary hospital admissions. Additionally, the strategy acknowledged that the high prevalence of comorbidities with CKD significantly impacts the morbidity and mortality rates among Aboriginal people (Department of Health and Families, 2010).

The key focus areas of the strategy were social determinants of health, primary and secondary prevention, self-management, information sharing, and improving the quality of care. The strategy indirectly recognised the charter's principles, even though the rights-based approach was not explicitly mentioned. It promoted access to culturally safe care and equity through proper resource allocation, additional supplies, and ongoing financial support. However, as noted earlier, as shown in the ANZDATA Registry (2024), CKD morbidity and mortality in the NT have increased each year. Additionally, no subsequent policy version has been released by NT Health.

Discussion

The findings of this policy analysis can be explained through Walt and Gilson's (1994) health policy triangle framework, which argues that most policies focus on content rather than context, processes, and the actors or stakeholders involved. In this research, the analysis of the policies and frameworks yielded similar findings: the importance of these documents lay mainly in their content rather than in a focused, targeted process to address renal care for Aboriginal people in rural and remote NT communities.

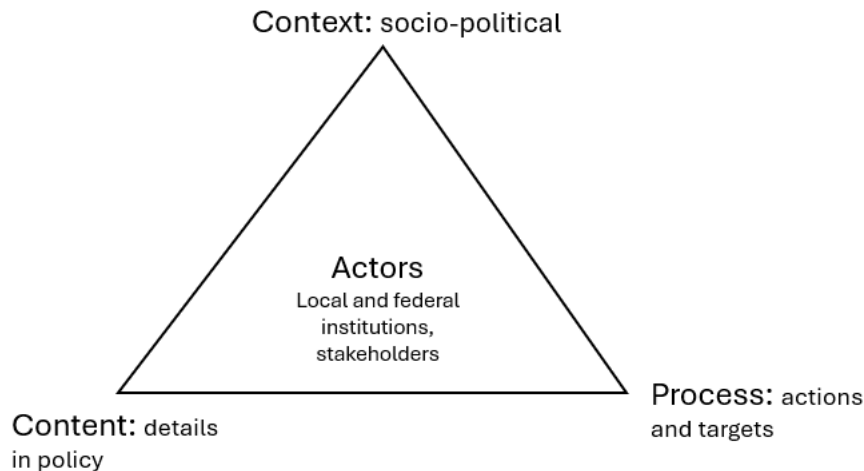


Figure 4: Adapted health policy triangle framework

The Content

The analysis revealed that the policies highlight the health disparities faced by NT Aboriginal people, underscoring the need for urgent action. These include a lack of accessible, safe, and high-quality renal care, insufficient training for health professionals, limited healthcare resources near Aboriginal communities, and poor patient involvement in treatment decisions. The healthcare rights-based approach was not explicitly present in the assessed policies and frameworks, except for two.

The Context

The analysis of most documents did not clearly specify who would be responsible for planning and decision-making related to policies, or how participatory decision-making with stakeholders would be achieved. Policy making and implementation are sociopolitical processes, and political will is a key factor in financial decisions related to policy implementation (Beisheim et al., 2025). NT Health Service is already strained by inadequate funding and the high expenses of rural and remote health delivery (NT Health, 2025). This context is not addressed in any of the policies.

Research evidence from NT in the last two decades shows that the proposed policy improvements are not leading to better outcomes. There is disturbingly consistent research evidence over the last 25 years

on communication challenges between NT Aboriginal renal patients and health professionals (Cass et al., 2002; Devitt et al., 2008, 2017; Kerrigan, 2022; Kerrigan et al., 2020a, 2020b, 2021; Lawton et al., 2015; Lowell et al., 2012; Mitchell et al., 2016; Ralph et al., 2023). Even with critical language barriers, there is consistent research evidence that interpreter support is not given as required for NT Aboriginal patients (Cass et al., 2002; Kerrigan, 2022; Kerrigan et al., 2020a, 2020b, 2021; Lawton et al., 2015; Lowell et al., 2012; Mitchell et al., 2016; Ralph et al., 2023).

The Process

The analysis revealed that the policies and frameworks lack targeted processes with clear implementation guidelines to achieve the intended outcome. For example, culturally safe care is an area that the policies have tried to address through the cultural respect and cultural security frameworks of the last two decades. However, recent research from NT by Waugh et al. (2025) on perioperative experiences of Aboriginal people found that they received poorly informed care and sometimes faced confrontational threats from staff, such as “You need to have the surgery, or you are going to finish up [die].” The participant added, “they should not go around telling [that], you are just really scaring them ... I would rather go home and die [than stay and have surgery].” Unfortunately, the research evidence shows that Aboriginal patients in the NT felt threatened even with well-developed policies and frameworks meant to support them.

The Actors

The primary players in the renal care policy scene in the NT are NT Health and the federal government. More Aboriginal community-controlled organisations, such as the Aboriginal Interpreter Service (AIS) and Aboriginal Community Controlled Health Services (ACCHS), should be supported and funded to implement policies specific to the Aboriginal people of the NT. Notably, the most recent research by the Aboriginal Medical Services Alliance Northern Territory (AMSANT) (2025) showed that health care facilities in the NT, especially ACCHSs, face infrastructure challenges, funding shortages, inadequate patient access, and a lack of transportation to specialist care. It is important to note that the policies and frameworks discussed above demonstrated that ACCHS was the most effective approach for delivering culturally responsible, high-quality care to Aboriginal patients.

The NT’s renal care policies and frameworks do not explicitly show collaboration with other government agencies, which is essential for addressing fundamental human rights issues. Also, the predisposing factors for kidney failure extend beyond individual health indices. For example, better housing, electricity, and access to clean water influence health in ways similar to an individual’s genetic predispositions and biological health (AIHW, 2011; Clifford et al., 2015). Better infrastructure, better living conditions and access to healthcare are fundamental human rights that must be addressed to reduce the health disparities and realise healthcare rights for Indigenous Australians.

Recommendations

The research explored the policies for Aboriginal people, who constitute 30% of the NT population. Other states have smaller proportions (3-4%) of the Aboriginal and Torres Strait Islander population

than the rest of Australia. These policy assessments can give a better understanding of the policy issues that can inform future policies for the broader Aboriginal and Torres Strait Islander people. The findings demonstrate that solutions to the renal health challenges faced by NT Aboriginal people need coordinated effort by local, territorial, and federal governments. Therefore, more coordinated action, human resources and training are needed within governance processes to ensure the implementation and monitoring of policies.

Unless health policies include targets and affirmative actions (Panicker, 2023), with scrupulous monitoring of the progress, they cannot deliver the required outcomes. Monitoring of policy implementation could benefit Indigenous Australians with CKD; importantly, Aboriginal community-led bodies should be funded to support policy implementation. The effectiveness of policy implementation should be evaluated using data disaggregated by factors such as Aboriginality, geographical location and gender. The policies and frameworks should be revisited based on these evaluations, and social prescribing initiatives can be one way to address the challenges of policy implementation. According to the WHO (2022), social prescribing is the way of connecting people to a range of non-clinical services in their community to improve health and well-being. However, social prescribing must be led by Aboriginal people, in consultation with their stakeholders.

Further research is essential to identify the factors hindering the implementation or progress of renal health policies aimed at addressing Indigenous health disparities. This highlights the need for such an investigation, as the analysis revealed that ongoing policies and frameworks over the past two decades have not led to significant improvements in the renal health of NT Aboriginal people.

Conclusion

This research explored recent and current renal policies and frameworks that guide NT renal care. Even though Indigenous patients' healthcare rights, as envisioned in the Australian Charter of Healthcare Rights, are sometimes reflected in the policies, these policies do not impose any obligations to ensure that healthcare rights are realised in practice, and no renal policies address all seven of the charter's principles. Unfortunately, many of the policies, strategies, and frameworks remain aspirational, even with the best vision and aims. Health targets and affirmative action measures by the NT Government and the federal government, along with strong political will, are necessary to ensure the healthcare rights of the NT people are realised.

References

- Aboriginal Medical Services Alliance Northern Territory (AMSANT). (2025). Facing the Health Gap: The Key Challenges Undermining Progress in Aboriginal Health Outcomes in the NT.
- Anderson, I., Crengle, S., Leialoha Kamaka, M., Chen, T.-H., Palafox, N., & Jackson-Pulver, L. (2006). Indigenous health in Australia, New Zealand, and the Pacific. *Lancet*, *367*(9524), 1775–1785. [https://doi.org/10.1016/S0140-6736\(06\)68773-4](https://doi.org/10.1016/S0140-6736(06)68773-4)
- Anderson, I., & Loff, B. (2004). Voices lost: Indigenous health and human rights in Australia. *Lancet*, *364*(9441), 1281–1282. [https://doi.org/10.1016/S0140-6736\(04\)17146-8](https://doi.org/10.1016/S0140-6736(04)17146-8)
- Angell, B., Eades, S., & Jan, S. (2017). To close the gap, we need to identify the best (and worst) buys in Indigenous health. *Australian & New Zealand Journal of Public Health*, *41*(3), 224–226. <https://doi.org/10.1111/1753-6405.12612>
- Australia and New Zealand Dialysis and Transplant Registry (ANZDATA). (2024). *ANZDATA 47th annual report 2024 (data to 2023)*. <https://anzorrg.org.au/reports/anzdata-47th-annual-report-2024-data-survey-2023>
- Australian Commission on Safety and Quality in Health Care (ACSQHC). (2008). Australian Charter of Healthcare Rights.
- Australian Commission on Safety and Quality in Health Care (ACSQHC). (2019). Australian Charter of Healthcare Rights (2nd ed.). <https://www.safetyandquality.gov.au/our-work/partnering-consumers/australian-charter-healthcare-rights>
- Australian Government. (2013). National Aboriginal and Torres Strait Islander Health Plan 2013–2023. <https://www.health.gov.au/sites/default/files/documents/2021/02/national-aboriginal-and-torres-strait-islander-health-plan-2013-2023.pdf>
- Australian Health Ministers' Advisory Council. (2016). Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health. Australian Government.
- Australian Institute of Health and Welfare (AIHW). (2011). Health and the environment: A compilation of evidence. Cat. No. PHE 136.
- Australian Institute of Health and Welfare (AIHW). (2022). *Australia's health 2022: In brief*. <https://www.aihw.gov.au/reports/australias-health/australias-health-2022-in-brief/summary>
- Australian Institute of Health and Welfare (AIHW). (2023). *Aboriginal and Torres Strait Islander Health Performance Framework*. 1.10 Kidney Disease. <https://www.indigenoushpf.gov.au/measures/1-10-kidney-disease>
- Beisheim, M., Asseburg, M., Ballbach, E. J., Eickhoff, K., Fischer, S., Godehardt, N., Kurtz, G., Meyer, M., Müller, M., Roll, S., Sahm, A., Wagner, C., & Zilla, C. (2025). Politics matters! Political will is a

- critical condition for implementing the Sustainable Development Goals. *Earth System Governance*, 24, 100244. <https://doi.org/10.1016/j.esg.2025.100244>
- Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal*, 9(2), 27–40. <https://doi.org/10.3316/QRJ0902027>
- Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589–597. <https://doi.org/10.1080/2159676x.2019.1628806>
- Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. Sage.
- Calma, T. (2009). A human rights-based approach to social and emotional well-being. *Australasian Psychiatry*, 17(1), S15–S19. <https://doi.org/10.1080/10398560902948613>
- Carroll, C., Booth, A., & Cooper, K. (2011). A worked example of “best fit” framework synthesis: A systematic review of views concerning the taking of some potential chemo preventive agents. *BMC Medical Research Methodology*, 11(1), Article 29. <https://doi.org/10.1186/1471-2288-11-29>
- Cass, A., Lowell, A., Christie, M., Snelling, P. L., Flack, M., Marrnganyin, B., & Brown, I. (2002). Sharing the true stories: Improving communication between Aboriginal patients and healthcare workers. *Medical Journal of Australia*, 176(10), 466–470. <https://doi.org/10.5694/j.1326-5377.2002.tb04517.x>
- Clifford, H., Pearson, G., F. P., Walker, R., & Zosky, G. (2015). Environmental health challenges in remote Aboriginal Australian communities: Clean air, clean water and safe housing. *Australian Indigenous Health Bulletin*, 15(2).
- Department of Health and Families. (2010). Northern Territory Chronic Conditions Prevention and Management Strategy 2010–2020. Northern Territory Government. <http://hdl.handle.net/10137/371>
- Devitt, J., Anderson, K., Cunningham, J., Preece, C., Snelling, P., & Cass, A. (2017). Difficult conversations: Australian Indigenous patients’ views on kidney transplantation. *BMC Nephrology*, 18, Article 310. <https://doi.org/10.1186/s12882-017-0726-z>
- Devitt, J., Cass, A., Cunningham, J., Preece, C., Anderson, K., & Snelling, P. (2008). Study Protocol – Improving Access to Kidney Transplants (IMPAKT): A detailed account of a qualitative study investigating barriers to transplant for Australian Indigenous people with end-stage kidney disease. *BMC Health Services Research*, 8(1), Article 31. <https://doi.org/10.1186/1472-6963-8-31>
- Dixon-Woods, M. (2011). Using framework-based synthesis for conducting reviews of qualitative studies. *BMC Medicine*, 9(1), Article 39. <https://doi.org/10.1186/1741-7015-9-39>

- Freeman, T., Baum, F., Lawless, A., Labonté, R., Sanders, D., Boffa, J., Edwards, T., Javanparast, S. (2016). Case study of an Aboriginal community-controlled health service in Australia: Universal, rights-based, publicly funded comprehensive primary health care in action. *Health & Human Rights, 18*(2), 93–108.
- Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*, Article 117. <https://doi.org/10.1186/1471-2288-13-117>
- Gale, R. C., Wu, J., Erhardt, T., Bounthavong, M., Reardon, C. M., Damschroder, L. J., & Midboe, A. M. (2019). Comparison of rapid vs in-depth qualitative analytic methods from a process evaluation of academic detailing in the Veterans Health Administration. *Implementation Science, 14*(1), Article 11. <https://doi.org/10.1186/s13012-019-0853-y>
- Gorham, G., Howard, K., Cunningham, J., Barzi, F., Lawton, P., & Cass, A. (2021). Do remote dialysis services really cost more? An economic analysis of hospital and dialysis modality costs associated with dialysis services in urban, rural and remote settings. *BMC Health Services Research, 21*(1), Article 582. <https://doi.org/10.1186/s12913-021-06612-z>
- Gray, M. A., & Oprescu, F. I. (2016). Role of non-Indigenous researchers in Indigenous health research in Australia: A review of the literature. *Australian Health Review, 40*(4), 459–465. <https://doi.org/10.1071/AH15103>
- Gruskin, S., Mills, E.J., & Tarantola D. (2007). History, principles, and practice of health and human rights. *Lancet, 370*(9585), 449–455. [https://doi.org/10.1016/S0140-6736\(07\)61200-8](https://doi.org/10.1016/S0140-6736(07)61200-8)
- Hill, K., Barker, B., & Vos, T. (2007). Excess Indigenous mortality: Are Indigenous Australians more severely disadvantaged than other Indigenous populations? *International Journal of Epidemiology, 36*(3), 580–589. <https://doi.org/10.1093/ije/dym011>
- Hoy, W. E. (2014). Kidney disease in Aboriginal Australians: A perspective from the Northern Territory. *Clinical Kidney Journal, 7*(6), 524–530. <https://doi.org/10.1093/ckj/sfu109>
- Hoy, W. E., Mott, S. A. & McDonald, S. P. (2019). An update on chronic kidney disease in Aboriginal Australians. *Clinical Nephrology, 93*(1), 124–128. <https://doi.org/10.5414/cnp92s122>
- Hughes, J. T., Freeman, N., Beaton, B., Puruntatameri, A.-M., Hausin, M., Tipiloura, G., Wood, P., Signal, S., Majoni, A. W., Cass, A., Maple-Brown, L. J., & Kirkham, R. (2019). My experiences with kidney care: A qualitative study of adults in the Northern Territory of Australia living with chronic kidney disease, dialysis and transplantation. *PLoS ONE, 14*(12), Article e0225722. <https://doi.org/10.1371/journal.pone.0225722>
- Josif, C., Kruske, S., Kildea, S., & Barclay, L. (2017). The quality of health services provided to remote dwelling Aboriginal infants in the top end of northern Australia following health system changes:

- A qualitative analysis. *BMC Pediatrics*, 17, Article 93. <https://doi.org/10.1186/s12887-017-0849-1>
- Kerrigan, V. (2022). Batji-gum dilba (good talk medicine): Improving culturally safe communication between doctors and Aboriginal patients in the Northern Territory of Australia [PhD thesis, Charles Darwin University]. ProQuest Dissertations & Theses Global. <https://doi.org/10.25913/vmrv-q919>
- Kerrigan, V., Lewis, N., Cass, C., Hefler, M., & Ralph, A. P. (2020a). “How can I do more?” Cultural awareness training for hospital-based healthcare providers working with high Aboriginal “caseload”. *BMC Medical Education*, 20(1), Article 173. <https://doi.org/10.1186/s12909-020-02086-5>
- Kerrigan, V., McGrath, S. Y., Lee, B., Puruntatameri, P., Herdman, R. M. (2020b). Ask the Specialist: Larrakia, Tiwi and Yolngu stories to inspire better healthcare. Apple Podcasts. <https://podcasts.apple.com/au/podcast/ask-the-specialist-stories-to-inspire-better-healthcare/id1516150200>
- Kerrigan, V., McGrath, S. Y., Majoni, S. W., Walker, M., Ahmat, M., Lee, B., Cass, A., Hefler, M., & Ralph, A. P. (2021). From “stuck” to satisfied: Aboriginal people’s experience of culturally safe care with interpreters in a Northern Territory hospital. *BMC Health Services Research*, 21(1), Article 548. <https://doi.org/10.1186/s12913-021-06564-4>
- Kidney Health Australia (KHA). (2023). What is chronic kidney disease (CKD)? [Fact sheet]. <https://assets.kidney.org.au/resources/KHA-First-Nations-Factsheet-What-is-CKD.pdf>
- Kiernan, M., & Hill, M. (2018). Framework analysis: A whole paradigm approach. *Qualitative Research Journal*, 18(3), 248–261. <https://doi.org/10.1108/QRJ-D-17-00008>
- Kirmayer, L. J., Gone, J. P., & Moses, J. (2014). Rethinking historical trauma. *Transcultural Psychiatry*, 51(3), 299–319. <https://doi.org/10.1177/1363461514536358>
- Lawton, P. D., Cunningham, J., Hadlow, N., Zhao, Y., & Jose, M. D. (2015). Chronic kidney disease in the Top End of the Northern Territory of Australia, 2002–2011: A retrospective cohort study using existing laboratory data. *BMC Nephrology*, 16, Article 168. <https://doi.org/10.1186/s12882-015-0166-6>
- Lowell, A., Maypilama, E., Yikaniwuy, S., Rrapa, E., Williams, R., & Dunn, S. (2012). “Hiding the story”: Indigenous consumer concerns about communication related to chronic disease in one remote region of Australia. *International Journal of Speech-Language Pathology*, 14(3), 200–208. <https://doi.org/10.3109/17549507.2012.663791>
- Madden, R., Axelsson, P., Kukutai, T., Griffiths, K., Storm Mienna, C., Brown, N., Coleman, C., & Ring, I. (2016). Statistics on indigenous peoples: International effort needed. *Statistical Journal of the IAOS*, 32(1), 37–41. <https://doi.org/10.3233/SJI-160975>

- Mazel, O. (2018). Indigenous health and human rights: A reflection on law and culture. *International Journal of Environmental Research and Public Health*, 15(4).
<https://doi.org/10.3390/ijerph15040789>
- Mitchell, A., Lowell, A., & Ralph, A. (2016). Report on the Patient Educator Service at Royal Darwin Hospital, 2001–2009: Insights into inter-cultural communication in healthcare. Aboriginal Resource and Development Services.
- Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science and Medicine*, 106, 128–136. <https://doi.org/10.1016/j.socscimed.2014.01.043>
- National Aboriginal & Torres Strait Islander Health Council. (2004). National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013: Framework for action by governments.
- Northern Territory (NT) Government. (2012). Language Services Policy.
https://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=atsia/languages/subs/sub138%20attach%20c.pdf
- NT Health. (2012). Renal Services Framework 2012–2017. Northern Territory Government.
- NT Health. (2015). Northern Territory Aboriginal Health Plan 2015–2018. Northern Territory Government. <https://digitallibrary.health.nt.gov.au/nthealthserver/api/core/bitstreams/6dce59e2-8cbf-4ce0-92c6-811c7d1db280/content>
- NT Health (2016a). Aboriginal Cultural Security Framework 2016–2026. Northern Territory Government. https://families.nt.gov.au/___data/assets/pdf_file/0007/689695/aboriginal-cultural-security-framework.pdf
- NT Health. (2016b). Aboriginal Cultural Security Policy. Northern Territory Government.
<https://health.nt.gov.au/media/pdf/atciwp-awards/aboriginal-cultural-security-policy.pdf>
- NT Health. (2017). Northern Territory Renal Services Strategy 2017–2022. Northern Territory Government. <https://hdl.handle.net/10070/833454>
- NT Health. (2021). Aboriginal Health Plan 2021–2031. Northern Territory Government.
https://health.nt.gov.au/___data/assets/pdf_file/0015/1035501/nt-aboriginal-health-plan-2021-2031.pdf
- NT Health. (2024). Kidney Plan 2024–2029. Northern Territory Government.
https://health.nt.gov.au/___data/assets/pdf_file/0004/1378939/nt-health-kidney-plan2024-2029.pdf

- NT Health. (2025). NT Health Service Agreement 2025-2026. Northern Territory Government. https://health.nt.gov.au/___data/assets/pdf_file/0009/1559817/service-agreement-2025-2026-original.pdf
- O'Sullivan, D. (2016). Indigenous health: Capabilities and freedom. *Ethnicities*, 16(5), 733–751. <https://doi.org/10.1177/1468796815603756>
- Panicker, L. (2023). *Transparency, accountability, and dignity: An exploration of healthcare rights for Indigenous patients in renal care*. Doctoral dissertation, Charles Darwin University. <https://doi.org/10.25913/jnjf-fj77>
- Paradies, Y. (2016). Colonisation, racism and Indigenous health. *Journal of Population Research*, 33(1), 83–96. <https://doi.org/10.1007/s12546-016-9159-y>
- Parkinson, S., Eatough, V., Holmes, J., Stapley, E., & Midgley, N. (2016). Framework analysis: A worked example of a study exploring young people's experiences of depression. *Qualitative Research in Psychology*, 13(2), 109–129. <https://doi.org/10.1080/14780887.2015.1119228>
- Ralph, A. P., McGrath, S. Y., Armstrong, E., Herdman, R. M., Ginnivan, L., Lowell, A., Lee, B., Gorham, G., Taylor, S., Hefler, M., & Kerrigan, V. (2023). Improving outcomes for hospitalised First Nations peoples through greater cultural safety and better communication: The Communicate Study Partnership study protocol. *Implementation Science*, 18, Article 23. <https://doi.org/10.1186/s13012-023-01276-1>
- Reilly, R., Evans, K., Gomersall, J., Gorham, G., Peters, M., Warren, S., O'Shea, R., Cass, A., & Brown, A. (2016). Effectiveness, cost effectiveness, acceptability and implementation barriers/enablers of chronic kidney disease management programs for Indigenous people in Australia, New Zealand and Canada: A systematic review of mixed evidence. *BMC Health Services Research*, 16, Article 119. <https://doi.org/10.1186/s12913-016-1363-0>
- Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), *Analysing qualitative data* (pp. 173–194). Routledge.
- Rix, E. F., Barclay, L., Stirling, J., Tong, A., & Wilson, S. (2014). “Beats the alternative but it messes up your life”: Aboriginal people's experience of haemodialysis in rural Australia. *BMJ Open*, 4(9). <https://doi.org/10.1136/bmjopen-2014-005945>
- Rix, E. F., Barclay, L., Stirling, J., Tong, A., & Wilson, S. (2015). The perspectives of Aboriginal patients and their health care providers on improving the quality of hemodialysis services: A qualitative study. *Hemodialysis International*, 19(1), 80–89. <https://doi.org/10.1111/hdi.12201>
- Rix, E. F., Barclay, L., Wilson, S., Stirling, J., & Tong, A. (2013). Service providers' perspectives, attitudes and beliefs on health services delivery for Aboriginal people receiving haemodialysis in rural Australia: A qualitative study. *BMJ Open*, 3(10). <https://doi.org/10.1136/bmjopen-2013-003581>

- Sabanayagam, D., Makris, A., Sciberras, F., Scholes-Robertson, N. J., & Wong, G. (2025). Dialysis care in Australia: A call for reform and innovation. *Medical Journal of Australia*, 223(2), 58–60. <https://doi.org/10.5694/mja2.52672>
- Srivastava, A., & Thomson, S. (2009). Framework analysis: A qualitative methodology for applied policy research. *Journal of Administration and Governance*, 4(2), 72–79.
- Taylor, J., & Kukutai, T. (2015, October 22–23). Indigenous data sovereignty and indicators: Reflections from Australia and Aotearoa New Zealand [Paper presentation]. UNPFII Expert Group Meeting “The Way Forward: Indigenous Peoples and the 2030 Agenda for Sustainable Development”, New York.
- United Nations High Commissioner for Human Rights. (2011). National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Australia: First cycle. <https://www.ohchr.org/en/hr-bodies/upr/au-index>
- United Nations High Commissioner for Human Rights. (2015). National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Australia: Second cycle. <https://www.ohchr.org/en/hr-bodies/upr/au-index>
- United Nations High Commissioner for Human Rights. (2021a). National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Australia: Third cycle. <https://www.ohchr.org/en/hr-bodies/upr/au-index>
- United Nations High Commissioner for Human Rights. (2021b). Universal Periodic Review – Australia, Letter from the High Commissioner to the Foreign Minister. https://www.ohchr.org/sites/default/files/2021-11/HC_letter_to_Australia.pdf
- Vermunt, N., Elwyn, G., Westert, G., Harmsen, M., Rikkert, M. O., & Meinders, M. (2019). Goal setting is insufficiently recognised as an essential part of shared decision-making in the complex care of older patients: A framework analysis. *BMC Family Practice*, 20, Article 76. <https://doi.org/10.1186/s12875-019-0966-z>
- Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning*, 9(4), 353–370. <https://doi.org/10.1093/heapol/9.4.353>
- Wagh, E. B., Hefler, M., Pascoe, S., Mayo, M., Hare, M. J., Story, D. A., Wilkshire, N., Henwood, P., Croker, D., & Ross, J. (2025). What do Aboriginal people in the Northern Territory value during the operation journey? A qualitative study. *Medical Journal of Australia*, 223(1), 30-37. <https://doi.org/10.5694/mja2.52695>
- World Health Organisation (WHO). (2022). A toolkit on how to implement social prescribing, <https://www.who.int/publications/i/item/9789290619765>

Zolnoori, M., Williams, M. D., Leasure, W. B., Angstman, K. B., & Ngufor, C. (2020). A systematic framework for analysing observation data in patient-centred registries: Case study for patients with depression. *JMIR Research Protocols*, 9(10), Article e18366.
<https://doi.org/10.2196/18366>