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Understanding barriers and facilitators of access to dental care and completion of treatment for Aboriginal adults

An evaluation of the Aboriginal Liaison Program

Jones K, Keuskamp D, Brennan DS, Roberts-Thomson KF

CITATION

Jones K, Keuskamp D, Brennan DS, Roberts-Thomson KF. Understanding barriers and facilitators of access to dental care and completion of treatment for Aboriginal adults: An evaluation of the Aboriginal Liaison Program. APHCRI Centre of Research Excellence in Primary Oral Health Care, University of Adelaide, 2016.

APHCRI Centre of Research Excellence in Primary Oral Health Care

Australian Research Centre for Population Oral Health

School of Dentistry

The University of Adelaide

SA 5005 Australia

T   61 8 8313 3291

F   61 8 8313 3070

E   arcpoh@adelaide.edu.au

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Background

The general and oral health of the Aboriginal and Torres Strait Islander population of South Australia (SA) is significantly worse than the general population. As a consequence, Aboriginal and Torres Strait Islander oral health was identified as a priority in South Australia's Oral Health Plan 2010 – 2017 and in Australia's National Oral Health Plan 2015 – 2024.

Despite suffering poor oral health, prior to 2005 only a small percentage of Aboriginal people attended SA Dental Service clinics. Effective health promotion has the potential to play an important role in reducing oral health inequalities amongst Aboriginal people. Through the Aboriginal Liaison Program (ALP), partnerships have formed between the SA Dental Service and Aboriginal Health/Case Workers. These partnerships have been pivotal in raising the profile of oral health and increasing the acceptability of dental services among Aboriginal people, resulting in an increase in Aboriginal people accessing dental care.

The ALP began in late 2005 in response to an identified need to improve oral health outcomes for Aboriginal people in the SA metropolitan region. Four demonstration sites (Salisbury, Noarlunga, Parks and Port Adelaide) were selected based on population numbers provided by the Australian Bureau of Statistics. Funding was initially provided by the Central Northern Adelaide Health Service's Health Improvement Pool. However, since then, the SA Dental Service has covered the cost of expanding the program and the increased number of courses of dental care.

Initial planning for the program involved consultation with the Executive Director of Aboriginal and Torres Strait Islander Health and with a number of key Aboriginal staff who provided an insight into the oral health needs and expectations of the community, and ways to assist people to access dental care.

One of the barriers identified initially was the two-year-plus waiting time for general dental care at the South Australian Dental Service's Community Dental Clinics. As a result, one of the main objectives of the ALP has been to refer eligible Aboriginal adults to participating SA Dental Service Community Dental Clinics for priority dental care. Over the life of the ALP, several policy changes have enabled it to meet the needs of Aboriginal people. Currently, the Program is available to Aboriginal adults 18 years and over with a current Centrelink card. Clients receive free priority care (general and emergency) at all Community Dental Clinics in SA.

Since the ALP began in 2005 over 18,000 patients have visited a dental clinic for dental treatment. However, some clients who are referred do not take up the care while other clients begin a course of care but do not complete it.

AIM

This study aimed to understand why some Aboriginal adults who are referred for dental care do not take up or complete a recommended course of dental care. The study

> Explored why some Aboriginal adults take up a course of care after being referred and the perceived enabling and disabling factors and attitudes around beginning and completing a course of dental care.

> Has the potential to improve the practices of staff of the SA Dental Service in supporting Aboriginal clients in accessing dental care. It could also improve the communication about dental care available to Aboriginal people and thus improve their oral health and access.

Methods

RESEARCH APPROACH

A qualitative research approach was used to develop an understanding of the issues facing referred Aboriginal clients. A purposive sampling method was employed. Semi-structured face-to-face interviews were undertaken for three groups of people,

> Those people who access care and complete the course

> Those that access care but do not complete

> Those who do not access care following a referral.

This three-group approach allowed us to develop an understanding of the enabling and disabling factors to beginning and completing a course of care for those referred to the ALP. A sample of 54 people was recommended however a final sample of 41 people was achieved (a response rate of 76%). Thematic analysis of transcribed interviews was performed.

Aboriginal adults who have been referred for care in each of the three categories of receipt of treatment were asked to participate in the interviews. Interviews took place at either the nearest dental clinic, Aboriginal community centre or public library venue conveniently located for the participant; or if requested, in participants' homes.

Sampling

SA Dental Staff stratified participants into one of three groups: referral made but no treatment, referral made and some treatment, referral made and treatment completed. A total of 18 people per strata were selected. Postcards of introduction (Appendix A) using the *Healthy Smiles, Healthy Life* logo from the ALP were sent to those who had been sampled. One week after the postcards were sent, participants were initially contacted by an SA Dental Aboriginal Oral Health Program worker to further obtain consent to be contacted by an Aboriginal project officer from the Australian Research Centre for Population Oral Health (ARCPOH, Appendix B). If consent had been given, an information sheet required by the University of Adelaide (Appendix C) was posted and the project officer called the participant to make an appointment for an interview time and location. Full consent forms were signed at the interview (Appendix D).

The semi-structured interviews took approximately 45 minutes to one hour to complete.

Participants were informed at the interview that they were free to refuse to answer any questions at any time or terminate the interview and that no future dental treatment would be compromised by answering or not answering the questions. Participants were also informed of the option to withdraw from the research at any time.

Inclusion criteria

The inclusion criteria were anyone identifying as Aboriginal and Torres Strait Islander 18 years and over who was referred for dental care through the ALP and had a current Concession Health Care Card. There were no explicit exclusion criteria other than not meeting the inclusion criteria.

Interview questions

The interview questions were designed to broadly address potential issues in a participant's ability to access public dental services. It was recognised that barriers and enablers could be related to both individual level and environmental factors. The questions were designed to cover these broad areas. Appendix E shows the Interview Matrix and the full list of possible questions available to ask participants.

Data transcription and analysis

Transcripts from the digital recordings of the interviews were made by an independent transcribing consultant. A themes-based coding methodology was performed on the transcribed conversations. Conceptual models were also drawn from the data (see examples in Appendix F). Coding of the transcripts was performed by a researcher blinded to the participant treatment group.

Conceptual framework for utilisation and access to services

Measuring access is difficult, involving dimensions of service characteristics, providers and systems and their integration with people, households and communities. All these elements of utilisation and access were apparent throughout the interviews and a conceptual framework developed by Levesque and colleagues[2] allows for easier navigation through the web of interview stories to arrive at some understanding of the different outcomes for people referred to the SA Dental Service through the ALP.

A patient-centred perspective into population health and a system-level understanding of access and utilisation has been adopted as this best reflects the emergent themes arising from the interviews. Access here is seen as the opportunity of any individual to engage with a health service. It is recognised that the dimensions of access theorised in the framework and identified in the project are not independent constructs and each often influences the other, and potentially in a different way for each individual's experience. The broad domains which define utilisation and access recognise the importance of each individual, community and health system factors which impact on access and utilisation or generate obstacles.

The five dimensions relating to accessibility of public adult dental services are:

> Approachability

> Acceptability

> Availability

> Affordability

> Appropriateness.

The five corresponding abilities of individuals which interact with accessibility are:

> Ability to perceive

> Ability to seek

> Ability to reach

> Ability to pay

> Ability to engage.

These dimensions and abilities will be used to interpret the findings from the interviews and reported in the Discussion.

ETHICS CONSIDERATIONS

Ethics approval was received via the SA Dental Service, from the Aboriginal Health Council of South Australia and The University of Adelaide. Approval to release names and contact details of clients who attended after referral and who did and did not complete their treatment, and those who did not attend after referral, was managed through internal SA Dental Service management protocols. No names were released outside of the organisation. Staff within SA Dental Service's Aboriginal Oral Health Program contacted all

ALP clients to seek further participation into the study and authority to release personal details to ARCPOH.

Reimbursement was provided to participants involved in the semi-structured interviews to recognise their contribution to the research and in reciprocity for their time. Consultation with the Aboriginal Oral Health Program from SA Dental Service suggested that $50 vouchers be made available to encourage participation. These have been used successfully before by ARCPOH and were well-received by participants.

Results

SAMPLING

Interviews were performed for 41 people accessing the Aboriginal Liaison Program. Although this was less than the recommended sample size of 54, due to failure to attend interview appointments, full enumeration of the sampling frame was achieved. All participants attending the interviews completed the interviews. Several analyses were conducted: core themes as described by participants themselves were reported, as were constructs that were not specifically mentioned by participants but were contextual descriptors. Finally, all participants were asked questions of access and services which may not be of relevance to themselves but may relate to others. These suggestions are also reported. The findings below are presented in groups categorised by the receipt of treatment.

THOSE WHO COMPLETED TREATMENT

Twenty-two individuals completed the recommended treatment. The primary themes which emerged from interviews with these participants were,

> Self-efficacy

> Health literacy

> Social cohesion

> Previous use of dental services

> Presence of a health advocate.

The dominant individual themes to emerge from the analysis of the transcripts for this group were around the identification of self-efficacy and health literacy. System-level enabling themes which emerged were the presence of an advocate within the system who took charge of the process of appointing and managing some of the processes and previous experience in using the SA Dental Service.

Self-efficacy, health literacy and use of services

Comparatively, those who completed treatment appeared to be more skilled at navigating their way through health systems and had access to higher level resources and services which made attending dental appointments more achievable. This group appeared not to have issues related to English as a second language (ESL) and had relatively high levels of social support and social capital available to them.

This group had higher levels of previous experience with services provided by the SA Dental Service and experience with private dental practitioners. While these clients did not identify having a 'dental home' *per se*, this group of participants showed higher levels of appearing skilled at navigating health systems and exhibited high levels of 'entrepreneurial' or efficacious behaviour.

> I think us as consumers need to follow up. You know, if we're not getting that call, or if, I think empowering us to, giving us the power I think to, or empowering people to be able to say "Can you give me an appointment card, so that I don't forget, or can you text me, or can you ring me before the appointment?". I'm a cheeky bugger.

While some participants of this group acknowledged some level of dental fear, the desire for better oral health outcomes and long-term dental health coupled with an ability to manage time and minimal transport restrictions in accessing appointments, appeared to work together to make accessing treatment achievable.

So I just contacted Nungkawarra and they had a dental thing then, and things were just whack, whack, whack and all done, and I just couldn't believe it … if you don't know what services are available out there, you usually find it, I do a lot of work with the Elders, I love working with the Elders, … but it's not really until something arises that you sort of say "Oh, look, this has come up, where's the best place for me to go?", and they know all the places to go. And we can get everything for free, they're deadly.

Participants in this group reported high proactive health attributes and very little confusion around the process of seeking and managing their dental care. This may have been facilitated by the presence of a health advocate. Many reported high levels of organisational skills which appeared to facilitate managing both transport requirements needed to attend appointments and self-management skills around managing appointments in an organised fashion to facilitate remembering to attend their scheduled appointments.

Social cohesion

This group mentioned positive social connections within the wider community, school and sporting responsibilities and utilisation of other community-based services and employment. They appeared to have complex but organised lives. There appeared no intersections between transport, access and time management issues. There were often references to planning, diaries and tricks of all kinds employed to managing appointments to facilitate family members and self-involvement in community activities. This appeared a highly competent group.

Participants mentioned that they thought the levels of culturally appropriate services provided by SA Dental Service to be good. They reflected that sometimes, individuals working in clinics were not very 'friendly' or 'nice' but appeared themselves to have enough individual resilience to overcome these negative attributes of the service providers to achieve health outcomes for themselves.

… you do get a lot of non-Aboriginal ones that are pretty good, but then there's some, too, that you feel uncomfortable with … it's like when you go into hospital, or even a dental clinic or wherever, you know, you see paintings and anything Aboriginal up there that puts you at ease straight way.

Participants felt that overall the service was trying to make oral health services better for clients by training staff in culturally appropriate approaches to Aboriginal clients, and that any racism or discomfort that was experienced came down to individuals being rude, ignorant or impolite and not very good at their job.

I notice that when I go to the Aboriginal one, that they are more aware and they more sort of tell you more and ask you more questions and all that sort of stuff. So you feel like you're being looked after better.

The dentist himself made me feel comfortable by talking like he did, and he was a Muslim, and he came out here from South Africa. He put me at ease straight away … and each time I went back … whether it was to do with, you know, the dark face I don't know.

Previous use of dental services

This group of participants referred often to past use of dental services, both in private and public dental services. Many viewed the SA Dental Services as their dental home and had past experience of the school dental services. Many commented on the expense of private dental care and how appreciative they were of the provision of dental treatment to Aboriginal and Torres Strait Islander clients in the service. This may reflect the higher levels of self-efficacy and health literacy amongst this group.

The individual as a health advocate

Of particular note was the role of an individual in the system – an advocate – who appeared to take charge of the process. This person may have aided in developing or supporting self-efficacy of participants within the system. A majority of participants who completed treatment reported the presence of this particular employee who appeared a bridge between the participant and the use of dental services. It is unclear what the exact role of this individual was, however their presence obviously had an impact not only on the individuals who were interviewed in this project but on members in the wider community and whose presence enabled the facilitation of completed treatment. The person was obviously well accepted by the community and word had got around about their ability to assist Aboriginal and Torres Strait Islander clients with assessing services.

This group provided much more detailed responses to questions than the no treatment group in particular, indicating higher levels of confidence and ease in talking about personal issues and perhaps social cognition. It is difficult to know whether the experience of receiving treatment made this group more open to discussing a point of interest or whether there were differences present in levels of comprehension and literacy.

THOSE WHO COMPLETED SOME TREATMENT

Eleven individuals had completed some treatment. This was a complex group with complex responses. There appeared to be two dominant subgroups of people who had completed some recommended dental treatment,

> Those participants who started treatment and did not complete the recommended treatment plan as their primary individual objective in seeking treatment had been resolved (i.e., relief of pain).They were generally satisfied with the level of treatment received.

> Those participants who did not complete treatment due to other system level factors/barriers.

Generally satisfied with the care received but did not complete treatment

People in this category tended to be those who had been interested in treatment for pain relief or to resolve aesthetic issues which were impacting on their quality of life and self-esteem. They reported having completed the majority of the recommended treatment as prescribed by the SA Dental Service, yet due to external circumstances and a perception that they had received enough treatment to resolve their quality of life or esteem issues, that the full resolution of the presenting dental problem or problems was not necessary given their immediate circumstances and that the costs of attending any further appointments was not justified.

> [I missed the appointment] partly because I work full time and the treatment that I needed done, I got done, and it was just a follow-up appointment. I think they sent me a letter out to say that I had missed an appointment and could I ring to make another one to follow up treatment.

Additionally, poverty, particularly around issues of affording or organising transport on the day of the appointment, was frequently cited as a factor in failing to attend the full series of appointments. These were complex responses around managing responsibilities and transport, particularly for women, many of whom did not drive. Attending dental care was sometimes viewed as something that occurred in an *ad hoc* manner due to financial restrictions or commitment on any given day.

> Not having a car, not having transport. Money, finance, not having money to get to the appointment, petrol, just the general things of getting from point A to point B.

> I can rock up, make appointments, just at that time I had lots of, 'cause my wife and all that, and looking after a 4-year old kid, I was the one that had to drive my son into the Women's and Children's Hospital and stuff. And it was just always fell on the days of my dentist and stuff. I thought he was more important, getting him done, and getting his hand working than my teeth. And it just all went from there … she said "You've only got two chances, like, to make new appointment otherwise you can't come back to us", it happened a couple of times. And the last appointment, 'cause I had one tooth and I couldn't make that appointment, so I didn't bother ringing her up because of her attitude, thinking it's only one tooth, so …

The quote above reflects the interaction between several barriers (i.e. financial, and those associated with caring responsibilities and children's ill health) expressed in completing a course of care.

Those who would have liked to complete treatment but did not

There were three distinct themes which emerged in this group of participants,

> There was a perception among some interviewees that a 'two strike' policy was employed by the SA Dental Service which was seen by them as a big barrier to the completion of a recommended course of care. While no such policy exists within the SA Dental Service and all ALP clients are placed on automatic recall if they fail to attend appointments, the perception of such a policy could be a barrier and further work to investigate how such a misperception can arise among some clients may be needed.

> Ineligibility for treatment during the provision of a full course of care due to having become ineligible for a valid health care card

> A level of discomfort with the service culture.

None of these issues are mutually exclusive and indeed sometimes intersected with the issues relating to having almost completed treatment as seen in the quote above.

This group comprised of people who reported that their treatment ended primarily due to system-level issues which served as barriers to accessing further care. This group was uncertain or apprehensive about how to go about accessing more care with the SA Dental Service due to a series of failed-to-attend appointments and hence misperceiving that they would be 'ineligible' for more treatment; and those who we no longer eligible, or thought they were ineligible, for public dental care due to employment and no longer meeting low income eligibility criteria. The following quote reflects the interaction between several individual and service-level barriers to completing the full course of care,

> Um … I felt uncomfortable going to a new dentist … I was new because I was referred from the Port Adelaide dentist to The Parks. It felt a bit like, I don't know, they were just trying to push me off to other people. I felt uncomfortable constantly and trying to readjust myself to the new environment and yeah. And then finding out I had to go to another one, like being pushed off. I have depression and I felt uncomfortable at The Parks and I didn't want to bother going. Yeah. They moved [me] because of a weight issue … [issue in the chairs] … they cancelled me on the program and don't think they told me how to get back on the program. They cancelled because I stopped attending. I missed more than two appointments … I really liked the first dentist … So I just kept on waiting for her 'til she got back from her holiday. And I missed my appointment on the 2nd of October, no September I think. No, 2nd of October I think I missed my appointment. Because I just forgot about it.

Due to the perception of a 'two-strike' policy, some participants were unclear how long their perceived ineligibility lasted for and most felt too uncomfortable to clarify the issue by calling to ask.

This group made more references to preferring being seen by or assisted by Aboriginal health care workers and discomfort about relationships with particular staff, but did recognise that some culturally appropriate service was being offered. These preferences may have been more heightened due to a lack of knowledge about how the service functioned and not knowing how to go about asking for more care. The availability of a designated Aboriginal worker may have resulted in a higher level of awareness and understanding about an individual's limitations and barriers they faced in attending for care and why a failure to attend was the outcome. Generally lower levels of self-efficacy and literacy were evident in this group.

> It was pretty good assessment because I dealt with the Aboriginal people … you know what I mean, and they understand how Aboriginal people was back in them days [sic].

THOSE WHO COMPLETED NO TREATMENT

Eight individuals comprised the no treatment group giving rise to limited emerging themes. Of note however, was the overall omission of themes related to competencies and social and environmental factors that were present in the other two groups comprising of those that had completed treatment or had completed a portion thereof. This group was in general less able or inclined to give comprehensive responses to many questions asked by the interviewer.

Emergent themes in this group who did not attend for care were,

> - Opportunistic referrals
> - Complex lives
> - English as a second language (ESL)/limited literacy
> - Dental fear
> - Limited self-efficacy
> - Limited literacy.

Although small, this group appeared to have had a higher proportion of participants that had been referred through an opportunistic referral. That is, they were not seeking dental care to resolve a current dental problem when the referral was made. Most were attending at a health centre for another medical problem and were referred from there. This may reflect a characteristic of people with lower levels of self-efficacy or health literacy that attend for dental treatment only when experiencing symptomatic conditions.

> A lot of Aboriginal people just don't worry about going to the dentist, sort of like the doctors. Some don't even like going to the doctor ... it's just a bit of a … fear and you get nervous about the unknown.

This group reported living complex lives; some had already experienced what they had misperceived as a 'two strike' policy and some had apparent low levels of literacy and comprehension and were restricted with limited capacity to speak and comprehend English. Issues around dental fear were also reported frequently in this group, who often made reference to a fear or mistrust about the cleanliness of the equipment and/or the removal of teeth which were not allowed to be taken home with the participant.

> As I said, I can handle most situations but when I'm at the dentist I'm nearly crying and shaking. It's someone taking a piece of my body. Do you know what I mean? I know that sounds a bit corny but to me ... I'm going to leave a

bit behind, it's like a piece of my body's gone now. It doesn't matter that it's a bloody tooth.

Some participants reported being a 'failure to attend' due to transport problems and some mentioned that they had been away and had missed appointments due to sorry business. For example, one elderly person had an arranged driver from Aboriginal Elder Care who failed to turn up to take her to the appointment; another reported feeling quite unwell on the day of appointment and didn't feel up to taking several buses to attend. These older adults had reservations about calling to cancel their appointment and did not feel confident to make another. The quotes below illustrate the complexity of issues that people in this group experienced in addition to efficacy and literacy issues they may be experiencing.

> Aboriginal Elder Care … had been giving me information to say, oh, you know, "we've got this dental, we've got to pick you up and take you to the dental mob", and I said, "yeah, no worries". But by the time I had the reminder, I wasn't home at that time… [was away] at a funeral.

> … hopefully that I and my family, nothing major happens amongst my family and let them know. Like I said, I would have maybe I didn't keep those and that, normally I let people know that, you know, I can't, there's something has, did come up with my daughter and that [sic].

The following quote is from a man who was trying to 'get his life back on track'. He was ready to manage his dental problems but did not know how to begin to try to address having what he perceived as a 'two-strike' policy reversed.

> Well I guess I don't really, I haven't been involved really properly so there's not much I can really say, apart from I'd be happy if you could help me, point me in the right direction and that would be great then I guess. Because in another level at the moment of life and I'm trying to get everything done.

> I had the same dental dentist that comes in here, same dental clinic. But they only just took that couple of wisdom teeth and I was supposed to go back but I didn't. Because, well, when I was, what happened, I had to go away back to Woody Creek and I had to go back there for about two months or something. My family was, my auntie was very sick so I stayed up there …

These people had busy and chaotic lives, experienced in a context of limited self-efficacy and literacy.

> Yeah, I wanted to go at the time, like when I read the message, but the next day I forgot I had to do it. I'm just so used to waking up in the morning and getting the kids ready for school and just relaxing.

People in this group reported high levels of uncertainty about how the system works in general, and how the Aboriginal component worked as well. Some were unsure of what the fee structure was for care.

Discussion

The findings from this study took the form of themes emerging from the interviews, which were grouped by the extent to which patients completed treatment. Themes illustrated the multiple, interacting factors that exist at individual, community and health system levels that shape access to care. These are interpreted below by use of the conceptual framework of Levesque and colleagues[2], who defined access as 'the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use healthcare services, and to actually have a need for services fulfilled'. Access is envisaged to proceed from health care needs and the perception of those, through health care seeking, reaching, and utilisation (multiple points of access) to consequences of care (economic, satisfaction-based and health-related).

DIMENSIONS OF ACCESS AND ABILITIES OF PERSONS

The 'approachability' dimension from the conceptual framework reflects people's identification that some form of health service exists and their understanding of the nature of that service. The dental health service was well known among interviewees. Some patients, especially those in the 'completed treatment' group, were able to draw on the support of others – advocates - for more detailed information about the services that were available to them. Confusion about the nature of services available, in particular the false perception of a 'two-strike' policy, was more apparent in groups who did not complete part or all of their treatment, and there was less mention of support and knowledge available to patients from the wider community in those groups. The corresponding personal dimension – ability to perceive – could be seen in what appeared to be greater health literacy, beliefs and trust of the group that completed treatment (again, enhanced by the support of advocates). Some viewed the public dental service as their 'dental home' and trust in the Service outweighed misgivings about how they were treated by individual staff. In contrast, those patients who completed less treatment cited more mistrust, whether it be of the medical profession in general, cleanliness of the service or details of the procedure. Their uncertainty about how the system works in general and how the Aboriginal component operated was also a significant barrier to access. Their level of literacy and by corollary their health literacy was lower also.

The dimension of 'acceptability' relates to cultural and social factors that make it possible for patients to accept them. Those completing treatment noted that one of the aims of the Service was to improve oral health services for Aboriginal clients, including making them culturally appropriate, and staff had been trained to do so. They also appreciated the staff's professionalism. Aspects of the personal dimension, patients' 'ability to seek' care (their personal values, culture, autonomy), were a strong determinant in the group completing treatment. Patients in this group displayed greater autonomy and this greatly facilitated their access to care. They were aware of their right to access care and acted to follow this through, e.g. asking for reminders from the Service staff. In contrast, the groups completing less treatment were less self-aware. There was some indication from those patients that they were uncomfortable about removal of teeth, which may highlight one aspect of cultural awareness that is essential for services if they are to maximise 'acceptability'. Culturally-associated mistrust of health professionals and health systems was also apparent in patients completing less treatment.

'Availability' of care refers to the geographic location, nature of accommodation and timing of access to care. There was little that emerged from interviews that suggested this was a barrier to access. The related personal dimension of 'ability to reach' care was strongly gendered, with many of the female patients unable to drive in order to attend appointments. Other patients cited a lack of occupational flexibility, with at least one stating that they had not attended a follow-up appointment because they worked full time. The strong social ties

that exist for Aboriginal patients were evident across all interview groups. However, in some cases these actually limited their ability to reach care. For example, there were several demands on their time from family and friends in ill health or from culturally significant events such as sorry business. Likewise, the poor health of a number of patients sometimes restricted their capacity to attend appointments.

Themes around 'affordability' of care and 'ability to pay' were strongly reflected in the themes emerging from interviews. Although services were provided for free, there was some confusion about this among patients, especially in the group who did not complete treatment. A lack of money to pay for transport to appointments was an often cited reason for failing to attend by those patients who did not attend. Some of those patients had few sources from which they could borrow money, which further restricted their capacity to pay for needed care. It appears that there is patchy knowledge of the Service fee structure for Aboriginal and Torres Strait Islander patients. Some patients thought accessing care was free but others thought there was a fee attached. Many only found out at the moment of attendance when going to make a co-payment but the receptionist asked if they were of Aboriginal heritage. Making sure that the right information on fee structures is widely circulated might be an important health promotion message to this group. Nearly everyone reported that they recalled receiving a reminder text or a reminder card about their appointment.

The 'appropriateness' of services relates to the fit between services and patients' need, its timeliness, and amount of care spent in appropriate assessment and treatment. The related personal dimension 'ability to engage' relates to participation and involvement of patients. As evidenced by the patients in the group completing treatment, their empowerment, and subsequent engagement and participation in the Service were distinct from patients in other groups. They were proactive about making appointments for preventive care. Particularly evident for patients in the group not completing any treatment was their limited capacity for self-management. Life was complex enough for them without the additional challenge of attending dental appointments. Most were referred from another health centre and therefore were unlikely to seek preventive care.

INTERRELATIONSHIPS AMONG DIMENSIONS

It must be remembered that the dimensions of access theorised in the framework and identified in the project are not independent constructs and each often influences the others, and this may vary among individuals and at different times during an individual's experience. For example, 'ability to pay' was often cited as barrier with regard to transport to appointments, but this could be circumvented by social networks which afforded transport to patients and thus enabled access through improving their 'ability to reach' appointments. However, patients who could rely on greater 'ability to seek' were the only ones who could avail themselves of the support of friends. In some cases, this meant they could even overcome some levels of dental fear (which would limit their 'ability to engage'). Other patients found that their poverty was exacerbated by low social support and/or a low capacity for autonomy, which resulted in them failing to attend appointments.

Access as conceptualised by Levesque and colleagues is dynamic and cumulative. This is reflected in the narratives of patients who completed treatment, who often relied on previous experience with services provided by the public dental service and experience with private dental practitioners. In contrast, those who completed no treatment demonstrated a lack of engagement with the health system in general, and uncertainty about its operation.

In summary, it was evident that across all groups there were system and individual level enablers and barriers to care, and these could be readily conceptualised by the chosen framework. Enablers and barriers interacted with each other to promote or prevent patients' access of dental care. The ways in which these factors interact are thus viewed to have both positive and negative impacts on patients' oral health.

Conclusions

IMPLICATIONS FOR POLICY

Possible service-related factors to improve access to services

> Explore the wider promotion of the project amongst Aboriginal health organisations used by Aboriginal clients. Many were unaware of the availability of the service or its payment structure as free. (Approachability)

Associated individual utilisation factors addressed: Ability to perceive, seek, pay, and engage

> Address the issue of insecurity of participants attending and having to ask for or claim service under the ALP. Better integration of information sharing between ALP and clinic receptionists. Additionally, ensuring that there are standard and consistent procedures for reporting Aboriginal and Torres Strait Islander origin on personal records may also be important (Affordability and Appropriateness).

Associated individual utilisation factors addressed: Ability to perceive, reach, pay and engage

> Timeliness of care and failure to attend appointments are issues – if resources were available in the future, walk-ins for clients may be an option to consider. (Acceptability and Availability)

Associated individual utilisation factors addressed: Ability to perceive, seek, reach and engage

> Correcting the misperception among some clients that a 'two strike' policy exists as it was a significant factor in lack of treatment completed. People may be lost from the system as a result of a misperception. (Availability, Approachability and Appropriateness)

> More use of health advocates - there appeared a high rate of completions amongst those who had an advocate within the system (Availability, Approachability).

STRENGTHS AND LIMITATIONS OF THE STUDY

The strengths of this study included the use of a conceptual framework for access and utilization of services that reflected a patient-centered perspective into population health and system-level understanding. The sample size was substantial for a qualitative study. However, the group who did not complete treatment numbered only eight, and they were less able or inclined to give comprehensive responses, limiting the themes that could be drawn. A further study with a larger sample of this group could offer greater understanding.

Further research could explore further the barriers and access issues from the perspective of male and female patients. Also, studies could examine recommendations such as the benefits of health advocates.

References

1. National Advisory Committee on Oral Health. *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2004-13*. Prepared by the National Advisory Committee on Oral Health;2004

2. Levesque JF, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations*. Int J Equity Health 2013*;12:18.

Appendices

APPENDIX A. POSTCARD

Aboriginal Liaison Dental Program Evaluation

We are writing to you to arrange a time to ask your opinion of the Aboriginal Liaison Dental Program. An Aboriginal Project Officer from the SA Dental Service will call you over the next week to ask your consent to participate in an interview about this program. We would like to arrange an appointment to hear your comments at a place that is convenient for you. We will be offering a $50 Coles/Myer voucher at the completion of your interview to compensate your time to attend.

Kelly Jones, Research Associate

The University of Adelaide

APPENDIX B. ABORIGINAL LIAISON PROGRAM TELEPHONE SCRIPT

Greeting,

My name is   ----------------- and I work with the SA Dental Service. I'm calling on behalf of the SA Dental Service Aboriginal Healthy Smiles program. I hope you might have seen a Health Smiles information card we posted last week saying we'd call and introducing the study.
We are doing an evaluation of the Aboriginal Liaison Program and dental care. We are hoping to improve the dental service for Aboriginal clients who need dental treatment and would like to talk to people who have been referred by the service"
As your name is on the list for dental referral we hope you would have time to answer questions about it. We would like to do a face to face interview with you, at a time that suits you to talk with you about your experience of that referral.
The interview will take around an hour and will be audio recorded. Consent will be taken at the interview and when it's finished we will give you a $50 dollar to compensate your time. Are you interested in participating?
Do I have consent to pass your contact details on to our Aboriginal Project Officer who will organise the interview?
My number is ……… if you would like to contact us further.

Thank participant.

APPENDIX C. ABORIGINAL LIAISON PROGRAM EVALUATION INFORMATION SHEET

Purpose of the study: To understand why many Aboriginal adults who are referred for dental care through the Aboriginal Liaison Project do not start or do not complete a recommended course of dental care.

How were you selected? All people referred through the Aboriginal Liaison Program will be invited to participate in this study until we have interviewed enough people.

What is involved? You will be asked to participate in a face to face interview at an Aboriginal health clinic or community centre close to you. We would like to talk to you for about 1 hour about your experiences with public dental care. Participation in the study is voluntary, and you are free to withdraw at any time. Talking with us will not affect your future dental care. With your consent we will record the interview.

Confidentiality: Any information derived from the interview will remain confidential and your individual identity will be protected. The information you provide will only be used for the purpose of research for which it was collected and not be made available to others.

Who is conducting this study? This Evaluation Study is conducted by the Australian Research Centre for Population Oral Health at the University of Adelaide in conjunction with the SA Dental Service.

Expected outcome: This project has the potential to improve the practices of staff of the SA Dental Service in working with Aboriginal clients. It could also improve the communication about dental care available to Aboriginal persons and thus improve oral health and access to dental care.

Contact details: Should you have any queries please contact Kelly Jones

Australian Research Centre for Population Oral Health

School of Dentistry, University of Adelaide

Phone (08) 8313 4946

Email kelly.jones@adelaide.edu.au

APPENDIX D. CONSENT FORM

Project Title: Aboriginal Liaison Program Evaluation

Researcher's name:

•   I have received information about this research project.

•   The research project has been explained to me and I fully understand the purpose and my involvement in it.

•   I understand that I may withdraw from the research project at any stage.

•   I understand that I may not directly benefit from taking part in the project.

•   I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.

•   I understand that I will be voice recorded during the interview. The recording will be destroyed once they are summarised and at completion of the project.

•   I have received a $50 voucher for my contribution to the research project

I agree to the interview being audio recorded.   Yes 0   No 0

Name of participant:

Signed: Date:

I have explained the research project to the participant and believe that he/she understands what is involved.

I have described the nature of the research to   (print name of participant)

and in my opinion she/he understood the explanation

Researcher's signature and date:

APPENDIX E. INTERVIEW MATRIX

Note to Interviewer: *Instructions to you are in italics. Questions for you to read out are in* normal *print*

Interview reference numbers for re-interviewed subjects should match up with their original reference. New subjects should follow the same location reference (i.e. CHE for Cheltenham) together with a unique number.

Interview Reference Number:

Always bear in mind that this interview plan should be used in a flexible manner. It can be adapted, if necessary, to the topics the interviewer seeks to explore, the type of informant being interviewed, and so forth.

Introduction of interviewer

Hello, my name is _____, and I have been asked to conduct interviews with people like yourself who have been referred through the SA Dental Service for dental treatment.

During the interview, I would like to discuss the following topics: SA Dental Services, access to dental services, the perception or the feeling of safety, and the assessment of dental services provided in your community.

Read out the following:

We are carrying out an evaluation of the Aboriginal dental referral program.

Your answers will be treated with confidentiality among project staff for the purpose of evaluating the Aboriginal dental referral program. We are trying to try and understand why some people come in for treatment and why others don't. Hopefully we can find some ways to improve the service to make access to treatment better. All responses will remain anonymous. At the end of the interview we will provide you with your gift voucher. The interview should last about an hour.

(Establish Rapport) [shake hands] My name is _____ and I have been invited to conduct these interviews by the University of Adelaide. I am [something about interviewer]

(Purpose) I would like to ask you some questions about your background, your education, some experiences you have had, in order to learn more about you and how SA Dental Service can better help Aboriginal clients.

(Time Line) The interview should take about an hour and you are free to stop the interview or not answer questions at any time.

(Transition): Let me begin by asking you some questions about where you live and your family

A. (Topic) General demographic information – bio sheet

1. How long have you lived in Adelaide?

2. Do you have family/support network here?

3. You had a referral made for dental treatment; can you recall what dental problem you were referred for?

4. Did you attend any dental clinic for any dental treatment after you had the referral made? (Cont'd)

Attendance problems		
Main questions	**Additional questions**	**Clarifying questions**
Can you tell me about visits you have made in the past for dental treatment?	What was explained to you about your most current dental problem? What was explained to you about the cost of a dental visit? Under what circumstances does visiting the dentist become a problem? What are your feelings about attending the dentist? What is your feeling about the SA Dental Service Aboriginal programs? How is your dental problem now? Which issues or problems make it difficult to attend?	Can you expand a little on this? Can you tell me anything else? Can you give me some examples?
In your experience, what things make going to the dentist difficult or easy? OR In your opinion, what are some problems which might stop people from going to get dental treatment?	Why? What were your reasons for attending/ not attending?	
Assessment of public services		
Main questions	**Additional questions**	**Clarifying questions**
Generally speaking, are people satisfied with the services offered by SA Dental Service? OR In your opinion, how satisfied are people with the public services available? OR Do you know of any reasons why people might be dissatisfied with dental services?	If not, what are the main problems that you have witnessed or heard about? How well do you feel SA Dental approaches cultural differences for Aboriginal clients? How would you describe your feelings about going to the dentist?	Can you expand a little on this? Can you tell me anything else? Can you give me some examples?
If so, ask the key informant a question dealing specifically with this.		
Conclusion of interview		
Are there any other safety or health problems that we have not discussed and that you find worrisome? OR Do you want to add anything on about public health services?		

APPENDIX F. EXAMPLE OF CONCEPTUAL MODEL BUILDING.

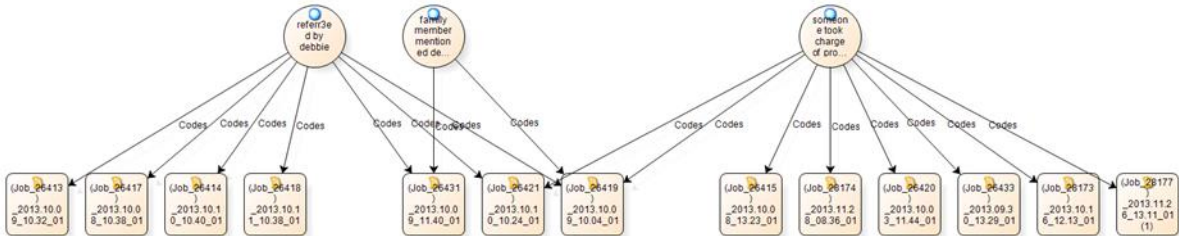*Figure 1. Conceptual model for **completed treatment** group and support received*

*Figure 2 Conceptual model for **completed some treatment** group and support received*

*Figure 2 Conceptual model for **no treatment** group and support received*