



“I feel like the worst mother in the world”: Neoliberal subjectivity in Indigenous Australian oral health



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ABSTRACT

Neoliberalism gained popularity during the post-Cold War period as a set of dominating ideologies, practices and policies that underpinned the movement towards globalisation. Neoliberalism champions competitive private markets, deregulation that facilitates economic activity, personal responsibility, and reduced public expenditure on infrastructure. A decade after the initial rise of neoliberalism, health inequities became concerns on the global stage. Oral health inequities aptly reflect social injustices due to the unique relation between material circumstances, access to health services and structural inequities. In Australia, Indigenous children experience early childhood caries at alarmingly higher rates than non-Indigenous children. Recently, neoliberalism has been suggested as an overwhelming contributor to Indigenous oral health disparities. This qualitative research is an extension of a single-blind parallel-arm randomised control trial that aimed to identify factors related to the increased occurrence of dental caries in Indigenous children. The objective of this constructivist grounded theory study was to generate an understanding of how neoliberal subjectivity exists for Indigenous peoples in the context of oral health in Australia. Experiences of ownership, guilt, failure, embarrassment, shame, and judgment were key in participants' experiences of neoliberal subjectivity; these feelings were exacerbated by experiences of bullying, financial limitations, and institutional racism. We argue that individual responsibility for health, as a tenet of neoliberal ideologies, furthers Indigenous oral health inequities and that neoliberalism as a societal discourse perpetuates colonial values by benefitting the privileged and further oppressing the disadvantaged.

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1. Introduction

Health equity scholarship has persistently called for increased consideration of political economies, contending that failing to acknowledge the relationship between political economies and biological measures of health, risks naturalising social conditions that directly shape health outcomes (Leatherman & Hoke, 2016; Sweet, 2018). Considerations of health inequities that fail to acknowledge the influence of power, historical context, and political economic processes, have ethical implications that, in the current neoliberal climate, permit victim blaming at the individual level when these systemic influences manifest as poor health (Leatherman & Hoke, 2016). Epidemiologists and sociologists have reiterated these notions, highlighting the need to integrate

political economies into explanatory models to minimise risks of naturalisation (Coburn, 2000; Navarro et al., 2003; Navarro & Shi, 2001). This sentiment has been echoed by the World Health Organisation who has called upon the international community to eliminate the “toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics” that manifest as health inequities across the world (Health, 2008). More specifically, some researchers have highlighted the influence of neoliberalism in shaping population health (Coburn, 2004; Navarro, 2007).

Neoliberalism is an economic and philosophical set of dominating ideologies, practices and policies that underpinned the movement towards globalisation. Influenced by economists Friedman and Hayek, this model is the predominant political orientation of many countries

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(Freeman, 2018). Neoliberalism promotes personal responsibility, competitive private markets, reduced public expenditure, and deregulation that supports the free market, benefitting those with power and economic strength (Huber & Niedzwiecki, 2018; Peacock et al., 2014). Neoliberalism differs from prior iterations of capitalism because of its endorsement of personal responsibility in which individual wellbeing is a consequence of personal choice (Houghton, 2019). Since the 1980s, neoliberalism in Australia has been embraced by both major political parties. The Labor governments of Hawke and Keating from 1983 to 1996 introduced programs of reform that prioritised economic liberalisation and involved reduced trade protections, privatisation of government corporations, and deregulation of markets (Van Gramberg, 2005). A mandatory superannuation program was introduced in 1993 to minimise reliance on the government for old age pensions, and university funding was deregulated which created competition and encouraged universities to generate more income by recruiting international students (Marginson, 2000). While advocates of neoliberalism cite widespread economic triumph, this pyrrhic victory has disproportionately benefited middle and upper classes, and substantially increased economic and health inequities across the world (Benatar et al., 2018; Gill & Bakker, 2011). A clear impact of neoliberalism on population health is through the modification of policies that structure social resources, such as the privatisation of healthcare and the associated transfer of costs and responsibility from governments to individuals (Labonté & Stuckler, 2016). However, there is increasing evidence to support the breadth of neoliberal influences on health, which are largely related to the overlooked power neoliberalism holds as a cultural doctrine (di Leonardo, 2008a; Gledhill, 2005). Dardot and Laval suggest that neoliberalism should foremost be understood as a way of life and a new subjectivity that forms the basis of human existence (Dardot & Laval, 2014).

The global experience of oral health for Indigenous peoples is well documented; almost without exception, Indigenous peoples experience alarmingly disproportionate rates of oral diseases (Nath et al., 2021). These patterns of disease have rightfully been attributed to the impact of strategic and intentional government policies of assimilation and colonisation on Indigenous wellbeing (Dudgeon et al., 2010; Durie, 2004). In Australia, Aboriginal and Torres Strait Islander peoples (subsequently, respectfully referred to as Indigenous) represent 3.3% of the population ("Australia's Health 2018," 2018). Prior to the 1980s, Indigenous children in Australia experienced better oral health than non-Indigenous children; presently, Indigenous children experience up to five times more untreated dental caries than their non-Indigenous counterparts ("Aboriginal and Torres Strait Islander health performance framework 2012: detailed analyses," 2013; "Australia's children," 2020). Dental care for Australian adults is primarily supplied by the private sector, however some individuals have access to publicly funded dental services, determined by means-testing. A large proportion of Indigenous adults are eligible for public dental services, however the long waiting times, required co-payments, and limited range of services presents barriers to access (Jamieson, Hedges, et al., 2020). These factors in combination with experiences of racism at the dentist, complexities of arranging dental appointments, distance from services, and dental fears create a myriad of challenges for Indigenous peoples in Australia. Generally, health care for Indigenous peoples in Australia is managed and provided through government-funded Aboriginal Community Controlled Health Services (ACCHS) and while approximately one third of ACCHS provide dental services, very few services in South Australia offer dental care ("AMA Report Card on Indigenous Oral Health," 2019). Reporting of Indigenous oral health in Australia, and indeed globally, has historically employed a deficit approach, which furthers current blame discourse and highlights the direct impact of neoliberal ideologies on academic research and government reporting (Durey et al., 2016, 2017).

Emerging literature indicates neoliberalism may further impact health at the individual level through the ideological process of internalisation (Peacock et al., 2013, 2014; Sweet, 2018). The pervasive effects of neoliberalism have become incorporated into the common-sense

way of how people understand the world around them, demonstrating how this political orientation has embedded itself into the everyday of people, and the organisation we operate within (Clarke et al., 2007; Harvey, 2007; Mirowski, 2013). The "neoliberalisation of consciousness" has been explained as the process where individual world views have increasingly become permeated by neoliberal principles (Di Leonardo, 2008b). Mirowski has termed the small, yet constant interactions with neoliberal policies and beliefs 'everyday neoliberalism' (Mirowski, 2013). The concepts of 'everyday neoliberalism' and the 'neoliberalisation of consciousness' demonstrate the subjective experience of neoliberalism at the individual level, which contributes to the development of individual identities and works to propel individuals into becoming neoliberal subjects (Houghton, 2019). Despite active engagement in their lives, individuals are restricted by discourses in what can be thought, said, and done (Staunæs, 2003); meaning, while individuals exercise choice in personal conduct, that choice is shaped by cultural narratives (Houghton, 2019). Important to this is the internalisation of neoliberal principles that idealise personal responsibility for health and promote self-blame for those with poor health. The construction of neoliberal subjects brings together neoliberal policy and ideology through governance and culture. Not only does neoliberalism create inequities and disadvantage, it encourages moral judgments of others' misfortunate and the internalisation of judgments upon oneself (Sweet, 2018).

Oral health reflects social injustices resulting from neoliberalism because of oral health's relationship between material circumstances, access to health services and structural inequities that contribute to disease development over one's life (Peres et al., 2019). Notably, individualistic and competitive neoliberal ideologies directly conflict with collective and holistic Indigenous values (Jamieson, Hedges, et al., 2020). Indigenous peoples in Australia have identified the conflicts between values of competition and selfishness with relational values of sharing and inclusion; noting the contrast between what is considered 'rich' among white people versus Indigenous peoples (Burbank, 2006; Habibis et al., 2020; A.; Moreton-Robinson, 2017). Despite these contrasts, due to the pervasive nature of neoliberal ideologies and the models of dental care in Australia, neoliberal policies continue to contribute to oral health disease burden among Indigenous communities (Jamieson et al., 2020b, 2021b). Jamieson and colleagues recently identified five ways in which neoliberalism contributes to oral health inequities experienced by Indigenous peoples, including the privatisation of health, increased wealth disparities, emphasis on personal responsibility, dominance of transnational corporations, and influences on systemic racism (Jamieson, Hedges, et al., 2020). Exploring the experience of Indigenous peoples and neoliberal subjectivity within the context of oral health provides an opportunity to consider factors beyond individual control that constrain one's ability to make optimum health choices. This goes beyond the traditionally accepted drivers of Indigenous oral health inequities such as oral hygiene behaviours, sugar consumption, and fluoride exposure. Therefore, this study aimed to understand how aspects of internalised neoliberal ideological principles, explored through the experience of neoliberal subjectivity, influence Indigenous peoples' experience of oral health in South Australia.

2. Methods

2.1. Methods

The present data derives from a randomised controlled trial in South Australia that aimed to reduce oral health inequities among Indigenous children, where Motivational Interviewing (MI) was one of four interventions (Merrick et al., 2012). MI is a psychotherapy intervention that encourages the identification, exploration, and resolution of participant ambivalence to behaviour change (Miller & Rollnick, 2009). The protocol (Merrick et al., 2012), cohort profile (Jamieson, Hedges, et al., 2021), primary quantitative outcomes (Jamieson et al., 2018), and

thematic findings (Poirier et al., 2021) have been published. Ethics approval for this project was received from the University of Adelaide Human Research Ethics Committee (H-057-2010) and the Aboriginal Health Council of South Australia (04-09-362). All participants provided informed written consent. Recruitment for the larger study occurred during pregnancy and therefore, the majority of interviews occurred with mothers. Each participant was interviewed up to three times, from the time of recruitment and until the child was 36 months old. Interviews were conducted in accordance with frameworks that were piloted by the research team prior to data collection (A1). Each MI followed broad directives, which included dental care during pregnancy, the importance of non-cariogenic drinks and foods for children, the importance of fluoride, and children's first dental appointments. While the focus of the project was preventing early childhood caries among children, participants used these interviews as an opportunity to reflect on personal experiences, which provided data concerning both parental role in childhood oral health as well as personal oral health for the present analyses. Interviews varied in length from 45 to 70 min and were audio recorded and transcribed verbatim.

This analysis employed a constructivist grounded theory approach (CGT) to generate a concept of neoliberal subjectivity in the context of Indigenous oral health (Charmaz, 2000). CGT has been suggested as similar in principle to traditional grounded theory, operating within a constructivist paradigm, rejecting ideas of emergence and objectivity of analysis, and instead acknowledging the influence of researcher subjectivity on findings. Accordingly, it is critical to recognise the positionality of those involved in the research process and acknowledge the influence of their experiences on data interpretation and reporting. As white female researchers, the primary author (BFP) and project lead (LMJ) have directly and indirectly benefitted from processes of neoliberalism throughout their lives and will never completely understand the Indigenous experience of neoliberalism. Therefore, the importance of ensuring relational understanding and meaning throughout interviews was central for the development of a theoretical model of neoliberal subjectivity. Hence, a senior Indigenous researcher (JH) conducted all interviews included in this analysis and assisted in interpreting meaning and generating understandings of data. The primary researcher (JH) spent four years conducting fieldwork across South Australia for this trial, and the primary author (BFP) spent significant time familiarising herself with the data as well as working with the same communities that participated in this project. During the familiarisation stage, discussions between the research team about the commonality of notions of failure and shame among participants created the desire to further investigate and explore the impact of personal responsibility, as related to neoliberal ideologies, on participant experiences of oral health. While analysing the data, the primary author (BFP) was continually reflecting on how her codes were being influenced by her life experience. Data analysis occurred over the course of a year, during which time the primary author and senior Indigenous researcher were conducting field work together and were able to discuss the data on a regular basis. NVivo software (QSR International Pty Ltd. Version 12.6.1) was used for organising data and a constant comparative approach was followed throughout the stages of initial coding, focused coding, and theoretical coding procedures (Charmaz, 2000). Initial coding was done line-by-line, staying close to the data, and maintaining participant wording in code generation wherever possible. Debriefing was conducted by disseminating initial findings to the wider research team to enhance credibility and consistency of findings with regard to research context and participants (Lincoln & Guba, 1985). The initial themes generated only related to personal feelings shared by participants but the story felt incomplete to the research team and therefore, data was re-visited to explore what (if any) factors participants indicated impacted these personal feelings. Similarly, while personal responsibility influenced the lens through which data were analysed, the concept of neoliberal subjectivity was only explored upon identifying the internalisation of these neoliberal expectations among participants. Memos, notes, and stories from data

collection and the primary stages of analysis informed the final conceptual model (Charmaz, 2000). Authors aimed to emphasise the relationship between feelings within the neoliberal subject as well as factors external to the subject that impacted these feelings; the final model resulted from discussions of individual pathways of action between components identified during analysis, combined with re-visiting of complete stories shared by participants.

2.2. Sample

This study utilised convenience sampling of the 448 mothers pregnant with an Indigenous child recruited during baseline. In accordance with CGT, purposive sampling of participants was employed until data saturation was reached (Aldiabat & Le Navenec, 2018); 266 interviews from 177 participants were included in this analysis, from the larger cohort of 585 interviews from 448 participants. Participant characteristics of age, employment and residential location were diverse (Table 1). Self-rated oral health measures, collected during baseline, are reported here to provide context for how participants rated their own oral health at the time of interview (self-rated oral health), as a proxy for dental service utilisation (self-identified need for dental work), and as a measure for impact of oral health on participants' lives in the past year (negative impact of oral health on your life in the past 12 months). Just under half of the participants rated their oral health as good (45.2%), many participants indicated a current need for dental work (85.2%), and oral health had impacted the majority of participants' lives in the past year (81.42%) (Table 1).

3. Results

The conceptual model derived from interviews with 177 carers of Indigenous children from communities across South Australia encompasses the relationship between both internalised feelings expressed by participants as well as the impact of external factors related to these feelings, in relation to neoliberal ideologies. There are two components to this model (1) the embodiment of neoliberal subjectivity and, (2)

Table 1
Participant characteristics.

	OVERALL SAMPLE (N = 177) N (%)
MATERNAL AGE AT THE TIME OF FIRST INTERVIEW	
14-24	59 (33.3%)
25-34	92 (52.0%)
35-44	21 (11.9%)
45+	5 (2.8%)
CHILDREN IN CARE	
1-3	113 (68.1%)
3-6	46 (27.7%)
7+	7 (4.2%)
EMPLOYMENT	
FULL TIME	17 (10.2%)
PART TIME	38 (22.9%)
UNEMPLOYED	111 (66.9%)
RESIDENTIAL LOCATION	
METROPOLITAN	79 (44.6%)
NON-METROPOLITAN	98 (55.4%)
SELF-RATED ORAL HEALTH	
GOOD	80 (45.2%)
POOR	97 (54.8%)
SELF-IDENTIFIED NEED FOR DENTAL WORK	
YES	152 (85.9%)
NO	25 (14.1%)
HAS ORAL HEALTH NEGATIVELY IMPACTED ^a YOUR LIFE IN THE PAST 12 MONTHS?	
YES	144 (81.4%)
NO	33 (18.6%)

^a Where "negatively impacted" relates to pain, satisfaction with appearance or ability to eat.

factors that exacerbate the experience of the neoliberal subject. The first component includes feelings and experiences of ownership, guilt, failure, embarrassment, shame, and judgment in the context of Indigenous oral health, which largely relate to the neoliberal ideology of personal responsibility for health. The second component includes experiences of bullying, institutional racism, and financial limitations external to the neoliberal subject, which relate to the neoliberal tenets of personal responsibility, reduced public expenditure on infrastructure, and competitive and private markets, respectively (Fig. 1). Sentiments of ownership were most prominent among participants (N=89), followed by judgment (N=69), guilt (N=68), financial limitations (N=54), institutional racism (N=31), shame (N=31), bullying or teasing (N=22), embarrassment (N=18), and failure (N=6).

3.1. Embodiment of neoliberal subjectivity

Many parents expressed personal responsibility for their children's oral health as a sense of **ownership**. Maintaining oral health was discussed as an expectation for anyone in a parenting role, in the wider context of ensuring child wellbeing, "It's our role as parents to look out for our little ones. It's our duty more or less, hey. If we don't do that, then how are we going to expect them to succeed in life (P115)." Parents expressed the desire to try and 'do right' by their children in spite of the multiple barriers to establishing and maintaining oral health experienced by participants, as exemplified by one parent working to cut out fruit juice for her child: "We're still in the process of doing it and trying to stick by it ... it does get a bit hard to but mainly sort of doing the right thing for her (P61)." Ownership directly related to being a 'good' parent for many.

"I'd be confident in going [to the dentist] because that's my baby girl and you know, just to have her have nice teeth, get used to the way the world works and all that you know, it'd be good. [My kids] can look back at me and go oh yes, well Mum used to take me to my dentist ... took me to doctors and if I had to go somewhere she took me... It'll make me feel happy because, you know, like everybody might do a couple of things wrong in their lives and at least my kids

can back me up in the future, I don't care what you say but my mum's the best mum (P75)."

Deviation from perceived oral health standards in children caused immense **guilt** for parents and related to personal 'irresponsibility', especially when children experienced pain: "I guess because it looks different, I would feel bad if he had [rotten teeth] in his mouth (P89)." Parents described feeling like a bad parent for unknowingly enabling high risk behaviours, such as sugar consumption: "I wish I had read labels properly, I just didn't know... That's terrible because I've just pumped all that sugar into his mouth (P129)." Many parents shared their difficulties navigating food and sugar marketing, coupled with limited nutrition understanding. Guilt was also discussed in terms of interactions with oral health professionals, where parents described carrying the blame that dental professionals put forth during appointments. Some parents thought that dentists made comments just to make them feel bad, "It's funny how dentists don't go into a little bit more detail [about oral health] to make you realise... they say it just to make you feel bad, you know? (P59)" Guilt also acted as a motivator to change household habits, such as children's diets, and prioritise prevention efforts.

"I feel worried enough about something we have no control over, so if we had to [have surgery] for something just because I hadn't bothered... Just gone, oh, whatever. Drink whatever, eat whatever you want, I'd feel really guilty (P35)."

Failure also related to an inability to fulfill personal responsibilities and was discussed in terms of dental surgery, dental visits, and children's futures. Largely, parents believed that tooth decay and dental surgery were preventable, and for that reason when discussions circulated to the possibility of children having to undergo surgery, some parents identified that surgery would be a measure of parental failure, "For me, if that was my child [having surgery], I'd feel like a failure, you know, like I didn't do enough to protect them from what they were putting in their mouth (P44)." One parent reflected on her experiences with an older child who had previously gone under general anaesthetic for dental surgery, this reflection fails to acknowledge the numerous challenges to maintaining

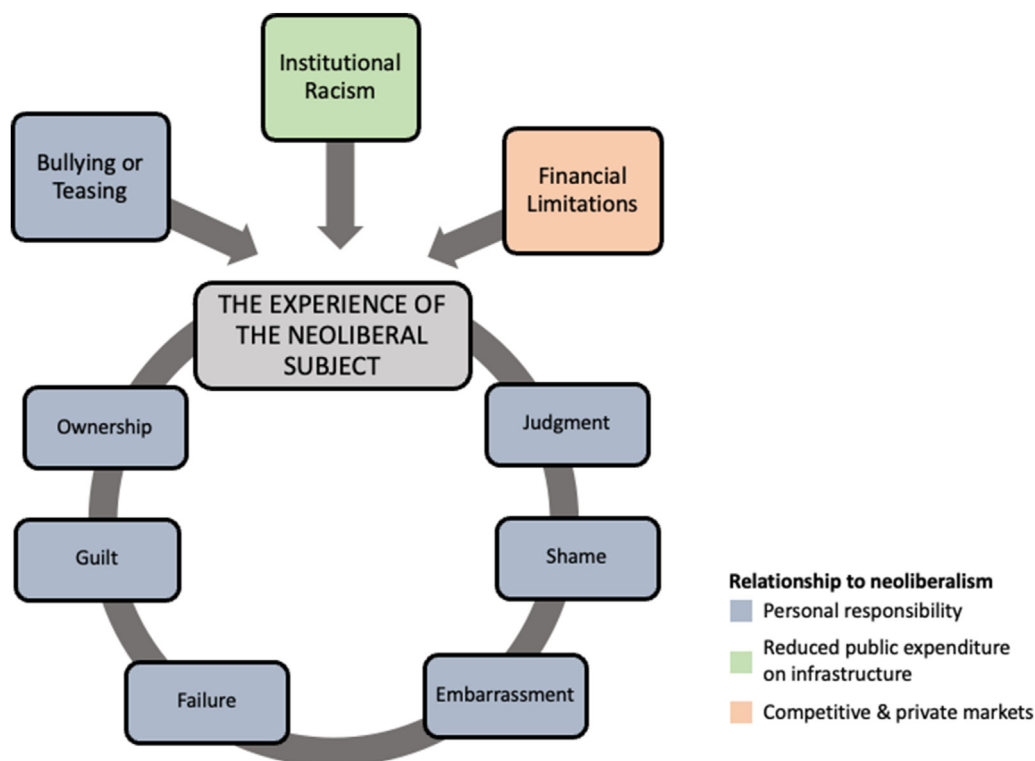


Fig. 1. Conceptual model of neoliberal subjectivity in the context of Indigenous oral health.

child oral health and demonstrates the internalisation of oral health expectations.

“It’s terrible. Yes, I feel bad already... I feel like I’ve failed... you know, [his rotten teeth are] maybe [because of] my lack of encouraging him. I’m the reason why he’s got the teeth that he has, because I’m the one that feeds him, I’m the one that does everything. I’m in control of what he suffers from. So now that he’s got really bad teeth, it’s my fault. I failed (P97).”

While some parents felt they had successfully bypassed the need for surgery, they worried the habits their children had inherited, such as drinking chocolate milk or iced coffee in their baby bottles, would have ramifications later in their lives, which parents understood as failures in terms of oral health. Other parents feared notions of failure that could result from dental visits, which added another layer to the challenges associated with attending dental appointments. Despite these fears, parents continued to do their best in meeting their children’s dental needs.

“If I’m to go to the dentist and they tell me that [my child has] to get their teeth taken out because I let them have cordial in the bottle I’d feel like the worst mother in the world. I’d feel like I’d failed so I dread it like I’m not scared of the dentist and... I take the kids up and it’s alright. But quietly I’m sitting there thinking oh my God please don’t tell me I’ve ruined my kids teeth (P95).”

Embarrassment related to personal responsibility for health and was discussed both in terms of parental embarrassment as well as potential child embarrassment in the future. In discussing possibilities of dental surgery for children with poor oral health, many parents discussed the embarrassment they would feel if the procedure was needed for their child, “It’s embarrassing. You know walking around with a kid, smiling, with teeth [rotten] like that. It’s like neglecting your kid (P27).” Parents also discussed embarrassment in terms of publicly enabling poor oral health behaviours for children, such as sugar consumption.

“I’ve seen people walk down the street and have... The kids have got Coke or, you know, strawberry milk in their bottles. I’ve never ever done that... I’ll never do it. I’d be too embarrassed if I was walking down to [the grocery store] with him, and if he had orange cordial in his bottle... I’d be embarrassed because you know, it looks wrong really... It’s not good, rots their teeth and it’s not healthy (P111).”

Parents discussed the potential embarrassment their children may experience in the future, many of these comments were grounded in personal experiences. Parents did not want embarrassment to hinder their children’s ability to talk, smile, or eat freely and without hesitation. Embarrassment was exclusively discussed in terms of school or social environments and assumed that other people would not consider the complex context surrounding maintenance of oral health.

“My teeth were corroded there for a little bit, and I guess I don’t want the same for [my kids], because I was a little bit embarrassed to smile, and things like that. I don’t want that for my girls. I want them to feel confident, you know, all the way throughout their life... I don’t want them to feel embarrassed, not to smile. And teeth are important... [to] socialising and things like that too. I don’t want them to be picked on at school, you know what, you’ve got yucky teeth, things like that. So, I do think ten steps ahead, you know, especially for them (P86).”

Embarrassment prevented some parents from attending dental appointments for themselves: “I’m embarrassed to go to the dentist though... That’s why I don’t want to go because my teeth are so bad (P89).” However, many participants were willing to overcome feelings of embarrassment for their children. Another parent shared an experience where she received information from her dentist about the importance of baby teeth as a precursor to strong adult teeth; this Mum felt particularly embarrassed because the dentist knew that all her children had had oral health

complications. This story exemplifies the limited transference of knowledge between health services and Indigenous families and the multifaceted challenges parents navigate in establishing and maintaining oral health for their children.

Shame was mentioned as a barrier to creating relationships with others, particularly during school years, due to low confidence or self-esteem, “I know how hard it was for me during school... I didn’t interact with anyone because I was so self-conscious about my teeth, and I actually missed out on meeting a lot of really good people (P118).” Shame impacted parent’s willingness to smile for photos and caused anxiety around job applications, “My boyfriend, his teeth are rotten and he’s ashamed... He’s thinking you know, what about when I get a job, no one is going to want to hire me with my teeth like this. He doesn’t want to smile. It sort of depresses him a bit you know, at the same time (P102).” Parents also discussed shame of teeth in terms of dental appointments, including transportation needs, poor oral health, and limited knowledge; the internalisation of personal responsibility and societal expectations of oral health was evident during these discussions. Many parents wouldn’t go to the dentist themselves or knew someone else who avoided the dentist because they felt shame, which created a further barrier to navigating a complex dental care system for many.

“Yes a lot of Nunga mums are really ashamed and that’s probably why they don’t take their kids to appointments in the first place because it’s just that cycle of being ashamed all the time. Not knowing how to talk to professionals and doctors and stuff like that, not having that confidence (P19).”

Parents not only held expectations of oral health responsibilities for themselves but also for those around them, as demonstrated by the various **judgmental** comments parents made about other parents. Judgment exhibited by parents was often a result of comparison or competition, “I’m better than half of the Mums that I’m friends with because they just don’t care about their children’s teeth (P118).” Judgment was also based on what parents believed others should know or should do in their role as a parent, based on either personal or societal standards, “[As a parent] that is your role, to be on the ball with that sort of stuff... when I see little kids [with rotten teeth] it breaks my heart because it’s just the things you have to do when you’re a parent. You have to do it. That’s what it’s all about (P64).” Parents used various words to describe others’ parenting behaviours, including terms like ‘lazy,’ ‘unfit,’ and ‘useless.’ “I think it’s lazy when people just allow their kids to thrive on soft drinks every day. Every day. You see like two-year olds, three-year olds drinking like 1-L bottles of Coke (P38).” Many parents identified that although they had differing parenting beliefs than others, they rarely translated comments made during interviews to other parents.

“One of their cousins had all his teeth out at the hospital... The parents are stupid. Within hours they’re back, he’s drinking Coke... Like he just went to have all their teeth ripped out and you’re rewarding him with Coke... but I don’t say anything to them... it’s not my place to say (P87).”

Some parents justified their judgments or comments by identifying that it is ‘not that hard’ to be a good parent or to ‘do the right thing’ in terms of children’s oral health, “I think [dental surgery] is bad, because... If your parents looked after them and give them the right thing, they won’t have to have it done. It’s not hard (P40).” These comments did not account for the complexities of oral health and nutritional knowledge, navigating services, and other barriers that impact oral health outcomes. Many parents who passed judgment on others used phrases such as, ‘no offence’ and ‘not to judge.’ “I’m one of those people, like I’m not a judgmental person, I’m not a judgmental mum but I’ll sit there and go oh my God that poor baby getting his teeth ripped out because he had chocolate milk in his bottle (P95).”

3.2. Factors that exacerbate the experience of the neoliberal subject

Experiences outside of the neoliberal subject that exacerbated feelings of ownership, guilt, failure, embarrassment, shame, and judgment included bullying, financial limitations, and institutional racism. Parents wanted to prevent their children from being **bullied** due to poor oral health because of the impact bullying has on confidence and feelings of shame, embarrassment, or depression for some.

"[I don't want her to] go through the experience I went through, because it was not pleasant. I was very upset and depressed and never liked going to school... it was all that harassment I got throughout my school years that's like, well, what's the point of being at school? What's the point of getting a good education and getting a good job if you're going to get picked on, kind of thing? So it's something I don't want her to go through (P107)."

Bullying related to externally imposed assumptions of individuals failing to meet oral health expectations. Many parents had either been bullied themselves or had witnessed others be teased because of their teeth, "I've actually been teased that my front top teeth have always been like, see they're, not really straight... [When] I'm in the group, walking around with that wobbly, disgusting, not disgusting, then they're just like wobbly teeth... that I feel conscious about (P13)." These personal experiences provided motivation for parents to continually pursue the best options for their children's oral health; good oral health meant limited bullying, increased confidence and a head start in life for children for parents.

Financial limitations, as a result of competitive and private markets, directly and indirectly exacerbated experiences of shame, guilt, and failure. Parents discussed having to make difficult decisions between buying food and buying oral health supplies, such as toothbrushes, toothpaste, and floss. Despite wanting what is best for their children, these items were inaccessible for some due to cost, "You go to some Nunga kids' homes and sometimes there'll be one toothbrush between ten kids (P152)." Parental worry about the uncertainty of costs associated with dental appointments, particularly with specialists such as orthodontists, caused apprehension or avoidance for some.

"I guess the dollar signs slam me and just I feel like if I go there they're going to be like no you're going to have to do this, this and this ... I guess it is that. It's the cost. Like I mean I know government, going to the government and like the dentists, like the school dentist is good. But when you've got bigger issues... that's too scary for me... I think that's sort of why I've backed off with my daughter at the moment with her teeth (P129)."

For some parents, when dental services were utilised the cheapest option was the only option to alleviate pain, which often was to pull teeth out, "[I've] rip[ped] a lot of teeth out, just because of the cost. I lost a lot of teeth like that (P4)." Some parents identified dental surgery at the hospital as the preferred option over preventive treatments for their children because it was free, despite the ramifications of dental surgery. Parents expressed great relief for government subsidies that enabled their children to attend dental appointments, although navigating these systems and accessing funding options for both their children and themselves posed challenges. Limited finances impacted participant's ability to complete dental treatments, sometimes forcing individuals to find alternative solutions.

"My Mum didn't have the money to do my teeth ... My dad paid for half with my braces, my Mum was supposed to pay the other half out of her pension, and she didn't, so I was too shamed to go back to the dentist and they just rotted on my teeth. I cut them off myself, my braces (P11)."

Institutional racism impacted parents' willingness or ability to make and attend dental appointments in a variety of ways. Dental staff, such as receptionists and nurses, were the forefront of many parent interactions

at the dentist and most discussions related to institutional racism reflected experiences of implicit bias or unhelpful assumptions from the dental team. While ACCHS provides culturally secure health services for many communities in South Australia, dental care is still provided by mainstream services that often fail to meet the needs of Indigenous communities. For parents this project, institutional racism related to reduced public expenditure on social services and infrastructure. In accessing services for prevention, one Mum was questioned by the receptionist about why she was coming in if there was no problem or emergency, "I just want to be treated as a person... all people should have a choice, and opportunity to thrive (P157)." Some parents were not confident that they would be treated well by dental staff due to previous experiences, which caused avoidance of booking and attending appointments. For some parents, an experience of racism in a non-dental healthcare setting, such as having child protective services called at the doctor's office, created an expectation of similar behaviour from all healthcare providers. Parents shared experiences where their feelings or worries were downplayed by oral health professionals, diminishing the importance of these concerns and the ability of parents to confidently ascertain their needs.

"I asked [the dentist] the other day if I could put my baby in [for an appointment] and he spoke to me like it didn't really matter that he had teeth and that I was concerned about some of his teeth... I didn't think he needed to be so casual because it is important... he's not understanding that a lot of Aboriginal children have tooth decay and have poor tooth, or gum, mouth hygiene (P90)."

Parents also highlighted difference between their needs and service provisions of mainstream health services, as articulated by one Mum, "Our bodies aren't meant to live the whitefellas way (P173)." Misalignment of expectations between parents and oral health professionals created disappointment and tension, particularly when parents were making strong efforts for their children's oral health: "I really don't like [that dental office] they are really quite rude... I just feel like they're trying to work against me, not with me (P123)." Parents expressed frustration at their reliance on government structures to provide care for their children.

"We're behind the eight ball and we can't invest [in our child's health], we rely on government to invest in our children's health... It's like there's a routine in society and we're not a part of society, so how can we be a part of that routine? Buy a house, get married, have bank accounts for each child... dental care, the whole lot. We haven't got it. We're not born into it... Society has put us into a position where we can't basically go above [societal structures] (P157)."

4. Discussion

Through the utilisation of CGT, a conceptual model was developed in relation to the experience of neoliberal subjectivity within the context of Indigenous oral health in Australia. This model includes five overarching experiences expressed by participants in discussing their oral health: ownership, guilt, failure, embarrassment, shame, and judgment. Specific themes within these categories relate to physical appearance, accessing oral health services, and desires or worries for children's oral health in future. This model also includes three factors that participants discussed as exacerbating their experiences: institutional racism, bullying, and financial limitations. Components of the conceptual model relate to neoliberal ideologies of personal responsibility, reduced public expenditure on infrastructure, and competitive and private markets. The findings presented here are similar to qualitative works regarding the constraints of structural factors on Indigenous peoples' oral health choices in Western Australia (Durey et al., 2016, 2017). However, this work is one of the first to explicitly link neoliberal ideologies with Indigenous oral health experiences in Australia. Unlike traditional analyses of barriers and facilitators to oral health, this work considers oral

health within the political economy and current health discourse, particularly with regard to personal responsibility for health. The consideration of sociopolitical discourse in the context of Indigenous oral health enables a shift in perspective and accountability for poor oral health from individuals to macro-level determinants of health, while simultaneously minimising opportunities to employ a deficit approach (Durey et al., 2017). As seen in our results, the impacts of ‘failing’ socially accepted responsibilities for health can create deeper and more complex barriers to accessing care which is often already inaccessible for many Indigenous communities.

4.1. Neoliberal subjectivity & Indigenous collectivist values

The embodiment of neoliberal ideologies for participants in this study was a result of externally imposed values that directly contradicted their cultural ways of thinking, doing, and being. Participants discussed the components of the neoliberal subjectivity model almost entirely within contexts outside of the home, such as health services, places of employment, and educational institutions. The neoliberal emphasis on the individual directly contradicts Indigenous collective and holistic values of participation, sharing, and ownership which create strong social cohesion but limit ‘success’ in neoliberal environments (Jamieson, Hedges, et al., 2020). In discussions of neoliberalism, Indigenous peoples from Tasmania have highlighted the stark contrast between white values of competition and selfishness with the relational orientation central to Indigenous culture and values of sharing, tolerance, and inclusion; noting that while white people may be rich in wealth, Indigenous peoples are rich in connections (Burbank, 2006; Habibis et al., 2020; A.; Moreton-Robinson, 2017). In the same study, participants reflected on the threat white people and neoliberal discourse pose to life itself, noting that the capacity for harmonious co-existence inherent to Indigenous spirituality and connection with country has been lost (Habibis et al., 2020). The judgment of others exhibited by participants in our study demonstrates that neoliberal ideologies are already endangering collective Indigenous ideologies that promote social cohesion; judging others further divides communities and risks normalising isolation and individualism. By encouraging division and debate among a collective society, neoliberal discourse distracts and limits that society's ability to contradict social norms. Chomsky has understood the threat this poses for some time, “The smart way to keep people passive and obedient is to strictly limit the spectrum of acceptable opinion, but allow very lively debate within that spectrum—even encourage the more critical and dissident views. That gives people the sense that there's free thinking going on, while all the time the presuppositions of the system are being reinforced by the limits put on the range of the debate” (Chomsky et al., 1998).

Factors that exacerbated the experience as a neoliberal subject for participants in this project included bullying, institutional racism, and financial limitations; all of which largely relate to differences in power and wealth between Indigenous and non-Indigenous people. Neoliberalism and its pervasive impact on all human lives operates within increasingly coercive and damaging power frameworks (Benatar et al., 2018). Unfortunately, experiences of power imbalances are not a new phenomenon for many Indigenous communities, who have histories wrought with imposed assimilation policies and acts of oppression. Present day oral health inequities are a result of unequal distribution of power and wealth between Indigenous and non-Indigenous communities (Jamieson, Gibson, & Thomson, 2020). Neoliberalism exceeds unjust power differences and incentivises power over others, while actively seeking to marginalise epistemologies outside of the hegemonic neoliberal discourse (Benatar et al., 2018). Rightly so, tackling power in-differences has been identified as a necessary priority for public health (Hastings, 2012), and this sentiment has been echoed by Jamieson and colleagues in the context of global Indigenous oral health (Jamieson, Gibson, & Thomson, 2020). The historic use of inequitable practices and negative stereotypes of Indigenous peoples in Australia have justified acts of injustice and avoided challenging dominant discourse (Aileen

Moreton-Robinson, 2005; Proudfoot & Habibis, 2013). Colonisation and assimilation have restricted the sense of control over one's life for many Indigenous peoples; the promotion of individualism and neoliberal ideology blames individuals for their circumstances, largely ignoring the immense influence of these historical and political circumstances on Indigenous health and wellbeing (Jamieson, Hedges, et al., 2020; Peacock et al., 2014). While not a direct finding from this work, sentiments of historic trauma were alluded to in some of the discussions of institutional racism. Both historic trauma and institutional racism directly relate to non-Indigenous power over Indigenous peoples, and current neoliberal practises enable the continuation of these oppressive circumstances. Failing to recognise and challenge discriminatory practices against Indigenous families and communities sustains the power relations that maintain Indigenous oral health inequities (Johnstone & Kanitsaki, 2009).

4.2. Moving beyond the paradox of ‘personal responsibility’

Neoliberal policies have impaired the lives of a large majority of Indigenous peoples to an increasingly intolerable extent (Rowden, 2009). Berlin anticipated the dangers of neoliberalism, “Complete liberty is not compatible with complete equality – if men were wholly free, the wolves would be free to eat the sheep” (Berlin, 2014). The assumption of neoliberalism that Indigenous oral health is due to personal failures is contradicted by the findings of this paper, which suggest that the experience of the neoliberal subject exacerbates oral health concerns for Indigenous peoples in Australia. The neoliberal development model persists as the ‘norm’ in public policy both in terms of progress measures and as a pre-requisite for future success (Benatar et al., 2018). Indigenous acknowledgement and critique of neoliberal tenets challenges expectations of the neoliberal state and generates needed discussion of the vast costs associated with championed ‘benefits’ of neoliberalism (Howard-Wagner et al., 2018). Incorporation of voices from other marginalised communities, with similar experiences of power differences and oppressive circumstances, would further contribute to the development of an understanding of the many pathways through which neoliberalism maintains oral health inequities. Neoliberal ideologies require buy-in of individualism to thrive. Without autonomous, isolated, and competitive individuals, markets would no longer be seen as the solution to societal problems and the demand for social welfare safety nets would increase (Rasooly et al., 2020; Sweet, 2018).

Suggestion on how to change the neoliberal model and societal discourse include the development of an ethical political ideology and framework which respects human rights, values social justice, and promotes social democracy; there remains significant work to be done on this front (Benatar et al., 2018). Participants from the study in Tasmania identified a vision where the ills of white values and neoliberal discourse were rebalanced by incorporating Indigenous values of support and connection to country (Habibis et al., 2020). As academics, researchers, policy makers, and actors in the maintenance of neoliberal ideologies, changes can be made to push society into an equitable and just future. All considerations of social inequities, particularly in relation to Indigenous health, must not only take into account the inherent relation between the neoliberal political economy and health outcomes, but also explicitly explore the pathways of neoliberal influence on the reported health inequity. We must move beyond the inevitability of current neoliberal and deficit discourses and develop a more nuanced understanding of the real world implications of neoliberalism on health inequities (Jamieson et al., 2020b, 2021b; Sweet, 2018). Privileging Indigenous understandings and critiques of neoliberalism and its impacts on well-being is the first step in challenging the acceptability of the complex social context Indigenous peoples navigate their health (Durey et al., 2017). Considering Indigenous experiences as neoliberal subjects provides a unique perspective, from the periphery of dominant culture, and helps shift the perspective and perceptions of individuals and systems completely embedded in neoliberalism's hegemony (Kowal, 2015).

4.3. Strengths & limitations

This paper adds to the limited qualitative research explicitly linking neoliberalism with oral health outcomes. The findings provide insights into the internalisation of neoliberal ideologies and the impact of these experiences on Indigenous oral health in South Australia. Health systems and services have historically excluded Indigenous voices despite their direct relationship with Indigenous health outcomes, highlighting Indigenous experiences in this paper provides the opportunity to critique neoliberalism from the periphery of hegemonic discourse. A strength of this paper is its Indigenous leadership in conducting MI, a conversational methodology that respects Indigenous traditions of yarning and works to decrease power dynamics between researchers and participants. While MI was effective in generating conversations and improving oral health knowledge among participants in this study, it is a resource intensive method that requires trusting, reciprocal relationships to be effective. A limitation of this paper is that participant characteristics and the majority of interviews represent maternal experiences, rather than the entire family, due to recruitment occurring during pregnancy. Future projects should prioritise paternal participation and engage the whole family, in line with Indigenous collectivist values. Additionally, neoliberalism or personal responsibility was not the focus of the interviews conducted in this study, more conclusive evidence could be garnered by explicitly discussing these topics with Indigenous families. Finally, other marginalised communities should be considered in future works to determine how internalisation of neoliberalism varies across disadvantaged communities with similar experiences of poor health to provide the most comprehensive recommendations for oral health practitioners, policy-makers, and services.

5. Conclusion

The embodiment of neoliberalism, expressed as ownership, guilt, judgment, failure, shame, and embarrassment, highlights influences on Indigenous oral health beyond biomedical understandings of oral disease. Exploring neoliberal subjectivity at the individual level provides an opportunity to move beyond deficit discourses focused on personal responsibility and stresses the need to consider structural impacts on Indigenous oral health inequities. The pathway to oral health equity must involve prioritising strategies that re-structure dominant neoliberal ideologies so that Indigenous peoples are no longer forced into resiliency by neoliberal systems that amplify poor oral health patterns. We recommend that specific funding be allocated to ACCHS in South Australia to enable the provision of dental care and decrease Indigenous reliance on mainstream services that pose additional challenges to the establishment and maintenance of oral health. Indigenous leadership must be prioritised in this process to ensure funding meets the needs of services. Additionally, we urge all health researchers, particularly those exploring experiences of disadvantaged health, to consider the influence of socio-political influences as standard practice. Any research failing to consider factors such as neoliberal ideologies will only tell half of the story, without a more comprehensive understanding of circumstances, health inequities will persist. Government, policy makers, health services, and researchers must continually examine their role in maintaining Indigenous oral health inequities and work in partnership with Indigenous communities to address the shortcomings of the neoliberal model, identify ways to challenge existing norms, and demand action that prioritises health equity.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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