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Building patient trust in health systems: A qualitative study of facework in the context of the Aboriginal and Torres Strait Islander Health Worker role in Queensland, Australia☆

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ABSTRACT

Healthcare services in Australia are the primary responsibility of state and territory governments, which recruit and deploy health providers in hospital and primary-care services. Among the various health professional roles, that of *Aboriginal and Torres Strait Islander Health Worker* (A&TSIHW) is one of only two positions that must be occupied by an Aboriginal and/or Torres Strait Islander person, carrying unique responsibility for enacting cultural brokerage and promoting cultural safety at the facility-level. Implicit to these responsibilities is the assumption that A&TSIHW will use cultural capital to build clients' trust in themselves and ultimately the broader health system. Drawing on 82 in-depth interviews including 52 with A&TSIHWs, we applied Kroegar's Facework theory to explore the structures, processes and relationships that contribute to, or inhibit, A&TISHWs' capacity and willingness to build trust (beyond themselves) in government health services in Queensland, Australia. Analysis demonstrates that despite A&TSIHWs viewing and enacting interpersonal trust-building as central to their role, structural features of the health system inhibit the development of service-users' system-level trust. Findings re-establish that health systems are not 'cultureless,' but rather, shaped by a dominant culture that privileges certain actors, types of knowledge, and modes of communication and action, which in turn influence efforts to build trust. The study demonstrates a novel theory-driven approach to exploring the interactions between behavioural and structural factors that influence the production of systems-level trust. In the context of the Queensland public health service findings highlight a disconnect between the expectations of, and support provided to A&TISHWs to engage Aboriginal and Torres Strait Islander service-users.

1. Background

Globally, community health workers (CHW) are valued for their ability to perform 'bridging' functions that link service-users to formal health services and vice versa. While the exact nature of the bridging functions varies from setting to setting (Perry et al., 2014; Scott et al., 2018) – spanning and often combining service extender, cultural brokerage and social action functions (Schaaf et al., 2020) – true of most CHWs is that their role depends on being trusted by, and having trust in, the health system (Assegaai and Schneider, 2022; Kok et al., 2017).

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In Australia, Aboriginal and Torres Strait Islander Health Workers (A&TSIHWs) have played a central role in the delivery of frontline primary health care in rural, remote and some urban settings for many decades (Topp et al., 2018; Tregenza, 1995). Typically located within primary care clinics, the A&TSIHW role is written into state and territory workforce policies as part of a multidisciplinary team of health professionals (McDermott et al., 2015). Distinct from other health professionals, however, the A&TSIHW role may only be occupied by an Aboriginal and/or Torres Strait Islander person. This is because among other health promoting and clinical tasks, A&TSIHWs are responsible for carrying out a range of 'cultural brokerage' functions. Cultural brokerage involves "guiding their non-Indigenous colleagues and ensuring best practice of care for their Aboriginal and Torres Strait Islander clients" (Dickson, 2020). Importantly, implicit to the concept as it relates to the A&TSIHW role, is the idea that A&TSIHWs will use their cultural connection and position to build Indigenous service-users' interpersonal trust in themselves, and ultimately, trust in the broader health system.

Although rarely explicitly discussed, A&TSIHWs' role as builders or *re*builders of trust in the government health system in Australia should be viewed as significant. Distrust of government generally, and government-run health services specifically among Aboriginal and Torres Strait Islander Australians is well documented (Waterworth et al., 2015; Yashadhana et al., 2020) and linked to a long history of racist policies, such as those that enacted systematic segregation, restricted cultural practice and use of language, and that produced the Stolen Generations (Wilkie, 1997; Wilson and Link-Up, 1997). Large disparities in access and health outcome indicators between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians are demonstrative of both this historical legacy and present-day experiences of structural violence (Queensland Productivity Commission, 2017), including among Aboriginal and Torres Strait Islander health providers themselves (Clark et al., 2021; Moreton-Robinson, 2007; Trueman et al., 2011), and their impacts on some individuals' and communities' ability and willingness to access government run health services (Waterworth et al., 2015).

Since 2008 Australian federal, state and territory governments have committed on paper to a national plan to 'Close The Gap' in both health and other social and economic domains (Council of Australian Governments (COAG), 2009). Among the myriad strategies described, policy targets to increase the number and proportion of Aboriginal and Torres Strait Islander health providers (Queensland Health, 2017; Health Workforce Australia, 2011, 2014) represent tacit acknowledgment that cultural connection may be an important precondition for many Aboriginal and Torres Strait Islander people to be willing to access government health services. A small but growing body of research including that led by Aboriginal and Torres Strait Islander health workers (Abbott. et al., 1979; Ellis, 1996; Howard, 2011; Jones et al., 2008) also provides evidence of the importance of health services employing Aboriginal and Torres Strait Islander providers to improve communication with, and *mitigate* distrust among, Aboriginal and Torres Strait Islander people wishing to access those services (Waterworth et al., 2015; Yashadhana et al., 2020). But no studies to date have explored the mechanisms by which A&TSIHWs contribute to *building* trust in themselves or in the broader health system, and barriers might exist to such an aspiration.

The current study emerged from a larger qualitative project which had an overarching aim to investigate the governance of the domestically unique A&TSIHW role in one state jurisdiction (Queensland) of Australia. Previous work has documented key findings in relation to the specific value of the role (Topp et al., 2021) as well as governance challenges relating to deeply embedded racial hierarchies and associated discrimination experienced by A&TSIHWs (Dickson, 2020; Topp et al., 2022;). During the course of the study, however, the issue of trust, and A&TSIHWs' role as potential 'broker' of systems-level trust emerged as an important theme, leading to the incorporation of an additional analytical focus: to investigate whether and how A&TSIHWs are able to translate Aboriginal and Torres Strait Islander service-users' interpersonal trust, into trust in the broader health system.

1.1. Theorising trust in, and of, health systems

Trust is well recognised as a critical component of effective health system processes and outcomes globally (Ozawa and Sripad, 2013; Wesson et al., 2019; Calnan and Rowe, 2006). To date, much of the international literature exploring trust in health care systems has focused on multiple, overlapping examples of interpersonal trust – for example between healthcare workers and patients or healthcare workers and their supervisors – and the circumstances that shape those particular relationships (Ozawa and Sripad, 2013; Okello and Gilson, 2015; Ozawa and Walker, 2011; Gilson et al., 2005). Interpersonal trust between patients and providers for example has been linked to better health outcomes; and interpersonal trust between healthcare workers and supervisors ('workplace trust') has been linked to healthcare workers' improved motivation and responsiveness towards service-users (Gilson et al., 2005; Sripad et al., 2018; Mechanic, 2004). Building on earlier work by van der Schee and colleagues (van der Schee et al., 2007) Gille and colleagues have more recently started to explore and deepen our conceptual understanding of what is meant by *public* trust in health systems; that is, a concept of trust which is not bound by the interpersonal relationships (patient-provider or employee-supervisor) and which may be applied at the level of group or society, rather than the individual (Gille et al., 2021).

While recognising and supporting these advances to a broader conceptualization of public trust, there still remains work to be done with regards to understanding how *individual* trust in the healthcare system (or parts thereof) is produced. Just as *public* or collective trust should not be solely understood as a function of cumulative instances of individual trust, nor should individual (experientially rooted) trust in the *health system* be understood solely as a product of cumulative interactions with individual health providers, (Kroeger, 2016). Rather, trust theory suggests that individual trust in the healthcare system is likely to be influenced by interpersonal interactions *set within* the system's structural and organisational characteristics (Gille et al., 2021; Kroeger, 2016; Giddens et al., 1994; Luhmann, 1979). A closer examination of the types and combinations of interpersonal interactions and their structural context within the health system is thus required.

1.2. The theory of facework

As noted above few theories address in any detail the 'black box' of how an individual comes to trust an organisation or system. One recent exception, is Kroegar's Facework theory (Kroeger, 2016). Grounded in a social constructionist paradigm this theory is apt for use in the field of health policy and systems research (HPSR) due to its view of trust as emanating within social systems (Giddens et al., 1994; Sheikh et al., 2011), which are themselves constituted and shaped by actors and their relationships.

Facework theory is defined by Kroegar as the translation of *interpersonal* trust into *organisation or system* level trust (Kroeger, 2016). Taking Giddens (1990) conception of 'facework' (rather than Goffman's (Goffman, 2003) original usage) and using structuration (Giddens, 1984) as a starting point, Facework theory suggests that organisation or system-level trust is the product of a mutually constitutive relationship between the system's rules and resources on the one hand, and the actors within the system who represent, interpret and reproduce those rules on the other (Sydow et al., 2006). To understand how an individual develops trust in the health system, Facework theory suggests we should consider the trust-promoting nature of a system's structural properties, and how these are reflected in actors' (or 'agents') interpretation and reproduction of those properties (Kroeger, 2016). More specifically, Facework theory identifies three essential conditions for interpersonal

trust to be translated into organisation or system-level trust; respectively: structural, representational and situational coherence. We describe each of these multi-dimensional conditions below and illustrate the dynamic relationship between each in Fig. 1.

1.2.1. Structural coherence

The first essential condition specified by Facework theory is structural coherence, which comprises three dimensions of legitimation, signification and domination. Coherence across these three dimensions demonstrates an organisation or system has integrity.

Legitimation refers to the rules of the system and the norms through which they are enacted. Rules and norms may support the translation of interpersonal to organisation or system level trust by providing a basis for shared understanding and predictability *and* by signaling the embeddedness of trust-promoting values, such as honesty, cooperation and reciprocity, within the system. In a health system context, rules or norms that signal fairness (e.g. predictable opening hours; regulated queues; transparent fee structures) rather than norms that imply favoritism or nepotism, are likely to support a service-user's impression of a trustworthy health system.

Domination or power refers to the rules that embed and constrain power within the system, and which elsewhere in the health literature are sometimes referred to as mechanisms of accountability. (Schaaf et al., 2017, 2022). To promote the translation of trust, such rules should limit the power exercised by a health system representative, demonstrating appropriate checks and balances and strengthening the predictability of any given encounter (Kroeger, 2016). Facework theory specifies, however, that the rules of a system should not so constrain the choices and behaviours of representatives that they are cannot make reasonable efforts beyond their job-description to assist a service user. Rules should empower health system representatives to act with discretion within appropriate limits. Rules permissive of such discretionary acts promote perceptions of a system that can be trusted to direct its structural power in ways that meet – rather than frustrate – a service-user's needs.

Finally, *signification* or meaning, recognises that trust in an organisation or system is more likely to develop where individuals can observe familiar language, symbols or concepts. Where service modality, infrastructure, or communication mechanisms enable service-users to understand and access health services more easily, for example, trust in the system is more likely to grow. Conversley, where the health system appears to 'speak a different language' with hard-to-interpret processes or routines, individuals may feel unsure or even fearful about interacting with, asking questions of, or seeking assistance within the health system, in turn affecting their trust in that system (Kroeger, 2016).

1.2.2. Representational coherence

The second major condition for the translation of trust is that of representational coherence. This focuses on the behaviour of 'representatives' of the system (in the health sector this may include healthcare workers, but also managers and supervisors at various levels) and the way their behaviour reflects, or fails to reflect, the values of the larger organisation or system as demonstrated by the structural features described above. Representational coherence is comprised of three dimensions; *tacitness*, *institutionalisation* and '*agentic*' behaviours.

Tacitness refers to the extent to which a representative behaves in ways that unconsciously demonstrate their own recognition of the system as trustworthy. Tacit behaviours play out not only in external representation of the system (e.g. explicit statements of trust or appreciation) but through internal processes. Senior managers, for instance, may tacitly project their trust in the health system to lower-level health workers through permissive (e.g. distributed) leadership styles; or conversely imply lack of trust in the system through actions to curtail health workers' decision making space or through limited information sharing. In an ideal case, a representative will assume trustworthiness of the system and contribute to its reproduction by continuously and tacitly displaying behaviours that imply the system's trustworthiness. Kroeger reminds us that tacit behaviours and implicit communication are usually perceived as more authentic by others (including service-users) and are thus more likely to support positive 'representation' of system.

Institutionalisation is demonstrated by more tangible behaviours that indicate the 'systemness' of the representative; that is, the degree to which a representative's behaviour is guided and constrained by (trust-promoting) system rules. Service-users may look for behaviourial cues such as whether healthcare workers arrive to work on time; appear to be following guidelines in relation to privacy and confidentiality; or adhere to standard patient registration and documentation processes. Facework theory suggests that where the *structural* properties and formal rules of a system demonstrate integrity, a high degree of institutionalisation

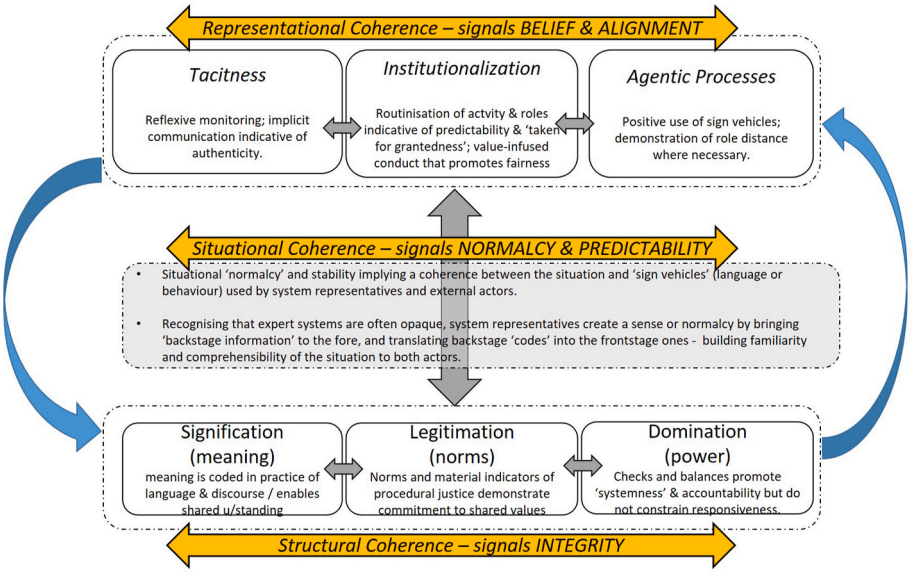

Fig. 1. An adapted* theoretical framework for Facework: the translation of interpersonal trust to system-level trust.
*Source: Author's own figure based on Kroeger F. (2017) FACEWORK: creating trust in systems, institutions, and organisations, Cambridge Journal of Economics. 41 (2) p.487-512.

among its representatives is more likely to contribute to the production of system trust, although (as discussed below) this may have limits.

A third dimension of representational coherence is *agentic process*. This dimension recognises that although institutionalisation (per above) is important, 'mere role fulfilment is not a very potent signal of trustworthiness' ((Luhmann, 1979) cited in Kroeger (2016) p.42). Even in the most inflexible of organisations or systems, actors are still capable of, and usually do exhibit some kind of agency (Giddens, 1987) p.122. Facework theory suggests that trust is more likely to be translated where representatives are willing to 'go above and beyond' their formal job description, supported and enabled by the organisation or system, in order to fulfil the true intent of their role. Where representatives do not demonstrate such agency, or where a representatives' attempts to go above and beyond are not be supported or enabled by formal or informal rules of the system (see *Domination* above), the coherence of the representative's position within the broader system, and the likelihood of building trust therein is weakened.

1.2.3. Situational coherence

The third condition of Facework is situational coherence (Kroeger, 2016). Situational coherence refers to the alignment between the structural properties of an organisation or system, and strategies being used by its representatives to enact day-to-day tasks, such that there is a sense of normalcy and stability for all actors involved. Situational coherence in a health system is built on the ability of healthcare workers and others to use language or other signals to help service-users understand what is happening in an otherwise highly opaque expert system. Information sessions or notices that help explain the procedures and expectations of service-users within a clinic setting, for example, improve awareness and predictability of a service encounter and help both healthcare workers and service-users preserve a sense of normalcy. Similarly, well understood role delineation and expectations of different types of healthcare workers make it easier for service-users to seek care, or ask questions in ways that do not result in embarrassment or shame. Such normalcy is a key prerequisite for generating trust in a healthcare setting where information asymmetry is the norm (Bloom et al., 2008), since without it, much energy is spent trying to define and understand the situation and importantly, avoid any associated risk.

2. Methods

2.1. Theoretical and researcher positioning

This study was grounded in the principles of critical realism, which aim to produce transformative change through identifying and explaining the interactions between context and mechanisms that lead to specific outcomes in specific places (Bhaskar, 2014). Within this ontological positioning, Facework theory (Kroeger, 2016) – integrated with Gidden's theory of structuration (Giddens, 1984) as outlined above – was incorporated to help understand the relationship between structural and agentic factors in the building of system-level trust. Overall, the research project was guided by consideration for Indigenist methodological approaches (Martin and Mirraboopa, 2003) that explicitly seek to place Aboriginal and Torres Strait Islander peoples' voices, experiences and interest at the centre of enquiry. The study was co-designed and undertaken by a team which included Aboriginal (JT, RC), Torres Strait Islander (ST) and non-Indigenous (SMT, VG, LE, AY) collaborators.

2.2. Data collection

The study was undertaken in a Hospital and Health Service (HHS) in Queensland, Australia. The state of Queensland has the highest number of A&TSIHWs of any state or territory in Australia (Wright et al., 2019) and the region in which the research was undertaken has the highest number of A&TISHWs of any local government area in Australia. Informed by the theoretical and methodological considerations outlined above, qualitative methods were used and the study was conducted in four phases: i) consultation with A&TSIHWs regarding overall study design and construction of an interview guide, ii) interviews and document review, iii) preliminary analysis and sharing and member checking of interpretation with all A&TSIHW study participants and, iv) finalisation and reporting back of findings to all A&TSIHW in the region, and other HHS stakeholders. A total of 83 interviews were conducted with study participants comprising four groups: i) current or former state-employed A&TSIHWs from the nominated study sites (n = 51); ii) currently employed (non-Indigenous) clinical professionals working at one of the nominated study sites (n = 19); iii) community members aged 18 years or more and resident in one of the communities linked to the study clinics (n = 8) and iv) key stakeholders (n = 5), comprising individuals with specific knowledge of health services and/or the A&TSIHW role in the state health system. Convenience sampling based on initial email communication, and subsequent consultation visits was used to recruit A&TSIHWs and non-Indigenous clinical professionals working in the study clinic sites. Participants were informed of the interview visit dates in advance and could choose to participate in an interview or not; for any individual who missed an in-person interview but wished to participate a phone interview was offered. Recruitment of community members was reliant on direct referral by local A&TSIHW, and snowball sampling where participants recommended and were willing to provide a direct introduction. Community interviews were only conducted where a direct introduction by an existing study participant was possible. Recruitment of key informants was purposive based on expertise or experiences, with invitations and subsequent interviews conducted either in person or over the phone. RC, JT and ST provided cultural advice and guidance throughout, but JT and ST were not directly involved in recruitment or interviews.

All except five interviews were face-to-face, and interviews ranged from 20 to 100 min. Interviews were conducted by one Aboriginal (RC) and two non-Indigenous team members (SMT, VG) in English. Participants took part in either an interview or a focus group. A&TSIHW interviews explored individuals' motivations for working as an A&TSIHW; their understanding of the value and purpose of the role; and their experiences in the role in relation to regulatory, organisational and sociocultural pressures and expectations. Clinician interviews explored their understanding of the value and purpose of A&TSIHW, and perceptions regarding barriers and enablers to effective integration and performance in primary healthcare teams. Community member interviews explored their understanding of the value and purpose of the A&TSIHW role and perceptions of its utility in the context of current community health needs. Key stakeholder interviews asked similar questions to those noted above, but were tailored to the expertise of the individual and often included an additional focus on the impact of historical and recent policy and organisational reforms on the A&TSIHW role.

2.3. Analysis

Initial coding was inductive (Glaser and Strauss, 2009), with themes identified iteratively. Following initial analysis and identification of trust as a major theme, a further two rounds of coding were conducted in an abductive process (Danermark et al., 2019), incorporating codes defined by Facework and other trust theory. Coded data were summarised and presented to A&TSIHWs in person or via video conference during which professional, contextual and cultural insights and critiques were provided and interpretations refined. In the results, to protect participant confidentiality, identification is limited to the participants' gender, their health professional role, and a sequentially assigned numerical ID.

This study received ethical approval from the Cairns and Hinterland Human Research Ethics Committee (HREC/2018/QCH/45310–1290) and James Cook University's HREC (H7687). Site Specific Approvals from the relevant HHS Governance Office SSA/2018/FNQ/45310-

20191.

2.4. Findings

Our findings are organized in two sections. First, we briefly examine the value placed on *interpersonal* trust by A&TSIHWs and the way Indigenous strengths based approaches influence its production. Second, and drawing primarily on A&TSIHWs' descriptions of their work and work environment, but supplemented by accounts from non-Indigenous health professionals, we analyse whether the foundational conditions of *representational*, *structural* and *situational* coherence were present to enable translation of Aboriginal and Torres Strait Islander service-users' interpersonal trust into broader trust in the system. In the Discussion we consider the usefulness of Facework theory for exploring the production of organisation or systems-level trust in this setting.

2.5. Recognition of the importance of interpersonal trust

The central value of interpersonal trust, and the effort made by A&TSIHWs to build interpersonal trust with service-users, were not just evident in, but often central to, the narratives of A&TSIHWs and their non-Indigenous colleagues. As articulated in the quotes below, A&TSIHWs consistently described trust as a central feature and focus of their work:

> *Most important thing about [the job]. You know […] they put me in a position where the trust got to come in.* [Male, A&TSIHW, #15]

> *You build a rapport. It's all to do with rapport. You've got to earn your trust with them.* [Female, A&TSIHW, #60]

> *I think over the years it's about building trust and rapport.* [Male, A&TSIHW, #66]

> *I had a phone call from a family. These people here, they trust me that much. They'll ring me before they ring an ambulance.* [Female, A&TISHW, #7]

Although the system-level focus of this study precludes an in-depth exploration, we used Martin and Mirraboopa's (Martin and Mirraboopa, 2003) and Askew et al.*'s* (Askew et al., 2020) framework for Indigenous Strength Based Ways of Being, Doing and Knowing, to briefly examine the antecedents of interpersonal trust between A&TSIHWs and their service-users. Table 1 summarises key elements of the framework, used here as a heuristic for unpacking the distinctive practices of Aboriginal and Torres Strait Islander health professionals, and provided a culturally-informed touch point for examining interpersonal trust between A&TSIHWs and service-users through a focus on empathy, person-centred practice, and respect.

Empathy – a strength based way of being – was described as a precondition to building and sustaining interpersonal trust, since it helped A&TSIHWs understand and respond sensitively to service-users' needs, in the context of often highly complex and intersecting social, cultural and physical life worlds.

> *Not sympathy but empathy. You're feeling what they're feeling. That's the only way you are going to really understand. If you haven't got empathy it's no good.* [Female, A&TSIHW, #60]

Table 1
Indigenous Ways of Being, Doing and Knowing, sourced from Askew et al. (Angus, 1999).

Indigenous Ways of Being	An everyday practice, starting with strength and emphasising empathy
Indigenous Ways of Doing	A pro-active, relationship focused approach to improving the health of service-users
Indigenous Ways of Knowing	Resistance against racializing practices, and a rejection of blame.

Person-centred approaches to care – a strengths-based way of doing – were also common in A&TSIHWs' accounts of trust-building, underpinned by an imperative to treat service-users as people rather than an 'occasion of care', and to give them agency in the management of their own health.

> *Just treat the person, don't just treat the sore, yeah? That holistic approach to health, because we don't just focus it [on] like acute care, it's more holistic approach.* [Male, A&TSIHW, #13]

> *So we're never going to close the gap if we're not going to give people the ownership to take on their own health.* [Female, A&TSIHW, #20]

Finally, respect – a strengths-based way of knowing – was consistently present in A&TSIHWs' accounts of their inter-personal trust building. Askew et al. (2020) describe this strengths based approach as asserting Indigenous people's humanity, in order see them as 'real people', and to reject the inclination to lay blame on the individual for experiences of ill-health (Askew et al., 2020). A&TSIHWs in this study frequently detailed the foundational respect that informed this way of interacting with their service-users:

> *You're earning their – their trust, their – and they got respect for you because you worry about them, you're concerned about them.* [Female, A&TSIHW, #60]

2.6. Translating interpersonal to organisation/system level trust

Having established the value A&TSIHW placed on building interpersonal trust, we sought to examine whether the foundational conditions of *representational*, *structural* and *situational* coherence were present, and likely to support the translation of service-users' interpersonal to system level trust.

2.6.1. Representational coherence

With regards representational coherence, we sought to understand whether A&TSIHWs tacitly signaled their own trust in the system; demonstrated a degree of institutionalisation; and established 'agentic' ability to adapt and respond (within acceptable boundaries) to address service-users' needs.

Overall we found strong evidence of agentic behaviours with many accounts of A&TSIHWs stepping outside the formal requirements of their job in order to resolve challenges (large and small, health service-related or otherwise) for their service-users.

> *Everybody knows what we do. And they sort of have certain people they trust, and we don't say it like, 'You can't contact me, you have to ask them. That's their job." We don't do that.' If someone contacts us for something, we deal with it [ourselves].* [Female, A&TSIHW, #53]

While Kroegar (Kroeger, 2016) describes these types of agentic displays as being linked to 'value infused care' which can promote trust, he does not specify *whose* values. Among participants in this study, A&TSIHWs' willingness to 'go the extra mile' was clear. As the quotes below illustrate, however, A&TSIHW participants did not link such actions to a sense of commitment to health system values, but rather *cultural* values, often expressed in terms of deeply rooted obligations to family and community.

> *If I walk up to the health centre and my auntie yell out to me, "Come, I want to talk to you." I have to go because that's my auntie calling out to me. And I can't disrespect.* [Female, A&TSIHW, #32]

> *As I told the nurses, our job doesn't finish here. […] We out in the street, we still health workers. We at home, we're still health workers. Even though we're not on call.* [Female, A&TSIHW, #38]

Indeed, going beyond formal job requirements or outside the scope of responsibilities to meet service-users' needs, was rarely linked to an

empowering organisational environment that promoted adaptation and responsiveness. A&TSIHWs more often described the adaptations and extensions of their work in terms of subversive acts, that challenged directives made by line managers or policies. Common examples related to the need to get out into the community or even, in some of the most remote settings, provide unsanctioned care in the absence of any other health professional.

> *You're going to be telling me - through instructions [clinical governance] you can call it, if you want – not to take a course of action to save that person's life? So, I would prefer to get into trouble from [Queensland Health] than to be getting into trouble from my Community where I 've got to live for the rest of my life.* [Male, A&TSIHW, #56]

Not surprisingly, given the above, we found equivocal attitudes towards, and evidence of, *institutionalisation* in A&TSIHWs behaviour. Institutionalisation is understood to promote trust by demonstrating a representative's 'systemness' or alignment with the routines and norms of the system. In an ideal situation where the structural features of the system reflect service-users' ideas of procedural fairness and predictability, a representative's alignment with those routines and norms will promote a service-users' perception that the system is functioning in a trustworthy manner. But where the structural features of the system do not reflect service-users' ideas of procedural fairness or other trust promoting values, whether or not the representative chooses to align with the rules and norms becomes less important. In this setting, A&TSIHWs described a tension between their own understanding of their job as boundary spanners, necessarily transiting between the clinic and community worlds, and requiring flexibility to respond to client needs as they arose; versus managers' and non-Indigenous colleagues' expectation that they would conform to a standard clinic-based appointment-driven service model. These different understandings of what 'systemness' should mean had implications for A&TSIHWs' willingness to demonstrate institutionalised behaviours, since complying with facility-based work norms and routines often resulted in their being delegated the most menial administrative or logistical tasks at the behest of other health professionals:

> *[We want to work] appropriately as what we're supposed to be doing. Talking to our Indigenous people out there, bringing them in and doing their obs[ervations], explain to them what needs to be done, why they're here. [This is what] we were trained for, not just for like we said before [a dogs body].* [Female, A&TSIHW, #2]
>
> *You're a gofer: "You - go do this and that!" Not all nurses, but a lot of nurses come in from mainstream and have never been in to a community and don't understand community dynamics.* [Male, A&TSIHW, #13].

Finally, while direct evidence of *tacitness* was difficult to evince from interviews, the antecedents of tacit (trust-projecting) behavior were clearly lacking in A&TSIHW accounts. All A&TSIHWs interviewed for the study were emphatic of the importance of building interpersonal trust between themselves and service-users, and cognizant of the importance of helping Aboriginal and Torres Strait Islander people access healthcare. However, near-daily experiences of disrespect (stemming from different sources, and explored further in the next section) meant that rather than tacitly signaling trust in the health system, A&TSIHW were more likely to be hyper-vigilant; aware of the need to manage both their own behaviours and their responses in the context of frequent inter-personal conflict within the clinic setting.

2.6.2. Structural coherence

Underpinning A&TSIHWs' lack of tacitness were a series of structural features of the public health system that employed them. As described earlier in this paper, certain structural features must be present in an organisation/system if it is to demonstrate the integrity necessary to support the translation of interpersonal to system level trust. One of those structural features is rules and norms that signal a 'congruence of values' and which embed a sense of procedural justice. Yet the accounts of A&TSIHW in this study emphasised a dissonance – not congruence – between the values of the health system and their own client-centred concerns.

Foundational to A&TSIHWs' perceptions of incongruent values, were experiences of weak recognition of their own role and professional marginalisation. Illustrative of marginalisation at the macro-level, for example, A&TSIHWs pointed to the lack of a named (A&TSIHW-specific) career stream within the state's health workforce structure (until November 2019 when a workforce reform was introduced); highly inequitable rates of pay, and limited or no access to professional development or basic benefits routinely afforded to other health professionals (c.f Topp et al., 2022). Marginalisation was experienced too at the district and facility level of the health system, interacting with more localised rules and norms. For example, although A&TSIHWs in this study were often the longest-serving staff members in their facility, their profession had limited or no representation in the corporate and organisational structures at either facility or district (hospital and health service) level. Lack of representation was both a consequence of, and contributor to, weak role-recognition and lack of trust in the competencies of A&TSIHW among other health professionals, illustrated in this observation of one medical officer:

> *I look forward to the health workers having a more defined career structure and more regulated. And it's good for them, and it's good for everyone to understand the role and know what the role can do.* [Male, Medical Officer, #18]

Another trust-promoting structural dimension, namely rules that *empower* representatives to deliver values-based care, was also largely absent. For A&TSIHWs in this study, facility-based rules and norms – underpinned by the lack of recognition and marginalisation outlined above – more often stripped them of the autonomy to promote, or opportunity to represent, service-users' needs, than they did empower them to do so. Examples of such discrimination and disempowerment were varied in nature, but included frequent instances of micromanagement such as being time-checked by colleagues, with the lack of respect so evident in some cases that even community members commented on it.

> *Every time when I come in the door, I looked at the nurse - she looks at the time or she goes like this here, like look[ing] at the wrist. I'm just like, "Yeah, you checking on me?" […] They would come and try and find something that you've done wrong or they - it's a scary feeling. It's a real scary feeling.* [Female, A&TSIHW, #32]

> *No, [A&TSIHW are] not respected. As I said earlier on, they are used as shields for the clinicians and doctors […] I don't see respect coming from any of those clinicians. They're all "Yeah, yeah, yeah" but the respect is still not there.* [Male, Community Member, #29]

A third trust-promoting structural dimension is *signification,* which recognises how familiar ideas or schema transmitted through communication, infrastructure or service modality can promote trust. In this study, A&TSIHWs' accounts regularly observed a dissonance between the language and service models promoted by policy guidelines and managers at all levels, driven by a clear imperative to meet key performance indicators, and the critical concepts of person-centred and holistic care that they (and their Indigenous clients) held to be central. This dissonance played out in daily conflicts as A&TSIHWs were instructed to compartmentalize their time with service-users to fit set opening hours and appointment-based service models, despite concerns around appropriateness and accessibility:

> *A lot of senior positions, they push for numbers, for funding, and we understand that. But you cannot say [to a client] like "Okay, so zip it now. That's enough. Come back tomorrow." Th[at client] probably won't be here tomorrow.* [Female, A&TSIHW, #40]

I'm confident, I've got the life experience, and it's just the key to it is the building rapport and trust. But I think if you come in to these communities, and [are] just impatient, just want to build stat[istics …] focusing on systems and KPIs and on that, you forget about what's happening to the people on the ground here. [Male, A&TSIHW, #13]

Yeah, because you're out there, you're talking to people around. That's the only way you'll win their trust in this battle, [Female, A&TSIHW, #50].

2.6.3. Situational coherence

The variable strategies A&TSIHWs were forced to adopt in order to help Indigenous service-users access to care were not conducive to situational coherence. Situational coherence requires alignment between the structural properties of the system *and* the behaviours of its representatives, such that all actors are comfortable and able to anticipate how the service encounter will proceed. As described above, thin or absent representation of A&TSIHWs in the corporate and management structures of facilities and district services, widespread lack of understanding of the role among non-Indigenous providers, and operational constraints that impacted A&TSIHWs' ability to deliver services in a respectful and flexible manner, all contributed to undermining situational coherence.

Indeed, A&TSIHWs described work practices often driven by a need to justify their presence and value to managers and colleagues while resisting their co-optation into menial administrative tasks. The need to challenge and mitigate the impacts of lack of cultural awareness among non-Indigenous staff was also frequently described, and an example of the weak situational coherence, as one A&TSIHW noted:

You have these non-Indigenous nurses […] not cultural awareness trained and they do this sort of stuff. That's where we come […] We tell them what not to do and the right way to do it. Otherwise, we lose that trust [of the community] and we lose that rapport too, I guess, in some cases. Where if [the non-Indigenous staff] do things the wrong way, [community members] won't access the service, as they see it as 'shame' [inappropriate]. [Male, A&TSIHW, #58]

This lack of coherence was also noted by some community members who described how the previously clear roles and responsibilities of the A&TSIHW were increasingly opaque even to service-users:

It's a big clinic now, but you see health workers just to and fro walking in to the office […]. But no one [in community] knows their roles anymore. [We] don't know if they're not being trusted [by managers]? We don't know what's going on. [Female, Community Member, #17]

Efforts to adapt their own strategies to accommodate, explain and mitigate the consequences of the norms and practices of primary health centres produced significant fatigue among A&TSIHWs, affecting their motivation to invest in any broader organisation or system-level trust building. As one participant explained:

I can give so much to the community […] but when you come back into a facility [and] there is no support for any of us. We need to […] stand together here in our own facility as a team. But there's a barrier. […] There's no cultural approach whatsoever and it's getting worse. It's getting worse. [Female, A&TSIHW, #20]

3. Discussion and conclusion

We applied Kroegar's theory of Facework to examine the interactions between structural features of the state health system and the position and behaviours of a key group of boundary spanners in relation to the production and translation of interpersonal trust into broader system-level trust. Understanding whether and how A&TSIHWs can engage in successful system-level trust building should not be a passing concern. A&TSIHWs are the only racialized health professionals in Queensland as well as the only professionals with service-wide responsibility for conducting cultural brokerage, a 'bridging' function (Schaaf et al., 2020) which carries explicit obligations to build trusting interpersonal relationships, and implicit expectations of strengthening service-users' trust in wider health service (Health Workforce Australia, 2014; Queensland Health, 2016). Understanding whether the preconditions for such trust building and translational work are in place represents one entry point for discussions about whether and how this boundary-spanning role is supported to carry out such work.

Although our analysis demonstrated A&TSIHWs viewed and enacted *interpersonal* trust building as central to their role, we found little evidence of system-level trust building (Fig. 2). The structural features of the health system in this case did not demonstrate coherence or signal integrity but rather displayed a lack of procedural justice, poor

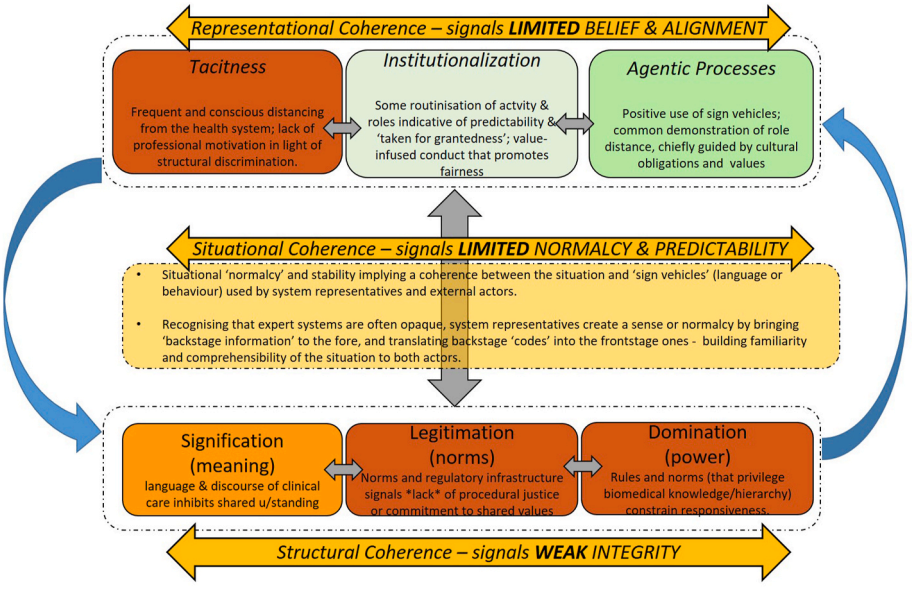

Fig. 2. Analysis of the preconditions for Facework by A&TSIHW in the Queensland public health system.
*Source: Author's own figure based on Kroeger F. (2017) FACEWORK: creating trust in systems, institutions, and organisations, Cambridge Journal of Economics. 41 (2) p.487-512.

alignment of values, and limited empowerment of A&TSIHWs as key representatives and boundary spanners of the cultural and health system worlds. Professional marginalisation in terms of career opportunities and inequitable job conditions emblematic of racism already documented within the system (Moreton-Robinson, 2007; Topp et al., 2022; Trueman et al., 2011; Jones et al., 2008; Angus, 1999; Wakerman et al., 2000) were commonly observed. Adherence to service models dictated by activity-based funding and associated measurement of 'instance-s-of-care', led to managerial emphasis on clinic- (versus community-) based service delivery; and in the absence of counter-veiling norms to empower A&TSIHWs to adapt or extend services to meet their service-users' integrative health needs, A&TSIHWs spoke of the disconnect between their own person-centred values, and the new public management values that dominated the workplace modes of practice.

Values inform norms ((De Herdt and Olivier de Sardan, 2015) p.22) and findings from this study demonstrated how rather than being empowered to utilise their unique knowledge and skills to improve access and acceptability of services among Aboriginal and Torres Strait Islander service-users, managerial norms tended to focus on (narrowly defined) indicators of performance accountability, lacking recognition of much of the real (relationship building) work A&TSIHWs engaged in. The co-constitutive nature of the racially discriminatory conditions of employment, biomedically dictated modes of service delivery, and the dominant (techno-managerial) performance culture (Kielmann et al., 2022), were evident in A&TSIHWs' cyclical lack of representation in clinic or district-level committees and frequent experience of menial task-shifting by non-Indigenous colleagues. Critically, such experiences were understood as a continuation of the same racially marginalizing practices that the A&TSIHW have themselves identified and for many decades, sought to counteract (Howard, 2011; Jones et al., 2008).

Weak integrity vis-à-vis the health system's ability to demonstrate shared values, procedural fairness or normative empowerment of A&TSIHWs as boundary spanners, had a strong influence on A&TSIHWs' agentic practices, (lack of) tacitness, and selective institutionalisation. Despite choosing to work within the system for a range of different reasons, A&TSIHW participating in this study frequently expressed distrust in the system, which they perceived as treating both them and Aboriginal and Torres Strait Islander service-users in a discriminatory manner. Although commonly enacting 'agentic' practices to improve their clients' access to services, A&TSIHWs were at pains to emphasise that these actions were motivated by cultural values and obligations and a sense of responsibility to help their community, rather than a desire to project the values and norms of the health system. Indeed, many A&TSIHWs described such adaptations and extensions of their work as subversive acts that challenged official policies or directives from line managers.

This analysis makes a theoretical contribution through its focus on the understudied question of how individual trust in the broader health system may, or as is the case here, may not, mature beyond instances of interpersonal trust with health providers. While recent developments in trust theory as it applies to health systems have focused on the importance of *public* (collective) trust and of actors, institutions, and networks outside the health sector (Gille et al., 2021), individuals' direct or indirect experiences within the health system remain a critical, sometimes outsized, factor in the production of public trust. This study contributes to building a better understanding of the role of health system representatives play and the influence of structural features of the health system in that process - particularly in a context of racialized or otherwise marginalized peoples.

The findings of this study may also be located within an existing body of research exploring the importance of 'workplace trust' (an employee's trust in their workplace) and its impact on health care providers' motivation and performance. Previous work examining community health workers (CHWs) in South Africa (Assegaai and Schneider, 2022) and health providers in Zambia (Topp and Chipukuma, 2016a, 2016b), for example, have pointed to the critical role of supervision systems and managerial support, and demonstrated the impact of decisions and institutions at multiple levels on health workers' trust in supervisors, colleagues and ultimately service-users. In a review of the influence of trust in workplace relationships on health worker motivation, Okello and Gilson (2015) demonstrate how trusting relationships encourage social interactions and cooperation with consequences for retention, performance and quality of care; and the importance of human resource management and organisational practices for sustaining both workplace trust and health providers' motivation. Building out from this work, a contribution of the current study is to use theory to demonstrate more clearly which types of behaviour (tacitness, institutionalisation and agentic actions) by key representatives (here, A&TSIHWs) promote trust in the broader system. Findings highlight the relationship between a representative's position and power within the system, and their conscious and sub-conscious decisions to reproduce (or challenge) systemic norms and processes in ways that are indicative of their own trust (or mistrust) of that system. Captured via the concept of 'representatation, and supported by a structurationist approach, this analysis thus provides a fresh theoretical basis for understanding how structural antecedents of a health system influence health providers' workplace (mis) trust, and the pathways by which this may subsequently impact the development of service-users' trust in the broader system.

Beyond its contribution to helping explain how system-level trust is or is not built, Facework theory provides another way to view the multiple and overlapping ways in which health systems are designed to serve the interests of already powerful actors. Study findings highlight a key point already been made clear by Indigenous scholars in Australia regarding the fact that the health system is neither 'cultureless' or value neutral. Rather, it is a social system (Sheikh et al., 2011) shaped by a dominant culture (Fanon, 1963) that privileges predominantly white actors (Moreton-Robinson, 2007) and biomedical knowledge, and embeds techno-managerial modes of communication and action. A clear implication is that building system-level trust among systematically marginalized or discriminated populations is unlikely to be achieved by hyper-localized or short-term interventions. In Australia, the modern-day public service sector is the product of the same organisational structures and institutions that historically established (Wilkie, 1997; Wilson and Link-Up, 1997) and still continues (Queensland Productivity Commission, 2017; Askew et al., 2020) to perpetrate racist policies towards Aboriginal and Torres Strait Islander peoples. In this setting at least, building or *rebuilding* trust among Aboriginal and Torres Strait Islander peoples will thus require significant reform to the structures, financing and institutions of governance as well as the prevailing norms and work culture that currently guide these dominant (albeit often overlooked) modes and methods of service delivery.

A limitation of the current study was the small number of Aboriginal and Torres Strait Islander service-users or community members able to be interviewed; this was in part due to careful application of ethical procedures relating to the recruitment of non-health professionals into the study. From a theoretical perspective, the small number of community members interviewed meant that our analysis was naturally skewed to a systems-side perspective. To some extent this was mitigated by careful privileging of A&TSIHWs' voices, a cadre whose concern for community perceptions of health care is central. Nonetheless, we acknowledge that complementary empirical work exploring the same questions from the perspective of Aboriginal and Torres Strait Islander peoples using the system would have strengthened analysis.

4. Conclusion

A&TSIHWs are meant to be members of integrated teams of health professionals responsible for helping build client engagement and self-management within a broader framework of holistic and culturally safe care. These responsibilities take on a particular significance given Australia's colonial legacy of targeted and structural violence towards Aboriginal and Torres Strait Islander peoples and the ongoing challenges

regarding their access to, and trust in, government services. We used Facework theory to structure an explanatory account of both the potential of, and threats to A&TSIHWs carrying out cultural brokerage and potentially transformative trust building work in Queensland, Australia. Drawing on interviews with state-employed A&TSIHW, non-Indigenous health providers and community members we found consistent recognition by A&TSIHWs of the importance of building interpersonal trust, but limited and ad hoc efforts by the same to translate or promote the growth of system-level trust. Overall, and notwithstanding the clear potential of A&TSIHW to act in a 'boundary spanning' role, embedded structural barriers and organisational devaluing of trust-building efforts clearly influenced A&TSIHW to choose not to invest in such work.

The study contributes a theory driven examination of the interactions between behavioural and structural factors that influence the production of system-level trust; and highlights the current disconnect between expectations of, and support provided to, A&TISHWs to build Aboriginal and Torres Strait Islander service-users' trust in government health services.

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Ethical approvals

This study received ethical approval from the Cairns and Hinterland Human Research Ethics Committee (HREC/2018/QCH/45310–1290) and James Cook University's HREC (H7687). Site Specific Approvals were provided by the Torres and Cape Research Governance Office SSA/2018/FNQ/45310- 20191.

Authors contributions

Stephanie M Topp: Conceptualisation, methodology, resources, data collection, formal analysis and wrote first draft. **Josslyn Tully**: Cultural oversight, resources, methodology, review and editing. **Rachel Cummins**: Cultural oversight, methodology, data collection, formal analysis, review and editing. **Veronica Graham**: Data collection, formal analysis, review and editing. **Aryati Yashadhana**: formal analysis, review and editing. **Lana Elliott**: formal analysis, review and editing. **Sean Taylor**: Conceptualisation, resources, cultural oversight, methodology and review and editing.

Declaration of competing interest

None to declare.

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