

ORIGINAL REPORT: QUALITATIVE RESEARCH

Oral Health in Young Australian Aboriginal Children: Qualitative Research on Parents' Perspectives

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Abstract: *Despite dedicated government funding, Aboriginal Australians, including children, experience more dental disease than other Australians, despite it being seen as mostly preventable. The ongoing legacy of colonization and discrimination against Aboriginal Australians persists, even in health services. Current neoliberal discourse often holds individuals responsible for the state of their health, rather than the structural factors beyond individual control. While presenting a balanced view of Aboriginal health is important and attests to Indigenous peoples' resilience when faced with persistent adversity, calling to account those structural factors affecting the ability of Aboriginal people to make favorable oral health choices is also important. A decolonizing approach informed by Indigenous methodologies and whiteness studies guides this article to explore the perceptions and experiences of Aboriginal parents*

(N = 52) of young children, mainly mothers, in Perth, Western Australia, as they relate to the oral health. Two researchers, 1 Aboriginal and 1 non-Aboriginal, conducted 9 focus group discussions with 51 Aboriginal participants, as well as 1 interview with the remaining individual, and independently analyzed responses to identify themes underpinning barriers and enablers to oral health. These were compared, discussed, and revised under key themes and interpreted for meanings attributed to participants' perspectives. Findings indicated that oral health is important yet often compromised by structural factors, including policy and organizational practices that adversely preclude participants from making optimal oral health choices: limited education about prevention, prohibitive cost of services, intensive marketing of sugary products, and discrimination from health providers resulting in reluctance to attend services. Current government

intentions center on Aboriginal–non-Aboriginal partnerships, access to flexible services, and health care that is free of racism and proactively seeks and welcomes Aboriginal people. The challenge is whether these good intentions are matched by policies and practices that translate into sustained improvements to oral health for Aboriginal Australians.

Knowledge Transfer Statement: *Slow progress in reducing persistent oral health disparities between Aboriginal and non-Aboriginal Australians calls for a new approach to this seemingly intractable problem. Findings from our qualitative research identified that structural factors—such as cost of services, little or no education on preventing oral disease, and discrimination by health providers—compromised Aboriginal people's optimum oral health choices and access to services. The results from this study can be used to recommend*

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changes to policies and practices that promote rather than undermine Aboriginal health and well-being and involve Aboriginal people in decisions about their health care.

Keywords: health services Indigenous, dental health services, social determinants of health, child health, health education dental, racism

Introduction

Improving Aboriginal and Torres Strait Islander (hereafter Aboriginal) health is a national mandate (Australian Government 2011), yet progress has been slow to reduce health disparities between Aboriginal and other Australians (Australian Institute of Health and Welfare [AIHW] 2013). An Australian public service report (Australian Public Service Commission 2007) described Aboriginal health as a “wicked” or intractable problem—one that is hard to solve, complex, symptomatic of deeper problems, persistent, and unique with no quick fix solutions. Rittel and Webber (1973) argued that resolution of this type of problem requires defining and understanding the complexity of the social context, adopting a holistic approach, seeing the bigger picture, collaborating across sectors with a view to attaining a shared understanding, showing courtesy and respect, and being open to innovative and flexible ways to address the issue.

The poor oral health of Aboriginal versus other Australians is well documented, with evidence of more dental disease periodontal or gum disease, often untreated (Roberts-Thomson et al. 2008; AIHW 2013). Aboriginal children have poorer oral health than do non-Aboriginal children, including higher rates of oral soft tissues’ disorders and hospitalization for dental admissions (AIHW 2013; Slack-Smith et al. 2013). Risk factors for oral disease include diets high in sugar (Jamieson et al. 2010), dental fear, poor dental attendance, low self-efficacy associated with poor oral health (AIHW 2013), alcohol consumption, and smoking,

including during pregnancy (AIHW 2006, 2013; Roberts-Thomson et al. 2014).

Yet constant reminders of dire health statistics have led some Aboriginal people to expect poor outcomes, feel disempowered, and be less motivated to engage with programs promoting health (Taylor et al. 2010). This implies that a diet of negative statistics, however serious, can be counterproductive. Taylor et al. (2010) suggest that media stories and public health campaigns need to balance adverse statistics with stories of success and empowerment that inspire rather than demotivate Aboriginal Australians to make changes. Evidence from a body of literature focusing on resilience challenges negative stereotypes and presents a more balanced perspective of Aboriginal health attesting to Indigenous peoples’ strength in the face of enormous and persistent adversity (Chandler and Lalonde 2008; Cox et al. 2014).

However, structural issues that adversely affect Aboriginal people’s oral health choices also need to be called to account. Macrofactors at the political economic level, such as policy and funding decisions, influence factors at the meso- or operational level, such as cost of services (Caldwell and Mays 2012). These, in turn, can preclude Aboriginal people from making favorable oral health choices. Yet, current discourse often blames Aboriginal people for their poor oral health, rather than the structural factors beyond their control that negatively affect their lived experience and ability to make optimum oral health choices (Playle and Keeley 1998; Durey et al. 2016). While such factors affect other socioeconomically disadvantaged populations (Australian Government Department of Health 2015; Wallace et al. 2015), Indigenous populations face the added burden of a legacy of marginalization and discrimination following colonization (Tuhiwai Smith 1999; Browne and Varcoe 2006; Paradies 2006). In colonized countries such as Australia, racism in health services persists; it often goes unreported and unchallenged,

despite its damaging health outcomes for Aboriginal people; and it can lead to their reluctance to attend services (Larson et al. 2007; Johnstone and Kanitsaki 2009; Shahid et al. 2009; Walter and Butler 2013).

Repeated Australian governments have committed to closing the gap in health disparities between Aboriginal and non-Aboriginal Australians by building partnerships among governments, service providers, and local Aboriginal communities (Council of Australian Governments 2008). While improvements in health and education outcomes are occurring (Holland 2016), progress is slow, and ensuring that improvements are sustained is critical.

To better understand the current state of play from an Aboriginal viewpoint, this article presents findings from a qualitative research project in Perth, Western Australia, that investigated the perspectives and experiences of Aboriginal carers, predominantly mothers, in terms of factors affecting their oral health and that of their children.

Local Context

Aboriginal Australians constitute 3% of the overall Australian population (3.8% of the population in Western Australia) and have a median age of 21.8 y, compared to 37.6 y for non-Indigenous Australians (Australian Bureau of Statistics 2011). In 2011, 34.8% of Aboriginal Australians lived in the major Australian cities and 43.8% in regional centers, with 21.4% living in remote Australia (Australian Bureau of Statistics 2011). Dental care in Western Australia includes private services with various items of treatment covered by insurance, public dental services that often also incur a treatment cost, free dental services provided by Aboriginal Community Controlled Health Services, hospital emergency dental services that can incur a cost, free school dental services for children aged 5 to 16 y, and volunteer services specifically targeting Aboriginal communities in remote areas.

Methodological Approach

Given its intercultural focus, our methodology was guided by the fusion of methodological paradigms proposed by Evans et al. (2009)—namely, Indigenous methodologies and whiteness studies. We adopted a decolonizing perspective involving Indigenous methodologies that prioritized Aboriginal people by applying their own focus, perceptions, and understandings to the research process (Moreton-Robinson and Walter 2009). Aboriginal stakeholders, including one of the authors, were central to the design, implementation, analysis, and dissemination of the findings of this project. We employed an Aboriginal assistant researcher to participate in data collection, analysis, and dissemination where highlighting the voices of Aboriginal parents/carers participants was integral to the project.

A decolonizing perspective also critiques the concept of whiteness, reflected here in the dominant Western biomedical paradigm in which oral health in Australia is situated. Frankenberg (1993) and Moreton-Robinson (2009) informed our understanding of how the notion of racial “whiteness” is conceptualized as a structuring or organizing principle representing power in colonized countries. White people, as in Anglo-Australians, are advantaged in social relations where whiteness is the norm—the benchmark against which differences from that norm, such as Aboriginality, are judged, measured, and often ignored (Moreton-Robinson 2009). While whiteness can refer to skin color, it also represents a racialized social structure that sanctions “Western” approaches to knowledge: health professionals are trained in a biomedical model of health where beliefs and values attached to that model are privileged over other knowledge, including Indigenous knowledge, and are reflected in policy and practice (Kowal 2008). While this advantage operates through a set of cultural practices that are often taken for granted—unnoticed and unexamined

by those who benefit from them—they also shape the lives and social relations of those who are disadvantaged (Frankenberg 1993; Moreton-Robinson 2009).

This is evident in the increasing focus in developed countries on individual responsibility for making health and lifestyle choices (Beck and Beck-Gernsheim 2002), reinforced by public health messages on what the individual needs to do improve health outcomes. This approach often ignores the socioeconomic and historic context of Aboriginal people’s lives and collective experiences of discrimination, including that in health care, which can negatively affect their making optimum oral health choices (Durey and Thompson 2012). Our project aimed to privilege the voices of Aboriginal participants by hearing their perspectives on the issue, to better understand the barriers they face and the enablers to oral health and how they intersect with current oral health approaches.

Methods

The research team consisted of the authors—1 Aboriginal and 3 non-Aboriginal researchers—and 1 Aboriginal assistant researcher. Following a suggestion from the local Aboriginal community to investigate Aboriginal perspectives of oral health, extensive consultation with key Aboriginal stakeholders occurred from 2013 to 2014 in Perth, Western Australia. This led to a larger research project seeking to understand the perspectives and experiences of barriers and enablers to oral health identified by Aboriginal health workers, teenagers, parents/carers, and non-Aboriginal dental professionals working with Aboriginal children. Some results of this project have been reported elsewhere (Durey et al. 2016). This study focused on parents, mainly mothers and 2 fathers, and carers who were family members.

Recruitment relied on the professional networks of the researchers and research assistant, who contacted

leading Aboriginal community and service organizations, which resulted in a snowball approach to identifying potential participants. The research team used purposive sampling to follow up Aboriginal and non-Aboriginal contacts at playgroups, Aboriginal health services, and family day care centers with a high proportion of Aboriginal children. Criteria for inclusion in the project were that participants were Aboriginal and were parents or carers of young children. The project was explained to each contact, such as the coordinator of the center, who then discussed it with parents/carers to see if they wanted to be involved in the research. Participants at each site self-selected to be involved. A time was arranged for the researchers to attend the center, explain the project to participants, and request their written consent prior to a group discussion. Depending on the time allocated, the researchers brought morning tea for participants and children or contributed to lunch. At the end of the discussion, participants were offered a \$30 supermarket voucher as a token of appreciation for their time. Participants ($N = 52$) were overwhelmingly young mothers, with 2 fathers and some grandmothers. Coordinators of the various centers, who were often mothers or grandmothers themselves, also participated in the discussions.

Nine group discussions involving 51 participants, as well as 1 interview with the remaining individual ($N = 52$), were conducted across 10 sites between April and December 2014. These were held at playgroup centers, family day care centers, community centers, and 3 health services in the Perth metropolitan region. Where possible, 2 researchers—1 Aboriginal and 1 non-Aboriginal—were involved in data collection. Eight group discussions and the interview were audio recorded; written notes were taken during the other discussion. All were transcribed and imported into NVivo (<http://www.qsrinternational.com/product>), a computer program that helps organize and manage data during analysis. Participants were asked to complete a short demographic

Table.
Participant Locations.

| Location: Code | Participants, <i>n</i> |
|-----------------------------------|------------------------|
| Playgroup center | |
| L1 | 5 |
| L2 | 3 |
| Family day care center: L3 | 5 |
| Community center: L4 | 8 |
| Health services | |
| L5 | 7 |
| L6 | 6 |
| L7 | 8 |
| Community center | |
| L8 | 3 |
| L9 | 6 |
| L10 | 1 |
| Total | 52 |

questionnaire covering age, sex, identification as Aboriginal, highest education qualification, ages of children, and postcode. Interview and group discussion questions were guided by topics related to what oral health meant to participants; what motivated them to care for their teeth and their children's and to go to the dentist; the barriers and enablers that they face; the effect of diet, including sugary drinks, on oral health; and how oral health, including dental services, could be improved for Aboriginal parents with young children. Information about participants and locations was de-identified and numerically coded to indicate quotes from the site of data collection (see Table).

Responses in each group discussion and interview were analyzed independently by 2 researchers, 1 Aboriginal and 1 non-Aboriginal to identify themes related to barriers and enablers to oral health. These were then compared for similarities and differences, discussed and revised under key themes, revisited, and interpreted for meanings

attributed to participants' perspectives. This iterative approach to data analysis identified key themes and anomalies from responses, which were summarized and interrogated with existing evidence in the literature. The findings were also interpreted by critically examining them within a broader structural context in light of Indigenous methodology and the concept of whiteness. This decolonizing approach privileged the Aboriginal voice and identified how the Western biomedical approach to oral health intersected with Aboriginal perspectives and lived experience.

Ethics approval for this research was granted by the Human Research Ethics Committee at the University of Western Australia (RA/4/1/5792) and the Western Australian Aboriginal Health Ethics Committee (No. 466).

Findings

Findings showed that oral health was important, with some participants motivated to proactively maintain their oral health and that of their children

despite structural barriers. Many participants accessed mainstream as well as Aboriginal-specific oral health services. A key theme emerging was the role of broader structural factors at meso- and macrolevels in informing oral health choices. These included cost, competing demands on limited budgets, the organization of services, and discrimination from health providers. These factors led many participants to avoid dentists for themselves or their children and self-manage their pain unless it was severe, in which case emergency hospital services were usually accessed. Participants were generally satisfied with the free dental service provided at schools, recommending that a similar public service be available for the 0- to 4-y age group. Participants also wanted more education on preventing oral disease from pregnancy onward, delivered in ways that were culturally appropriate and responsive to health literacy levels.

Maintaining Oral Health

Participants from most groups were aware that oral health was an indicator of general health and well-being, including brushing teeth, keeping gums healthy, having fresh breath and a healthy diet, and avoiding sugary food and drinks: "He's still breast feeding. He doesn't have cow's milk—I offer it to him but he won't drink it. But he does love water so I give him heaps and heaps of water but won't give him cordial or soft drink" (L2).

Participants proactively maintained oral health for themselves and their children, including modeling good oral health practice:

My kids started it when they were little, I think they had 2 teeth, honestly, they had 2 teeth, my little boy would come in and look at me and I would be brushing my teeth and I'd say, "Come here," and I would give him a little brush with . . . Bart Simpson on it. . . . They've got really good teeth, both my kids. (L6)

Creative ways to facilitate good oral health practice were to make

toothbrushing fun for children, and some mothers mentioned “Spiderman” and “Barbie” toothbrushes as a motivating factor for brushing teeth: “I’ve got this little brush that lights up when you press the thing. . . . When he sees me brushing . . . he looks at me—his attention span is so small and he’ll stand there for a couple of seconds and then pass it back to me” (L2) and “One, because they watch you doing it. From this little age, they are watching. And two, they want to know what to do with the toothbrush” (L3).

Others noted past experience of dental disease as a motivating factor in maintaining oral health:

When I was young, I had rotten teeth because Nan reared me up and she used to give me the bottle with cordial. . . . And that made me—growing up and having rotten teeth—and chip my teeth and having caps on. And now me having a baby, I just want him to have good teeth. I don’t give him cordial, and if I give him orange juice, it is watered down. Mainly I give him water. I want him to have good teeth. I don’t want his teeth to get like mine and do the same as what happened with me. (L2)

Another participant maintained her oral health until diagnosed with a thyroid problem, after which her oral hygiene deteriorated: “I was very good with my teeth. I did my teeth right up until before I had that, you know, thyroid problem. And then when I had it, you know, like, you are that sick that the teeth were the last thing you worry about” (L5).

It was clear from these responses that oral health was important to participants and their children and was actively maintained unless other priorities took precedence, such as illness. However, while some mentioned the importance of dental checkups, several avoided dental visits.

Avoiding Dental Visits

Reasons given for avoidance included how services were organized around cost of treatment and long waiting times that often led to self-management of dental pain, as well as fear of dental

treatment and dental extraction. Dentists were generally not visited for prevention: “The only time our family goes is if we are crying in pain” (L6).

Managing Pain

Discussions from most groups noted that dental pain was generally self-managed with analgesia, alcohol, or alternative methods, such as oil of cloves. If it became unbearable, participants might go to the hospital emergency department to have the tooth extracted, which often incurred a cost. Fear of dental extraction was also a reason to avoid the dentist for participants who wanted to retain their teeth.

While Western Australia has a public and private system of dental services, few participants across groups were insured privately. Those who accessed public services for treatment were often placed on long waiting lists. Those attending the dentist at the Aboriginal Community Controlled Health Service were seen that day on a “first come, first served” basis if they arrived by 8 AM. They often had to wait even if they were 1 of the 5 or 6 people assessed as suitable for treatment that day. Public dental services generally incurred a copayment for each item of service that was treatment focused:

It costs you money as well. Like, if I’m not in pain, then I’m not going to go and fork out, you know, what is it, \$80 or whatever to go and have it just checked when I don’t even feel the pain, so there is nothing wrong. And when you have got, like lots of kids, it’s not going to happen. (L7)

Discrimination

Discrimination was cited as a reason to avoid dental services in most discussion groups, though not in the interview. Participants felt discriminated against because of their Aboriginality, socioeconomic status, the state of their oral health, and bringing children to services that were not child friendly. Several participants discussed the difficulty of attending dental services when they were caring for children:

I was a single mum, no support, no family over here. So when I did get into that dentist early in the morning, they said, “What did you bring your kids here for? . . . And they said “We can’t treat you, you have got to find a place for your children.” And I’m like “Well, what am I meant to do with them?” and they’re like “Well, ring up someone to come and get them” and I’m like “I don’t have anyone” and they said “Oh, everyone has someone.” And they freaked out. (L3)

This experience was exacerbated for parents who wanted public dental treatment but were unable to be at the service by the required 8 AM because “you have to take your kids with you, you can’t leave your kids at school before 8:00, you know what I mean, there are all these things that restrict you getting your teeth done” (L1).

This participant went on to say:

I think that discriminates against people with children and people that have got to get their kids to school. We are told we have to have our kids at school every day but what if you have a toothache you have to get to the dentist? (L1)

Other participants felt discriminated against for different reasons, including staff at dental services making negative assumptions about their Aboriginality. One participant wanted to be:

. . . treated like everyone else that walks in the door. Some people when they see an Aboriginal person coming, we are all put in that category, we are all put in that box if they have had a bad experience with another Aboriginal person. They wouldn’t do that to an Italian woman if they had a bad experience with another Italian woman. But they will do it with an Aboriginal person. Do you see what I mean? (L6)

A participant in another group discussion elaborated on negative stereotypes that some people hold about Aboriginal people:

It’s really ignorance. It’s pure ignorance and rudeness on their part. They [staff] come with all these assumptions . . .

Anything negative that happens, what she was describing, that is used to reinforce the bias they already have. "These blackfellas come in and they are just so nasty—oh here comes another one, watch them watch them, they are going to make trouble." (L3)

These experiences were exacerbated by not having enough money to pay for a service:

She doesn't want to go there. The people at the desk, the receptionists—their sour faces. She is frightened she is going to lose her temper because she is in so much pain and she's going to get there and they are going to say with their sour face, "You haven't paid your bill." That bill is 2 years old. And she is going to lose her temper because she is . . . and start swearing and then they are going to kick her out. So she is scared of the confrontation and the drama and the rejection and what will happen when she turns up. And the fact that in front of all these people she is going to be humiliated because she has got no money, and hasn't been paying the bill. (L3)

These experiences resulted in many Aboriginal people feeling shame and humiliation, leading to their reluctance to return to the service.

Shame

In several discussions, participants talked about the shame they felt about the state of their oral health and its effect on their self-esteem: "If we have good oral health, you feel happier in yourself. We are all frightened to laugh. When we laugh, we laugh like this [puts hand over mouth] and hide our teeth when we smile" (L7).

Others noted the corrosive nature of shame from being humiliated and its effect on oral health, and they were concerned about relatives with missing or decayed teeth:

She was really upset, she was devastated, staying home, real "shame" you know. And she finally got to go to the dentist and she didn't have any money. They did something. But then they kept sending her this bill. And

she was too embarrassed because she didn't have the money so she never went back for treatment. Her teeth are just falling out. And when you are talking about self-medication, what in our family is grog and drugs, it's an excuse but it is kind of not an excuse if you are in a lot of pain. They are ashamed and they are also broke, they have got no car, they have got no money, they can't get to the dentist at 7.30 in the morning even if they tried. (L3)

Feeling shame about their oral health was exacerbated if participants were treated disrespectfully, patronized, or judged negatively by staff, which often led to avoiding dental visits altogether:

It feels degrading and it makes me want . . . I want to see change. But this particular time I wasn't in a good mood, wasn't in a good space. I was like, "I'm not coming back." Because you will go back to the services that look after you, and if you don't get that service, you just don't go back. People don't like it . . . if you're getting bad service at that dentist, why would you go back? (L6)

For participants to return to dental services, they wanted to "feel comfortable and to feel welcomed" (L6) by the office staff and the dentist, rather than patronized. The last thing they wanted was:

. . . another lecture on how to look after your teeth, when it's actually other stuff that keeps you from accessing [the service] in the first place. But then they just treat you like you don't know anything and like you're from another planet and they give you more lectures. . . . You are in pain, and you're there to receive health not to be lectured. (L6)

While participants in most group discussions spoke of negative experiences of oral health care, they also had strong views on what needed to change.

Enablers to Oral Health

Many participants were concerned about the state of Aboriginal children's

oral health where "you see a lot of little kids who have rotten teeth" (L2). They were aware that the causes of decay involve sugary diets and drinks, in babies' bottles as well, and not brushing teeth regularly. They also knew that waiting for the child to turn 5 y before they could access the school dental service was too late:

Yes, you got to start there, not when they get to school; half their teeth have all gone at 6 or 7 . . . so they have got to have their mouth sorted early on, and they have got to have baby teeth in place for the next ones to come down. (L1)

Prevention of disease and oral health education were considered key from pregnancy onward. However, this was not provided for most mothers. One mother of 5 had never been offered dental education or care during pregnancy. Participants in most groups valued the free public service offered by the school dental service, although not all children accessed it. Participants nonetheless felt that this type of service should be extended to include 0- to 4-y-olds:

As part of their prenatal care, they should actually have a free dental service for these mums to be able to, use and teach them about their teeth, have a look at their teeth, and go, "Ok baby's drawing a lot of calcium out of you, which is affecting your teeth. Let's look at this now. How can we fix it?" How can we get this on board? I think this is a huge factor because educating the parents from such a young age with their babies also educates the parents. (L3)

This participant highlighted a key issue around the content of oral health education:

We are told, "You shouldn't do this, you shouldn't do that." There isn't really a concrete understanding of how bad soft drink is for people. And I think we understand it when it starts to affect someone in our family. And then we are like "Oh, that is what soft drink does to your teeth" (L3)

Clear explanations of how to prevent oral disease, including eating a healthy diet within a limited budget and regular toothbrushing, could help parents be role models for their children. However, 1 participant felt that the responsibility did not lie just with the parents. Broader structural issues, such as upstream determinants, should also be called to account if oral health is to improve. These macro- and mesofactors affected parents' optimum oral health and included the intense and multifaceted advertising of unhealthy food to adults and children and the cost of consistently providing a healthy diet for families:

Like what you were saying about the effect of alcohol and cigarettes, the way they use that shock tactic should be applied to sugar—if you want to get the message through, show the shocking facts about what sugar does to poor little kids and adults. (L3)

This participant had a clear vision of what needed to happen to improve the oral health of young Aboriginal children—particularly those <5 y, who were ineligible for the school dental service (even if their teeth were rotten). She called for dental services to be made available for this group and for an invitation to be sent out to parents/carers:

By the playgroups and preschools—even if you think your kids teeth are fine—bring them in. At least check them. Once a year you should be invited in and get a free health check, dental check for these babies. So you see them at 2 years old and “Oh yes, you get a good tick,” and they come in the next year and it's, “Ooh, that tooth, that's not going to last. We are going to have to do something about that.” Here, they get nothing till they are 5, and that is just ridiculous. And then you are looking at dental emergencies instead of treating it when it could have been treated with a filling or whatever. And now they are in the children's hospital being put under [general anesthetic], which is dangerous and stressful, having a hospital procedure and something really painful when it could have been prevented. So it is like

this great big hole in the system. This massive big hole where these kids are just falling in. (L3)

In addition to this participant's plea to the government to “help us stop something before it gets to an emergency” (L3), she argued that this approach would reduce costs of emergency treatment. She highlighted the need to increase access to care by providing services that welcomed children. This was particularly important for those struggling to make ends meet to access services in the face of competing demands:

I think the biggest problem is, I honestly think they need to make it more family friendly as maybe a couple of days a week going, “OK we are going to have this crèche” [location where babies and young children are cared for] with 2 people on standby to look after the children. I don't have a health care card, but I am on a low income. So when you are on a low income without a health care card, you can't actually access the dentists through the health system, because you don't actually have that health care benefit. So you are actually having to fork out. You have to find that money first when you are on that lower scale of income, and you might go “OK.” You might prioritize your money for your bills, your food, and your petrol. Now what you have got left over might be \$100—well, I can't go to the dentist because what I need done, it's not going to cover that. Maybe the dentists need to start looking at starting a service where you can start paying off your dental work. (L3)

Discussion

Findings indicate that oral health is important to Aboriginal parents/carers who want their children to grow up with healthy teeth. This positive finding offers an opportunity for policy makers and service providers to consider how best to facilitate this. This requires reviewing current approaches to oral health for Aboriginal children where structural factors outside individual control can often compromise rather

than promote oral health. Such factors include cost—and not just that of dental services, which can preclude attendance, but also that of participants consistently providing a healthy diet for their families, which is often out of reach on limited budgets. Dental services organized mainly to provide treatment do not meet participants' need to be more informed about preventing disease and promoting oral health. Aboriginal participants want more education in this area from pregnancy onward, with clear explanations about causal factors and reasons to change behavior. They also want to be welcomed and treated with respect rather than judged and blamed by health professionals if their oral health or their children's is poor.

These findings support Beck and Beck-Gernsheim's (2002) argument that, in the current neoliberal climate, individuals are held responsible for making optimum health choices. In this context, this includes conforming to biomedical and behavioral messages, such as going to the dentist for regular checkups, eating healthy/sugar-free food, and stopping smoking. Beck and Beck-Gernsheim argue that the burden of risk is projected solely onto the individual, who faces penalties for “noncompliance” that include blame and “personal failure.” This argument is supported by our findings, where Aboriginal participants experience a sense of shame if their oral health is poor or are humiliated when they feel staff negatively judge and discriminate against them. This perspective reproduces the discourse that Aboriginal people are seen as the problem when they do not comply with expert professional knowledge and advice to improve their health (Playle and Keeley 1998; Durey and Thompson 2012). However, the structural factors informing Aboriginal participants' oral health choices are not addressed in this discourse. These might include discrimination from service providers, cost of dental services, difficulty of providing a healthy diet on a limited budget, and being exposed to intensive corporate advertising of high-sugar,

low-cost processed food and drinks that are a significant risk factor for dental caries. This broader perspective shifts the focus of accountability for poor oral health in Aboriginal parents and children beyond individual responsibility to macrolevel determinants of health. Shifting the focus away from holding individuals responsible for their health choices to refocusing the lens on the broader structural context can help inform how the problem of poor oral health in Aboriginal people can be more effectively addressed.

Changing the discourse to focus on the social structure “beneath the surface” (e.g., understanding factors influencing Aboriginal people’s “noncompliance”) to account for events “on the surface” (not turning up for appointments) offers a more critical appreciation of the problem by locating it in a broader social context (Scambler 2007). However, addressing upstream determinants of oral health is usually avoided, such as calling governments or corporations to account for policies and practices that compromise Aboriginal parents/carers’ capacity to make optimum oral health choices. While our findings indicate that participants can identify structural factors having a detrimental effect on their oral health, they are unable to change these factors as individuals. Such evidence takes the issue of poor health beyond the realm of individual responsibility to the social structure “beneath the surface” (Scambler 2007), which adds another layer to interpreting the findings. Without protection and support, ongoing experiences of shame resulting from discrimination can exacerbate rather than improve health inequities (Peacock et al. 2013).

Viewing policy and health services through the lens of oral health for Aboriginal people adds a layer of complexity to the current neoliberal argument that is symptomatic of deeper problems when the filter of race is added. Colonization has left a legacy of discrimination privileging whiteness over Indigeneity in Australia, Canada, and Aotearoa/New Zealand, where

marginalizing Indigenous peoples across contexts—including health, education, and employment—continues to negatively affect health and well-being (Tuhiwai Smith 1999; Browne and Varcoe 2006; Larson et al. 2007; Pease 2010).

Inequitable power relations are sustained when discriminatory practices against Aboriginal parents and their children go unrecognized and unchallenged by policy makers and service providers who deliver health care to Aboriginal Australians (Johnstone and Kanitsaki 2009; Moreton-Robinson 2009). Such practices must be addressed for their negative effect on Aboriginal people’s health and well-being and the part they play in Aboriginal people’s choice to attend dental services to improve their oral health (Frankenberg 1993; Johnstone and Kanitsaki 2009; Moreton-Robinson 2009; Durey and Thompson 2012). Evidence suggests that when practitioners who are trained in Western models of health care examine their assumptions and any negative stereotypes they hold about Aboriginal people and their culture, they are less likely to project these beliefs onto their patients and more likely to challenge the status quo (Pitner and Sakamoto 2005). This offers an opportunity for dental schools to address this issue through ongoing professional development that endorses dental professionals to continue to deliver respectful care to Aboriginal people.

A way forward to address this issue from a decolonizing perspective is to privilege Aboriginal voices to understand the complexity of the social context in which many Aboriginal people live and the role that structural factors play in their lived experience, including making optimum decisions about oral health. If Aboriginal people are to willingly attend dental services, our findings suggest that health services need to deliver more than evidence-based care by instituting policies and practices that are nondiscriminatory, nonjudgmental, and respectful (Durey and Thompson 2012). Refocusing the lens in this way highlights

the importance of policy makers and health practitioners being accountable for services delivered to Aboriginal people by reflecting on whether the care they offer promotes or compromises good health outcomes (Durey and Thompson 2012).

Limitations

The strength of this research was the use of a methodological approach that not only involved the collaboration of Aboriginal and non-Aboriginal researchers but also privileged Aboriginal parents’ voices to better understand the barriers and enablers to oral health they face in the context of their lived experience. However, given that participants were parents of mainly preschool children, there might be differences in responses from parents of teenagers. While the research focused on Aboriginal parents living in Perth, we believe that the findings could be applicable to other metropolitan and rural Aboriginal communities in Australia and elsewhere because of the legacy of colonization and discrimination in policies and practices affecting the lives and choices of Indigenous peoples (Ramsden 2002; McGibbon et al. 2014).

Conclusion

If blaming Aboriginal people for poor oral health choices in the current neoliberal climate continues and if discrimination against Aboriginal people in health services is ongoing, health disparities between Aboriginal and non-Aboriginal Australians are likely to persist. Given the apparent intractability of the problem, juxtaposed with the national priority to improve Aboriginal health (Australian Health Ministers’ Advisory Council 2015), policy makers and health service providers are well placed to reflect on their role in maintaining the problem, acknowledge its complexity, and look for innovative and effective solutions. This includes addressing the shortcomings of the neoliberal model, which focuses on individual responsibility

for health, by holding it accountable for its failure to adequately address broader structural factors informing optimum health choices (Schrecker and Bambra 2015). Engaging Aboriginal people in their health journey is a key recommendation to improving their health. This includes listening to their perspectives on barriers to oral health and suggestions for improvement—factors integral to making their voices heard, sharing knowledge, and building intercultural understanding. The Australian government's implementation plan for 2013 to 2023 aims to develop a health system flexible enough to support Aboriginal and Torres Strait Islander Australians to make healthy choices and access care that is free of racism where services proactively seek, welcome, and respect Aboriginal people (Australian Government Department of Health 2015). The challenge is whether these good intentions are matched by policies and practices that translate into sustained improvements to oral health for Aboriginal Australians.

Author Contributions

A. Durey, contributed to conception, design, data acquisition, analysis, and interpretation, drafted and critically revised the manuscript; D. McAullay, contributed to conception, design, and data interpretation, drafted and critically revised the manuscript; B. Gibson, contributed to conception, design, data analysis, and interpretation, drafted and critically revised the manuscript; L.M. Slack-Smith, contributed to conception, design, data acquisition, analysis, and interpretation, drafted and critically revised the manuscript. All authors gave final approval and agree to be accountable for all aspects of the work.

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