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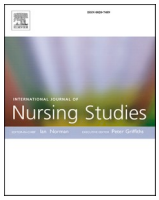

Truth-telling is required for health equity for Aboriginal peoples: A qualitative study

Ieta D'Costa [a,*], Lynette Russell [b], Karen Adams [a]

[a] School of Medicine, Nursing and Health Science, Monash University, Clayton, Melbourne, VIC 3800, Australia
[b] Monash Indigenous Studies Centre, School of Philosophical, Historical, and International Studies, Monash University, Clayton, Melbourne, VIC 3800, Australia

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ABSTRACT

Background: The World Health Assembly has called for a Global Action Plan to address health inequities imposed upon Indigenous peoples. In seeking equity, Aboriginal peoples and allies have called for truth-telling about colonisation and its relation to healthcare. Australian healthcare, largely based on the biomedical model, is inadequate in terms of design, delivery, and access for Aboriginal peoples. Healthcare employees are known to contribute to health inequities.
Purpose: This study explores non-Indigenous healthcare employee perceptions and experiences of engaging with Aboriginal peoples.
Methods: Forty-nine health professionals from an Australian hospital participated in qualitative interviews. Interviews were audio-recorded, and data analysed with reflexive thematic analysis. Interviewees volunteered for the study and were first recruited in January 2020. The study is not registered.
Results: Four themes were identified, including perceptions of: colonisation, Aboriginal peoples and knowledges, racism toward Aboriginal people, and healthcare inequities imposed upon Aboriginal people. Many participants were oblivious to how colonisation and racism create present healthcare inequities. This limited understanding was a consequence of feelings of distress and subsequent disengagement with the history of colonisation.
Conclusions: Healthcare education requires better truth-telling methods to achieve health equity. We suggest trials of collaborative modes of education from arts and humanities that simultaneously recognise continuing colonial ideology and promote antiracism. Crucially, as the World Health Assembly notes, from design to implementation, these strategies must foreground and involve Aboriginal peoples, and deeper understanding of what it is to be an Indigenous ally.

What is already known

- Healthcare systems struggle to provide equitable access and delivery of service for Indigenous peoples worldwide and racism plays a significant role.
- Healthcare employee bias and poor understanding of racism contribute to health inequity.

What this paper adds

- Our findings highlight the lack of understanding amongst Australian healthcare workers of the relationship between present day health inequities and colonisation.
- Feelings of distress at the atrocities committed often led to disengagement with colonial history and a 'will-to-forget'.
- We suggest implementing better truth-telling methods into healthcare training and trials of collaborative modes of education from arts and humanities.

1. Introduction

The World Health Assembly has called for a comprehensive Global Action Plan to urgently address the significant health inequities imposed upon the world's Indigenous peoples (World Health Organisation, 2023). Poor healthcare provision for Indigenous peoples contributes significantly to this inequity (Silburn et al., 2016). Nurses have an

* Corresponding author.
E-mail address: Ieta.Dcosta@monash.edu (I. D'Costa).

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important role in improving this situation, comprising a majority (59 %) of the healthcare workforce and making 'a central contribution to national and global targets related to a range of health priorities' (World Health Organisation, 2020) p xii. Further, the nursing profession aspires to advocate for better equity in healthcare and take responsibility to challenge their own assumptions and biases (International Council of Nurses, 2023). However, nurses and other healthcare colleagues often work within healthcare services where these aspirations face significant challenges.

For many Indigenous peoples, colonisation processes largely ignored and undermined Indigenous healthcare systems (Secretariat of the Permanent Forum on Indigenous Issues, 2009). Colonists instead imposed healthcare models that traditionally excluded Indigenous peoples (Anderson, 2002) and were not designed for Indigenous peoples' needs (Refshauge, 1997). The biomedical model often applied in Australian healthcare is largely incompatible with Indigenous understandings of health and wellbeing (Anderson, 1995). Additionally, healthcare employee bias and poor cognisance of racism further impacts health equity (Grant and Guerin, 2018; Shaburdin et al., 2022) and delivery (Gilroy et al., 2024) for Indigenous peoples. It is within this challenging context that nurses and other healthcare employees seek to promote equity.

1.1. Settler colonisation

Settler colonisation is a process where settlers seek to replace Indigenous peoples' lives and livelihoods with settler societies (Wolfe, 2016). Australia was colonised by the British on the claim that the land was *terra nullius*, or empty of people, thus allowing colonists access to the resource of Aboriginal lands (Moreton-Robinson, 2015). Frontier wars raged with both settler and Aboriginal deaths, although estimates indicate far greater Aboriginal casualties (Evans, and Ørsted-Jensen, 2014). With little to no humanitarian protection, many Aboriginal peoples were systematically dispossessed, massacred or removed to missions and cattle stations, working as indentured labourers (Moreton-Robinson, 2015). Others were stolen from their families and placed within white families or white-run institutions for the purposes of assimilation (Watson, 2017; Moreton-Robinson, 2015). Researchers have also asserted that some Aboriginal people tolerated coexistence, albeit an asymmetrical one with pastoral managers, as being on country allowed preservation of cultural practices on ancestral lands (McGrath, 1987).

Tuck and Yang note that 'everything within a settler colonial society strains to destroy or assimilate the Native in order to disappear them from the land' (Tuck and Yang, 2012) p 9. The fact that settlers directly and indirectly benefit from 'the erasure and assimilation of Indigenous peoples is a difficult reality for settlers to accept' (Tuck and Yang, 2012) p 9. Australian settlers may express a sense of deep personal belonging to the land, but there is often the underlying guilt of the colonial processes that produce 'racialized structural power relations' (Moreton-Robinson, 2015) p 7.The unearned benefit to settlers is essentially a result of the historical racist foundation of Australia, whereby 'whiteness confers certain privileges to those whose skin colour represents sameness' (Moreton-Robinson, 2015) p 9.

1.2. Health impacts of colonisation

Historically, settler doctors and scientists advised politicians and the public on matters of health, with most assuming that these standards applied only to white people (Anderson, 2002). Meanwhile, Aboriginal peoples were erroneously considered incapable of being healthy: until the 1880's Aboriginal people 'were ignored completely in medical texts' and considered a dying people (Anderson, 2002) p 28. Well into the 1900's, 'segregation and medical policing' of Aboriginal peoples 'to protect vulnerable whites (from)… seeds of laziness or supposed infectious diseases as hookworm' was the norm (Anderson, 2002) p 222. While some doctors and educators denounced such policies, the incorporation of scientific racism into healthcare was widespread (Anderson, 2002; Lupu and Ryan, 2022) Although many in healthcare now accept that the concept of race is fallacious and unethical, the idea that race determines social rank and some medical conditions persists (Blakey, 2020).[1] Indigenous scholars maintain that colonial ideas of the past continue in altered forms informed by the ideology of racism (Moreton-Robinson, 2015).

Such colonial ideas are evident in Aboriginal patients' and non-Aboriginal healthcare employees' incongruent descriptions of racism in healthcare. Aboriginal patients frequently describe experiencing racism in healthcare, with one study finding that 93 % of Aboriginal participants reported such incidents (Ziersch et al., 2011). This is concerning as such experiences of racism are associated with high psychological distress (Ziersch et al., 2011; Kelaher et al., 2014) and poorer physical and mental health (Thurber et al., 2021). However, healthcare employees often believe that their workplaces are racism-free, even when they acknowledge that racism is detrimental to health (D'Costa et al., 2023, Clark-Hitt et al., 2010, Grant and Guerin, 2018). Additionally, employees may assert that health inequities belong to individuals (Fogarty et al., 2018) rather than the socio-historic-political contexts that people live in (D'Costa et al., 2023, Paradies et al., 2015). It is likely that poor understanding of racism and settler colonisation processes contribute to these beliefs (D'Costa et al., 2023, Grant and Guerin, 2018, Rix et al., 2013). The current study builds on an earlier quantitative report on the confirmation of hospital employee bias against Aboriginal peoples (D'Costa et al., 2022) and employee perceptions of racism (D'Costa et al., 2023). Here, we further explore hospital employee understandings of and experiences with Aboriginal peoples to better understand these issues.

2. Theoretical framework

Relevant to this study is postcolonial theory, which recognises that colonisation and racism cause significant power imbalances between settlers and Indigenous peoples (Gandhi, 1998). The theory investigates normalised and dominant colonial epistemologies and has a focus 'that recognises, refuses, or replaces…colonial firms of thinking and bodies of knowledge' (Watson and Wildre, 2018) p 3. The theory scrutinises a violent and painful colonial history and how it impacts the present, acknowledging that for many in colonised countries there is a 'will-to-forget…impelled by…the urge for historical self-invention' (Gandhi, 1998) p 4.

Settler arrival narratives, for instance, often reiterate a 'need to make a new start' (Gandhi, 1998) p 5, absenting the violence inflicted on Aboriginal peoples with a 'wilful forgetting of the nature of that arrival-of colonial conquest and racism' (Moreton-Robinson, 2015) p 10. However, Aboriginal peoples' 'ontological relation to land cannot be shared' (Moreton-Robinson, 2015) p 11. Therefore, an inherent tension exists in the self-legitimised, violent and racist claim of British settler sovereignty of Australia and the embodied, ontological relationship that Aboriginal peoples have with Australia. Essentially, this tension is kept away from settler consciousness for many by 'forgetting of the nature of …colonial conquest and racism' p 10, while conquest and racism remains an everyday fact of life for Aboriginal peoples (Moreton-Robinson, 2015).

[1] Examples are the tendency to associate African-Americans with hypertension, rather than examine social and environmental factors (Blakey), or documented poorer pain management as a result of racial profiling (Hoffman et al., 2016).

3. Methods

3.1. Study context

This paper reports on the findings of qualitative study completed as part of a larger project. Briefly, the first phase of the project quantified hospital employees' implicit racial bias toward Aboriginal people, finding bias an issue (D'Costa et al., 2022).

The next phase was a qualitative study aiming to further understand employees perceptions and experiences of racism and working with Indigenous people.

The qualitative data and analysis were large, complex and involved and this produced two publications. The first publication focused on race and racism (D'Costa et al., 2023) while this article concentrates on hospital employees' understandings about, and experiences with Aboriginal peoples.

The study took place on the lands of the Kulin nation which is comprised of five language groups of the Aboriginal peoples in the south and central state of Victoria, Australia (Koorie Heritage Trust, 2024). Ethics approval was obtained from Monash University Human Research Ethics Committee Project ID 22230. The Human Research Ethics and Governance Manager at the hospital was consulted, and letters of agreement were obtained from the Chief Medical and Nursing Officers at the hospital.

3.2. Participant recruitment

Detailed description of participant recruitment has been previously reported (D'Costa et al., 2022). Briefly, all 2871 hospital employees were invited via email to participate in an Aboriginal Australian race-based Implicit Association Test. As all staff contribute to the culture of an organisation and care of patients, all staff were invited to participate to capture the perceptions of a diverse range of healthcare employees.

The 538 employees who completed the Implicit Association test had the option to leave contact details for a follow-up interview, forming the qualitative data for this research. Forty-nine non-Indigenous participants consented to an audio-recorded interview.

3.3. Participants

Details of age and gender of the 49 participants are in Table 1. Professions included nurses, allied health therapists, doctors, physicists, researchers, radiation therapists and administrative staff. Further details of diversity and employment are not specified due to confidentiality concerns. In keeping with postcolonial theory, we allocated letters of the alphabet to refer to each participant rather than anglicised or ethnically derived pseudonyms.

3.4. Data collection

Semi-structured interviews were conducted in March 2020 in private rooms within the hospital. Author one conducted all interviews and in the course of interview participants made it clear that they were not Aboriginal people.

Table 1
Demographic participant data: age and gender.

Characteristics	Total (n = 49)
Gender	
Female	33
Male	16
Age	
<30	8
31–45	27
46–60	10
>60	4

Pertaining to this report, each participant was asked these questions, after which conversation was free ranging:

1. What do you know of Indigenous Australians and where did this knowledge come from?

2. Have you had any interactions with Indigenous people in the course of your work?

If so, what was that experience like?

3. How have those experiences affected you?

Interview times ranged from 14 to 40 min, with an average time of 25 min. Verbatim transcriptions were sent to participants for further comments or changes. Several participants clarified their responses in the returned transcripts.

3.5. Data analysis

Data were analysed via the reflexive thematic approach described by Braun et al. (2019) who list the six phases as: familiarisation with data, coding, generating initial themes, reviewing themes, defining and naming themes, and writing (Braun et al., 2019). Researchers make active choices in generating and interpreting codes and themes from interview data (Braun et al., 2019). Therefore, it is essential to note that author one was a health employee of Indian ethnicity, and authors two and three are Aboriginal people. Author two has an academic position in anthropology and history, and author three has an academic role in the Faculty of Medicine, Nursing, and Allied Health, with a background in nursing.

All transcripts were read and reviewed by the interviewer with notes on impressions. Authors one and three read and coded transcripts independently, followed by group discussions with all authors to achieve consensus. New codes were not generated after 20 of the 49 transcripts were reviewed. Coded data were entered into NVivo release R·1 version 1·6. Codes were reassessed over several weeks and finalised. Sub-themes and themes were reviewed to ensure that the underlying concepts and stated beliefs in the transcripts were captured as we saw them. In identifying codes and themes, author one's agreement with participant statements was sometimes challenged; for example, her occasional use of deficit discourse thinking in not noting the socio-political-historic causes of inequitable morbidity imposed upon Aboriginal peoples. The codes, sub-themes and themes are summarised in Table 2.

4. Results

Analysis of interview data identified four main themes (see Table 2).

1. *Perceptions of colonisation: 'Trying to not think of that' (Participant S)*

Table 2
Themes and subthemes.

Themes	Sub-themes
Perceptions of colonisation	Poor literacy about continuing colonisation
	Discomfort with colonisation
	Paucity of formal education on colonisation
	Lack of recognition of colonisation
Aboriginal peoples and knowledges	Diverse understandings of Aboriginal peoples and knowledges
	Varied school curricula and education
	Heterogeneity or homogenised
Racism toward Aboriginal peoples	Witnessing and participation
	Drivers of racism
	Strategies to ameliorate racism
Healthcare inequities imposed upon Aboriginal peoples	Drivers and barriers of healthcare inequities
	Amelioration of healthcare inequities
	Discomfort ascertaining Aboriginal status
	Poor understanding of equity

Participants commonly described colonisation as involving past devastation and atrocities. For example, 'I know that due to the colonisation of Australia … there's been a long-lasting effect on Aboriginal wellbeing across all parts of life.' (Participant Qq). Participants also struggled to outline the continuing nature of colonisation. For instance, 'in some senses, [colonisation] continues to today… it is more enlightened. Stolen generation type activities stopped some time ago'. (Participant C).

Participants expressed discomfort and an avoidance of thinking about the violence of colonisation. Instead, some people preferred to engage with Aboriginal knowledges which gave them comfort:

> The … genocides, taking children away, all that sort of historical stuff…I'm actively trying…to not think of that…trying to move past that and see Indigenous people in a more positive light. I've read… Dark Emu and learning more about the nice history- the agricultural and cultural background. (Participant S).

Participants' struggle to engage with understandings of colonisation likely related (in part) to a paucity of formal education about colonisation. For example, 'I went to primary and High school…But we didn't learn about what happened with genocide, White Australia policy and things like that.' (Participant R) Some thought that schooling had 'changed significantly' (Participant E) for younger people they knew. However, others disagreed, for example Participant Nn, considered;

> These things don't get studied in schools…women being raped, … it's 'let's not talk about it, it was a bad thing, we are not like that anymore. Let's move on'.

Some participants believed understanding and recognition of colonisation was lacking. For instance, there is 'still no adequate apology or recognition of horrors done' (Participant Ee). Others identified barriers to truth-telling about colonisation, for instance:

> It means recognising the genocide and horrific acts of the past. I believe it's hard for people to reconcile this because they may view Australia as the lucky country… Indigenous Australian are not appropriately given a voice in this country and it allows their needs and right to be forgotten and pushed aside for the benefit of the majority. (Participant Vv).

Overall, participants had varied understandings of colonisation and sometimes expressed discomfort and avoidance with a violent history. Participants also thought greater education and recognition of colonisation was needed.

2. *Aboriginal peoples and knowledges: 'Oldest living culture' Participant Q*

Participants broadly described Aboriginal peoples as having ancient and continuing knowledges, referring to one of the 'oldest living cultures in the world' (Participant Q) However, some thought sophistication of Aboriginal knowledges and peoples was largely ignored and superficially commercialised by mainstream Australia:

> The portrayal of Indigenous Australians …was marketed…like something in a…gift shop, rather than this living thriving thing. (Participant Bb).

Varied school curricula experiences impacted participant understandings. For instance, at some schools, Aboriginal Elders in the community led this education with 'cultural spaces set aside to learn, understand, and practice the local culture.' (Participant T) Others had little history of Aboriginal peoples' relationships with settlers in school; 'We learn a very white Australia.' (Participant R).

Some participants recognised heterogeneity of Aboriginal knowledge and peoples: 'When we use the term Indigenous Australians, we are homogenising a very diverse group of people.' (Participant A) Conversely, others homogenised and stereotyped:

> I know about the cultures, the Dreamtime, the religion, the diet of the Indigenous person, the multifaceted aspects to their societies, their family structures, so their Aunties and Uncles and Cousins and the way that their communities are structured.
>
> (Participant Ii)

In summary, participants were aware that Aboriginal peoples are described as having one of the world's oldest continuing cultures. Some also noted a tendency for expropriation and commercialisation of Aboriginal culture and knowledge by the wider Australian community. There were varied understandings of Aboriginal diversity.

3. *Racism toward Aboriginal people: 'We settlers [need] to get over biases' (Participant Ww)*

Some participants described witnessing or participating in racism toward Aboriginal peoples. For instance, 'Aboriginal people were people to fear… they would take your land', (Participant Aa) and thinking such as 'all these [negative] things happening is their fault' (Participant N). One participant noted systemic racism in their school whereby Aboriginal children's needs were not met ending in punishment, for example, 'being constantly sent out of class for misbehaving' (Participant Qq).

Participants also posed ideas about drivers of racism. Some thought a deficit discourse in media promoted Aboriginal stereotypes; 'images of Indigenous people [with]…negative characteristics such as poverty, violence, drug addiction.' (Participant C). Others thought colonial superiority drove racism; 'Indigenous populations were being judged according to how they lived relative to the conventional way that European white settler/descendants were living.' (Participant Z) Another participant thought that guilt and shame of colonisation drove racism:

> I feel like it is easier to be… racist toward Indigenous people than to acknowledge the role that you or your ancestors may have played in creating problems and try to start doing stuff to address really complex issues.
>
> (Participant E)

Others speculated that fear of loss drove racism. For instance, 'fear of the unknown…or of threats [to] my way of life' (Participant Tt) and 'we through our nature, have an us and them mentality, having finite resources.' (Participant Ss) Participant Ww described complex tensions surrounding loss and ownership:

> We are meant to balance this complete opposite view of who is ... number one- 'they were here first…we should honour them, it's their land', but also 'it's my land too: I have lived here my entire life, and generations…

Participants also suggested strategies to ameliorate racism. Some thought education key 'through uni…there was an emphasis on self-education and identifying your privilege' (Participant Aa). Similarly, Participant Ww thought 'We settlers [need] to get over biases which were put in'. Participant C thought people needed 'to think about why' Aboriginal peoples experience inequity but conceded lack of a 'culture of thoughtfulness' and 'preoccupations with own hardships' could make this difficult. Some acknowledged that some people would find a viewpoint change challenging:

> They section off [into] us and them. And race is an easy way to do that, … but actually acknowledging Indigenous culture … requires a different view of ourselves, of the colonisation, [that] does not make us feel good. (Participant Cc).

In summary, participants saw various drivers of racism and suggested strategies to ameliorate racism toward Aboriginal peoples. However, participants also acknowledged complex challenges based on fear of loss of identity and property, sometimes leading to a deliberate choice to avoid confronting Australia's colonial history.

4. *Healthcare inequities imposed upon Aboriginal people: 'white institutions'*

Participants were very aware of the health inequities imposed upon Aboriginal peoples. For example, Participant B stated, 'it's very clear… the …difference in health'. There was understanding that causes of healthcare inequity were complex and multifactorial with Aboriginal peoples likely to 'have a lot of trouble accessing and getting care that you and I get in the city. Even if they live in the city'. (Participant Y) Participant G commented that 'environmental health and housing issues is probably harder for some Indigenous communities…in remote communities…there was [often] lack of access to fresh fruit and veggies.'

Participants acknowledged that there were systemic issues. However, rather than identifying that health issues are caused by systems of unearned privilege and disadvantage, participants expressed health issues as belonging to Indigenous peoples:

> The health system we have is not set up appropriately to deal … with Indigenous health issues. (Participant X).

Participants often provided reflections on why they thought that the healthcare system provided inequities. For instance, some thought that healthcare was established to meet the needs of a majority population, 'our health system is built around … stereotypical … white patients living in a city.' (Participant B) A further participant noted that Australian hospitals:

> are white institutions… hierarchical, led predominantly by white males, these dynamics are challenging…for me, as a person of colour and, I think, for Indigenous people…there's an underlying feeling… you are in the other category. (Participant Uu).

Participant Mm experienced Aboriginal people explaining to them that metropolitan hospital environments were often 'intimidating and devaluing…that there is no spiritual connection there [in hospitals]'. Others, in considering why more Aboriginal peoples did not attend mainstream healthcare, speculated as to possible reasons such as, 'a lack of trust,' (Participant Ee), 'fear' (Participant O) and feeling 'unsafe among a group of people who see them as different and less worthy.' (Participant P) Some participants questioned their colleagues' ability to provide culturally safe care:

> There was a grandmother caring for her grandchildren. She had been a child of the stolen generation… authorities who said 'trust us' and then removed children, now- we want them to trust us…and get upset when they don't. (Participant Cc).

Other participants thought that they did not see Aboriginal patients because they were being referred to other services; 'other facilities [being] more accessible in rural or metropolitan areas'. (Participant O) Participant Ll speculated that some Aboriginal people may prefer to 'deal with things in their own community' even though Aboriginal Community Controlled Health Organisations do not provide tertiary care.

Participants also had opinions on how healthcare inequities could be ameliorated. Participant Pp described working in a hospital with 'better awareness of the challenges the health service presents for some Indigenous people'. Some participants stressed the importance of Aboriginal Hospital Liaison Officers; 'being aware we have a specific Aboriginal health worker, that helped me.' (Participant V) Participant Vv noted the importance of 'employee training and ongoing upskilling.' Others considered flexibility to be important, for example 'patients would turn up when they like, but they would turn up.' (Participant Ii) Other participants thought that lack of time was a barrier, 'busy-ness of the wards and clinics, sometimes being short staffed [so] you don't get a chance to think of holistic care for each patient.' (Participant Hh).

Participants also discussed the importance of ascertaining Aboriginal status. Some participants considered that non-Aboriginal people may have preconceived ideas of Aboriginality, as Participant P said, 'we have got people who tend to dismiss peoples' Aboriginality if they don't look like a "typical dark skinned Aboriginal person"'. Consequently, the continual need to explain or educate non-Aboriginal people about Aboriginal status falls to Aboriginal people who at often vulnerable times of presentation to a health service may not want to identify as Aboriginal.

Some participants felt uncomfortable determining Aboriginal status as they assumed Aboriginal patients would react negatively.

> When there is inequality, making a statement of identity is probably important… with a goal of ultimately improving status. But I think it is fair to resent the need to have to do this. I think I would if I were an Aboriginal person. (Participant J).

Some participants struggled with tensions between equality (everyone gets the same resources) and equity (everyone gets the same outcome). For instance, despite poorer access and outcomes to cancer care for Aboriginal people, equity was sometimes questioned:

> There's an underlying…resentful attitude… that 'we have to give them what they want'… for example… We've had a few Aboriginal patients that got transport … [and not] other patients who are not Aboriginal. (Participant Ww).

In summary, there was understanding of the major health inequities that the health system imposes upon Aboriginal peoples. Participants acknowledged the importance of flexibility, adequate time, and Aboriginal Hospital Liaison Officers. Participants also noted barriers such as healthcare privileging white middle-class male needs. Additional barriers included healthcare employee fears of causing offence to Aboriginal peoples, and inadequate understanding of health equity.

5. Discussion

This study aimed to better describe hospital employees' understanding of and experiences with Aboriginal peoples. We identified four themes, including perceptions of: colonisation; Aboriginal peoples and knowledges; racism toward Aboriginal peoples' and; healthcare inequities imposed upon Aboriginal peoples. The present study adds significantly to what is known about healthcare worker perceptions of working with Indigenous peoples. Firstly, this is the only Australian study that includes a diverse and holistic representation of employees from across one hospital. In comparison, other studies looking at employee experiences with Indigenous peoples have focussed on one or two professions (Grant and Guerin, 2018; Manhire-Heath et al., 2019). This work builds on the findings of Shaburdin et al. (2022)[2] who noted that some health workers problematised the culture of First Nations, migrants and refugees rather than health inequity. Thus, this study investigates to a degree, a microcosm of society, and therefore the systemic issues within a hospital and society, rather than individual professional perspective. Secondly, participants resoundingly described colonisation processes while similar studies have not focussed on this issue. The descriptions included: some understanding of colonial processes; unknowingly describing perpetuation of colonial processes and/

[2] For this study, 21 healthcare workers (predominantly white staff) were interviewed from two rural services in Victoria, Australia. In discussing views on the challenges of inclusivity for First Nations, immigrants and refugees in rural mainstream services, cultural difference was cited as problematic.

or; absenting or misunderstanding colonial processes in healthcare. The findings of this study as well as our work on racial bias (D'Costa et al., 2022) and the ideology of racism (D'Costa et al., 2023) is informed by postcolonial theory, which recognises that power imbalances arising from European colonisation are built upon ideologies of racism, whiteness and the will-to-forget (Gandhi, 1998; Moreton-Robinson, 2015). We suggest that the lack of understanding about colonisation processes and present day impacts most likely contribute to racism and detrimentally impacts the health of Aboriginal peoples.

Postcolonial theory offers a potential explanation as to why participants do not engage with the full history of colonisation. Tuck and Yang (2012) note that a sense of guilt often leads to 'moves to settler innocence' (p 10) where settlers attempt to relieve guilt without giving up land, privilege or power. Settler guilt related to health inequities imposed upon Aboriginal peoples and their impacts points to 'the racialised structural power relations' in Australia (Moreton-Robinson, 2015) p.7. Therefore, anti-racist education of itself cannot ameliorate health inequities. Structural reform is required so that Aboriginal peoples have the power to make decisions and deliver healthcare that meets Aboriginal needs. Indeed, multiple reports, inquiries (Anderson and Leibler, 2017; Wilson, 1997; Royal Commission on Aboriginal Deaths in Custody, 1998), and Aboriginal peoples' recommendations (Taylor and Habibis, 2020; Shahid et al., 2009), call for reforms, and identify truth-telling as a critical component to improve healthcare equity. The current findings add to the calls for truth-telling and a deeper, shared understanding of Australian history amongst nursing, medical, Allied health and healthcare administrator employees. The findings reinforce that a whole of workforce approach to truth-telling is needed.

Truth-telling is what Aboriginal peoples and non-Aboriginal Australian allies refer to in acknowledging the fact that Aboriginal Law 'was violated by the coming of the British to Australia (Anderson and Leibler, 2017) p.15. In truth-telling, the 'true history of colonisation must be told: the genocides, the massacres, the wars and the ongoing injustices and discrimination' (Anderson and Leibler, 2017) p 32. Of note, in Australia, the Nursing Council made an apology for its role in colonisation but clearly, the broader workforce does not understand past and current roles of healthcare employees in sustaining colonial processes. However, nurses, and all healthcare staff work within a social context, and we are part of a workforce which lacks understanding of colonisation and current inequity. Truth-telling in the health sector involves understanding that the Australian health system was founded for and by settlers based on racist ideology which have imposed the health inequities referred to above (Anderson, 2002). The cumulative intergenerational trauma due to colonial violence 'which are the lived experiences of Indigenous Australians is further compounded by the lack of recognition of this trauma by mainstream Australia' (Payne and Norman, 2024) p 11.

Australia has a poor history with truth-telling about the colonial past. Many countries who have experienced colonisation have had truth telling, including South Africa (Truth and Reconciliation Commission, 2006) and Canada (Truth and Reconciliation Commission of Canada, 2015). To date, there has been no formal national truth-telling in Australia. A national referendum in 2023 rejected an Indigenous Voice to advise the Commonwealth Government on Truth and Treaty. Of the eight Australian States and Territories only one has undergone a truth telling process. The State of Victoria's Yoorrook Justice Commission noted that injustice experienced by Aboriginal peoples 'impacts the health of First Peoples and their communities' (Yoorrook Justice Commission, 2022) p 43. However, in the State of Queensland, truth telling began but was ceased with a change of Government, giving a clear message that truth-telling about a violent and difficult past to create healing and a shared understanding is not wanted. Healthcare workers exist in this context and in a society which majoratively celebrates the onset of colonisation and has many memorials to colonisation including names of healthcare institutions.

Hospital employees work and live in societies where racism is entrenched. The Western biomedical practice and research models have measured, documented and focused on health inequity to the exclusion of the cause: the ideology of racism instituted with colonisation. Furthermore, the nature and cause of health inequity has always been clear to the Aboriginal people who experience it. Seeking remedies to inequity using measures within inequitable systems is a fraught matter. As Audre Lorde stated, "The Masters tools will never dismantle the masters house" (Lorde, 2012). In keeping with this notion and given that current healthcare strategies are not promoting truth-telling, we suggest introducing perspectives beyond the healthcare sector. Payne and Norman (2024) outlined the following specific Indigenous methods: yarning,[3] storytelling,[4] place-based learning,[5] and traditional justice approaches.[6]

There is an urgent need to review the strategies used to ameliorate inequity in health and other domains of life. One way forward is a new field of research entitled Indigenous Health Humanities. This is being set up by a multidisciplinary group of Aboriginal and non-Aboriginal people to 'redefine the parameters by which we understand health and humanity via a foregrounding of Indigenous sovereignty, both locally and globally' (Watego et al., 2021) p 2. Acknowledging the existing health inequity between Aboriginal and non- Aboriginal Australians, their approach is one based on the strength and resilience of Indigenous peoples and knowledges which are 'foundational for knowing, not just an ancient past, but a possible future' (Watego et al., 2021) p 4. Also, it may be that incorporating methods from the social sciences and arts sectors may better enable truth-telling to further health equity. In *Memory and Place*, authors speak of the power of 'taking leave of the usual houses of history- archives, books, universities- and rethinking where it is that histories are told and commemorative practices performed, and by whom' (Dalley and Barnwell, 2023) p 2. This may entail forms of local and regional yarning for example, on specific historical or cultural sites for Aboriginal peoples, or commemorative practices within healthcare institutions. Crucially, from design to implementation, strategies to improve equity must foreground and involve Aboriginal peoples and knowledges (World Health Organisation, 2023; Watego et al., 2021), together with a deeper understanding of what it is to be an Indigenous ally (Research for Development Impact Network, 2021).

6. Limitations

This study involved participants from a single Australian hospital rather than a range of health services. Additionally, as participants self-selected into the study it is likely many had an interest in Indigenous health inequity or social justice. This means that the study may have excluded employee perspectives from those with little or no interest in Indigenous health inequity. Participant ethnicity and cultural data were not documented to protect confidentiality. These limitations and reflections should be considered when interpreting findings.

7. Conclusion

Participants are aware that health inequity is significant for Aboriginal peoples. Despite this unambiguous knowledge being available for several decades, there remains incomplete comprehension of the central roles of colonisation and racism in the generation and maintenance of health inequity. Truth-telling should be incorporated into antiracism strategies to address part of this knowledge gap. The

[3] Described as a conversational, deep listening in a culturally safe place based on respectful relationships between Aboriginal and non-Aboriginal people in this instance.

[4] Indigenous story telling is more a form testimony, of 'creative rebellion'.

[5] Learnings from immersion in culture and Country, within sites of historical importance for example.

[6] The use of local, culturally specific truth-telling practices.

emotional distress and sometimes, denial, experienced by some healthcare staff could hinder meaningful remedial action. Therefore, we suggest trials of collaborative modes of education from arts and humanities foregrounding Aboriginal peoples that simultaneously recognise continuing colonial ideology, promote antiracism and functional Indigenous allyship to improve health equity.

CRediT authorship contribution statement

Ieta D'Costa: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Conceptualization. **Lynette Russell:** Writing – review & editing, Supervision, Methodology, Formal analysis. **Karen Adams:** Writing – review & editing, Supervision, Methodology, Formal analysis, Conceptualization.

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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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Data availability

Interview data is held in the Monash University Lab Archives for five years. It is not publicly available to protect participant confidentiality.

References

Anderson, I., 1995. Bodies, disease and the problem of Foucault. Social Analysis: The International Journal of Social and Cultural Practice 37, 67–81.
Anderson, W., 2002. The Cultivation of Whiteness: Science, Health and Racial Destiny in Australia. Melbourne University Press.
Anderson, P., Leibler, M., 2017. Final Report of the Referendum Council. Department of the Prime Minister and Cabinet (Australia).
Blakey, M.L., 2020. On the biodeterministic imagination. Archaeological Dialogues 27, 1–16.
Braun, V., Clarke, V., Terry, G., 2019. Thematic analysis. In: Liamputtong, P. (Ed.), Handbook of Research Methods in Health Social Sciences. Springer Nature Pte Ltd.
Clark-Hitt, R., Malat, J., Burgess, D., Friedemann-Sanchez, G., 2010. Doctors' and nurses' explanations for racial disparities in medical treatment. J. Health Care Poor Underserved 21, 386–400.
Dalley, C., Barnwell, A., 2023. Memory at scale: Interdisciplinary engagements with Australian histories. In: Dalley, C., Barnwell, A. (Eds.), Memory in Place, 1 ed. ANU Press.
D'Costa, I., Hunt, I., Russell, L., Adams, K., 2022. A racial bias test with tertiary cancer centre employees: why anti-racist measures are required for First Nations Australians cancer care equity. Aust. Health Rev. 47, 5–12.
D'Costa, I., Truong, M., Russell, L., Adams, K., 2023. Employee perceptions of race and racism in an Australian hospital. Soc. Sci. Med. 339.
Evans, R., Ørsted-Jensen, R., 2014. 'I Cannot Say the Numbers That Were Killed': Assessing Violent Mortality on the Queensland Frontier. Available at SSRN 2467836.
Fogarty, W., Bulloch, H., Mcdonnell, S., Davis, M., 2018. Deficit Discourse and Indigenous Health. Lowitja Institute.
Gandhi, L., 1998. Postcolonial Theory: A Critical Introduction. Columbia University Press, New York.
Gilroy, J., Henningham, M., Meehan, D., Nila, F., Mcglone, J., Mcatamney, A., Whittaker, K., Brown, B., Varlow, M., Buchanan, T., 2024. Systematic review of Aboriginal and Torres Strait Islander peoples' experiences and supportive care needs associated with cancer. BMC Public Health 24.
Grant, J., Guerin, P.B., 2018. Mixed and misunderstandings: an exploration of the meaning of racism with maternal, child, and family health nurses in South Australia. J. Adv. Nurs. 74, 2831–2839.
Hoffman, K.M., Trawalter, S., Axt, J.R., Oliver, M.N., 2016. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Proc. Natl. Acad. Sci. U. S. A. 113 (16), 4296–4301. https://doi.org/10.1073/pnas.1516047113.
International Council of Nurses, 2023. Health Inequities, Discrimination and the Nurse's Role: Position Statement.
Kelaher, M.A., Ferdinand, A.S., Paradies, Y., 2014. Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities. Med. J. Aust. 201, 44–47.
Koorie Heritage Trust, 2024. Koorie Heritage Trust [Online]. Available: https://kht.org.au/?s=kulin+nation [Accessed 7/11/2024].
Lorde, A., 2012. Sister Outsider: Essays and Speeches. Crossing Press, California, USA.
Lupu, J., Ryan, M., 2022. Introduction: health and medicine in historical social contexts. Hist Arch 56, 642–647.
Manhire-Heath, R., Cormack, D., Wyeth, E., 2019. '…but I just prefer to treat everyone the same…': general practice receptionists talking about health inequities. Aust. J. Prim. Health 25, 430–434.
McGrath, A., 1987. Born in the Cattle: Aborigines in Cattle Country. Allen & Unwin, Sydney.
Moreton-Robinson, A., 2015. The White Possessive: Property, Power, and Indigenous Sovereignty. University of Minnesota Press, Minneapolis, USA.
Paradies, Y., Jehonathan, B., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, A., Gee, G., 2015. Racism as a determinant of health: a systematic review and meta-analysis. PloS One 10.
Payne, A.M., Norman, H., 2024. Coming to Terms with the Past? Identifying Barriers and Enablers to Truth-Telling and Strategies to Promote Historical Acceptance. UNSW, Sydney.
Refshauge, A., 1997. Aboriginal health. New Doctor 67, 14–15.
Research for Development Impact Network, 2021. Indigenous allyship: principles and practice [online]. Available: https://rdinetwork.org.au/resources/skills-for-development-impact/decolonising-research/working-with-indigenous-communities/indigenous-allyship-principles-and-practice/#:~:text=Being%20an%20ally%20means%20supporting,cent%20of%20the%20Australian%20population [Accessed 27/5/2024].
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, e003581.
Royal Commission on Aboriginal Deaths in Custody, 1998. Royal Commission on Aboriginal Deaths in Custody.
Secretariat of the Permanent Forum on Indigenous Issues, 2009. In: Sigurdarson, B. (Ed.), State of the World's Indigenous Peoples. Department of Economic and Social Affairs; United Nations, New York.
Shaburdin, Z.M., Bourke, L., Mitchell, O., Newman, T., 2022. 'It's a cultural thing': excuses used by health professionals on providing inclusive care. Health Sociol. Rev. 31, 1–15.
Shahid, S., Finn, L., Bessarab, D., Thompson, S.C., 2009. Understanding, beliefs and perspectives of Aboriginal people in Western Australia about cancer and its impact on access to cancer services. BMC Health Serv. Res. 9, 132.
Silburn, K., Reich, H., Anderson, I., 2016. A Global Snapshot of Indigenous and Tribal peoples' Health. Melbourne, Australia, Lowitja Institute.
Taylor, P.S., Habibis, D., 2020. Widening the Gap: White Ignorance, Race Relations and the Consequences for Aboriginal People in Australia. Australian Social Policy Association.
Thurber, K.A., Colonna, E., Jones, R., Gee, G.C., Priest, N., Choen, R., Williams, D., Thandrayen, J., Calma, T., Lovett, R., 2021. Prevalence of everyday discrimination and relation with wellbeing among aboriginal and Torres Strait islander adults in Australia. Int. J. Environ. Res. Public Health 18.
Truth and Reconciliation Commission, 2006. Truth and Reconciliation Commission of South Africa Report. Cape Town, South Africa.
Truth and Reconciliation Commission of Canada, 2015. Truth and Reconciliation Commission of Canada, Canada. House of Commons.
Tuck, E., Yang, K.W., 2012. Decolonization is not a metaphor. Decolonization: Indigeneity, Education and Society 1, 1–40.
Watego, C., Whop, L.J., Singh, D., Mukandi, B., Macoun, A., Newhouse, G., Drummond, A., Mcquire, A., Stajic, J., Kajlich, H., Brough, M., 2021. Black to the future: making the case for indigenist health humanities. Int. J. Environ. Res. Public Health 18.
Watson, I., 2017. Civilizing missions and humanitarian interventions: into the laws and territories of first nations. In: Swiffen, A., Nichols, J. (Eds.), Legal Violence and the Limits of the Law. Routledge, London, United Kingdom.
Watson, J.K., Wildre, G., 2018. The Postcolonial Contemporary: Political Imaginaries for the Global Present. Fordham University Press.
Wilson, R., 1997. National Inquiry into the Separation of Aboriginal Torres Strait Islander Children from their Families: Bringing them Home. Australia, Human Rights and Equal Opportunity Commission.
Wolfe, P., 2016. Traces of History: Elementary Structures of Race. Verso Books, London, United Kingdom.
World Health Organisation, 2020. State of the World's Nursing 2020: Investing in Education, Jobs and Leadership Report.
World Health Organisation, 2023. Historic resolution calls for action to improve the health of Indigenous Peoples [Online]. Available: https://www.who.int/news/ite

m/29-05-2023-historic-resolution-calls-for-action-to-improve-the-health-of-indigenous-peoples [Accessed 27/5/2024].
Yoorrook Justice Commission, 2022. Yoorrook Justice Commission, Yoorrook with Purpose [Online]. Available: https://yoorrookjusticecommission.org.au/wp-content/uploads/2022/07/Yoorrook-Justice-Commission-Interim-Report.pdf [Accessed 9/11/2024].
Ziersch, A.M., Gallaher, G., Baum, F., Bentley, M., 2011. Responding to racism: insights on how racism can damage health from an urban study of Australain Aboriginal people. Soc. Sci. Med. 73, 1045–1053.