What Aboriginal people think about their access to health care

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A report presented to the Centre for Health Outcomes and Innovations Research (CHOIR) at the University of Western Sydney Macarthur on the 17th November, 2000.
Note on referencing:

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OPENING PARTICIPANT QUOTES

“Well I was taken off my mother when I was about three, four, like that. Same with my sister. And my mother was raped at thirteen [by a policeman] and had me at fourteen and this is from all the, round the Stolen Generation. It affected me, um, it affects everyone. Both male and female, because you were taken away from something that your own family, you’re pulled away from your own culture that I enjoyed as a kid, from what I remember. And, um, it's just not right, you know. They're trying to get us to be like them and then when we try to be like them, they put us down.”

(Aboriginal woman, aged between 40-50 years)

“It's really, really, aah, it’s um, the service that you get, really. Like, just say when you ring up, if she's [medical receptionist] nice and helpful, or he or she is nice and helpful, and um, they don't, you know, they don't make you feel, um, threatened or any thing.”

(Aboriginal woman, aged between 20-25 years)

“Um, with my upbringing, like I’ve even, I’ve, um, I actually lived on the mission all my life, school year life and moved away from there. With my son’s father we move to the town there. But, like, I've always, thing with myself, like I’ve never, ever thing with pride in me, because it's never really been, it’s never really ever been taught. I believe, I think with all the, see from our parents, you probably go back to our parents. See its probably the way they have been treated, um, and they really never had any pride… and they were treated badly. Like I didn't know all the things that Aboriginals got treated until I was in my late 30s. You know, because my parents and my grandmother never ever spoke about it, …the things that were done to them… what was done to them while they were growing up and parents from that way and whatever and it’s taught in with us, I think. I find… I haven't got it [pride] in me, that I feel pride… about me or friends, unless another person say it to me, you know.”

(Aboriginal woman, aged between 40-45 years)

“I used to be sort of shy and scared. And one day I went for this… and this German girl was there and I said: ‘I'm scared. I'm a bit frightened.’ We started talking and she says: ‘Hmm.’ She said: ‘Don't.’ She said: ‘whenever you walk into the room’, she said, ‘you hold your head up, right, and you think you're better than them.’ I've had that attitude ever since.”

(Aboriginal woman, aged between 50-59 years)
Macarthur Division of General Practice obtained funding from the Commonwealth Department of Health and Aged Care to conduct a two-year research project with the goal of increasing the use of primary health care services by urban Aboriginals in the Macarthur area. To achieve this goal, the project determined what difficulties, if any, Aboriginal people have in accessing primary health care services and then will seek to implement a health promotion program designed to reduce these access difficulties.

The Division contracted the Centre for Health Outcomes and Innovations Research (CHOIR) at the University of Western Sydney Macarthur to carry out the research. A three-phase plan was designed for the two years of the project:

**Phase 1:** Development and planning
Assess what difficulties, if any, Aboriginal people have in accessing primary health care services in the Macarthur area.

**Phase 2:** Implementation
Based on Phase 1 findings, an intervention program will be developed and implemented.

**Phase 3:** Monitoring and evaluation
The effects of the intervention program will be evaluated.

Phase One began with a qualitative study of medical receptionists in the area. The results of that study have already been presented in a report (see McInman, 2000, “The services General Practitioner Receptionists believe they provide patients: Does this service vary for Aboriginal patients?”). On the basis of these findings, it was decided that a further qualitative study should ask Aboriginal people in the area about their assess to health care facilities.

CHOIR contracted the services of McInman Research Centre to conduct this second study. The findings of this second study are presented in this report. This study involved qualitative interviews with 55 Aboriginal participants, aged 16-91 years, of widely varying backgrounds and educational levels. The interviews were semi-structured in nature and included a large number of probing questions in order to elicit a variety of responses. Because the researcher was concerned to let the participants speak for themselves, their answers vary greatly in terms of levels of understanding, articulation, and breadth of material discussed. To best comprehend the range and depth of information provided by the participants concerning their health and access to health care, most answers were categorised. These categories were not determined prior to the interviews, but were developed after the completion and transcription of all interviews. From a quantitative point of view, such categorisation is subjective and open to criticism. However, the categories emerged from a careful summary of themes provided by participants and closely reflect their comments.
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ABOUT THE AUTHOR

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DEFINITIONS

ABORIGINAL PERSON
The Commonwealth developed a definition of Aboriginal and Torres Strait Islander people following the 1967 Referendum (which was later endorsed by the High Court): “An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she is associated” (Barnes, White, & Ross, 1997). Throughout this report, however, the term Aboriginal was used to encompass both individuals of Aboriginal and Torres Strait Islander descent.¹ To be deemed an Aboriginal in this study individuals needed to fulfil two criteria: (a) believe they are of Aboriginal or Torres Strait Islander descent, and (b) identify as either an Aboriginal or Torres Strait Islander.²

KOORI
The name Koori, which is the name chosen by the Koori people of south-eastern Australia, has not been used in this study, except where participants specifically use the word, as some of the participants in this study have come from other areas of Australia and did not identify as Kooris.

ABORIGINAL HEALTH
The definition, developed by the Aboriginal Health and Medical Research Council of New South Wales (1999, p. 8), guided the research: “Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community.”

¹ The author of this report sought advice from Aboriginal elders in the south-western Sydney area and was assured that encompassing Torres Strait Islander people under the name Aboriginal would not cause offence. The author is under the impression that none of the participants in this study were of Torres Strait Islander descent. There was, however, one participant who had one parent of Torres Strait Islander descent and one of Aboriginal descent. She felt that the definition, as put forward above, was appropriate.

² An additional criterion sometimes used, that of “accepted as such by the community in which he or she is associated” was not felt necessary as it would be too difficult to assess whether the local community felt a particular participant was Aboriginal. Furthermore, the very action of discussing a participant’s status with the wider community would compromise their anonymity.
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPENING PARTICIPANT QUOTES</td>
<td>1</td>
</tr>
<tr>
<td>FOREWORD</td>
<td>2</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>3</td>
</tr>
<tr>
<td>ABOUT THE AUTHOR</td>
<td>3</td>
</tr>
<tr>
<td>DEFINITIONS</td>
<td>4</td>
</tr>
<tr>
<td>CONTENTS</td>
<td>5</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>7</td>
</tr>
<tr>
<td>LIST OF APPENDICES</td>
<td>9</td>
</tr>
<tr>
<td>SUMMARY</td>
<td>10</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>14</td>
</tr>
<tr>
<td>SAMPLE</td>
<td>19</td>
</tr>
<tr>
<td>METHODOLOGY</td>
<td>20</td>
</tr>
<tr>
<td>NOTE CONCERNING ANALYSES</td>
<td>21</td>
</tr>
<tr>
<td>RESULTS</td>
<td></td>
</tr>
<tr>
<td>SECTION A: CURRENT HEALTH</td>
<td></td>
</tr>
<tr>
<td>1. Perceived Health Status</td>
<td></td>
</tr>
<tr>
<td>1.1 Perceived health</td>
<td>22</td>
</tr>
<tr>
<td>1.2 Medical problems</td>
<td>22</td>
</tr>
<tr>
<td>1.3 Think about health</td>
<td>24</td>
</tr>
<tr>
<td>1.4 Concerns about health</td>
<td>25</td>
</tr>
<tr>
<td>1.5 Importance of health</td>
<td>27</td>
</tr>
<tr>
<td>1.6 Age and gender differences</td>
<td>29</td>
</tr>
<tr>
<td>SECTION B: HEALTH MAINTENANCE</td>
<td>35</td>
</tr>
<tr>
<td>2. Preventative Measures</td>
<td></td>
</tr>
<tr>
<td>2.1 Obtaining health information</td>
<td>35</td>
</tr>
<tr>
<td>2.2 Health pamphlets</td>
<td>40</td>
</tr>
<tr>
<td>2.3 Immunisation</td>
<td>45</td>
</tr>
<tr>
<td>2.4 Check-Ups</td>
<td>49</td>
</tr>
<tr>
<td>2.4.1 Check-Ups: Blood pressure</td>
<td>53</td>
</tr>
<tr>
<td>2.4.2 Check-Ups: Blood sugar</td>
<td>54</td>
</tr>
<tr>
<td>2.4.3 Check-Ups: Cholesterol</td>
<td>55</td>
</tr>
<tr>
<td>2.4.4 Check-Ups: Mammography</td>
<td>56</td>
</tr>
<tr>
<td>2.5 Alcohol</td>
<td>57</td>
</tr>
<tr>
<td>2.6 Smoking</td>
<td>60</td>
</tr>
<tr>
<td>2.7 Exercise</td>
<td>62</td>
</tr>
<tr>
<td>2.8 Nutrition</td>
<td>65</td>
</tr>
<tr>
<td>2.9 Relationships with check-ups</td>
<td>68</td>
</tr>
<tr>
<td>2.10 Age and gender differences</td>
<td>72</td>
</tr>
</tbody>
</table>

What Aboriginal people think about their access to health care.
### 3. Curative Measures

3.1 Last medical treatment 75
3.2 Preferred medical facilities 80
3.3 Bush medicine usage 84
3.4 Speed to seek help 88
3.5 Frequency comparisons about seeing a doctor 93
3.6 Age and gender differences 99

### SECTION C: ACCESS TO HEALTH FACILITIES

### 4. Medical Practices and Staff

4.1 Personal feelings about being in a medical practice 101
4.2 Personal experiences with receptionists 110
4.3.1 Personal experiences with doctors 122
4.3.2 Personal feelings about seeing a doctor 127
4.3.3 Kind of doctor Aboriginal people prefer to see 132
4.4 Age and gender differences 140

### 5. Access Problems

5.1 Financial difficulties 144
5.2 Transport difficulties 149
5.3 Telephone booking difficulties 152
5.4 Communication difficulties 154
5.5 Time of appointment difficulties 156
5.6 Difficulties using bush medicine 160
5.7 Shame 164
5.8 Age and gender differences 171

### 6. Making Health Access Easier

6.1 Should receptionists suggest others also attend? 175
6.2 Information designed with an Aboriginal flavour 178
6.3 Redesign Medicare cards 181
6.4 Effect of closing Aboriginal medical centres 185
6.5 Participants suggestions to make access better 189
6.6 Age and gender differences 192

### DISCUSSION

### RECOMMENDATIONS

### REFERENCES

| APPENDIX 1 | 236 |
| APPENDIX 2 | 238 |
| APPENDIX 3 | 242 |
| APPENDIX 4 | 246 |
| APPENDIX 5 | 255 |
| APPENDIX 6 | 258 |
| APPENDIX 7 | 261 |

---

What Aboriginal people think about their access to health care.
LIST OF TABLES

Table 1: Mean age of participants, separated by gender and age category (n=55)
Table 2: Number of reported medical problems reported (n=53)
Table 3: Extent to which participants are concerned about their health, separated by gender and age category (n=44)
Table 4: Relationship between medical problems and degree of concern about health (n=43)
Table 5: Relationship between the degree of concern about health and the importance of health (n=40)
Table 6: Relationship between the degree of thinking about health and the importance of health (n=40)
Table 7: Frequency of sources of health information (n=52)
Table 8: Number of individuals who have taken health pamphlets home, separated by gender and age category (n=46)
Table 9: Number of individuals who know what immunisation is, separated by gender and age category (n=43)
Table 10: Number of individuals who know that the government pays parents to have their children immunised, separated by gender and age category (n=31)
Table 11: Relationship between concern about own health and whether going to a doctor when healthy is a good idea or a waste of time (n=36)
Table 12: Number of individuals who have had their blood pressure measured, separated by gender and age category (n=52)
Table 13: Number of individuals who have had their blood sugar measured, separated by gender and age category (n=54)
Table 14: Number of individuals who have had their cholesterol measured, separated by gender and age category (n=33)
Table 15: Years since last mammogram (n=9)
Table 16: Number of alcohol drinkers, by age category and gender (n=44)
Table 17: Incidence of Aboriginal participants who drink alcohol to excess (n=25)
Table 18: Incidence of smoking among Aboriginal participants (n=44)
Table 19: Degree to which Aboriginal participants are happy with the amount of exercise they do, by age category and gender (n=35)
Table 20: Frequency with which Aboriginal participants exercise, by age category and gender (n=30)
Table 21: Kind of exercise Aboriginal participants participate in (n=30)
Table 22: Perceptions concerning nutrition
Table 23: Perceptions concerning types of food eaten
Table 24: Relationship between going to a doctor when healthy versus beliefs that going to a doctor when healthy is a good idea or a waste of time (n=40)
Table 25: Relationship between participants who believe that going to a doctor when healthy is a good idea, separated by if they have gone to a doctor when healthy or not, versus extent of thinking about health (n=20)
Table 26: Relationship between beliefs that going to a doctor when healthy is a good idea or a waste of time versus extent of thinking about health (n=36)
Table 27: The last time medical treatment of any kind was sought, by age category and gender (n=52)
Table 28: The reasons why participants choose to go to the medical centre (n=30)
Table 29: Preferred health facilities of participants for various health conditions
Table 30: Comparison between speed to seek a doctor versus speed to seek someone concerning a toothache
Table 31: Overall perceptions concerning medical receptionists, separated by gender and age category (n=38)
Table 32: The worst thing about seeing a doctor? (n=28)
Table 33: Ability to pay for transportation to a medical centre, medical fees, and medication costs ‘today’
### LIST OF APPENDICES

Appendix 1: Original “umbrella” questions used as the basis for the semi-structured interviews

Appendix 2: Expanded list of “umbrella” questions used as the basis for the semi-structured interviews after 17 interviews were completed

Appendix 3: Perceived health status of Aboriginal participants (in age order)

Appendix 4: Relationship between individual’s opinions concerning whether seeing a doctor when healthy is a good idea and concern about one’s health (in age order)

Appendix 5: Participants responses to: “In general, would you prefer to go to a doctor, chemist, or the hospital for medical problems?”

Appendix 6: Participants responses to: “Is there anything that could be done to make you feel more comfortable in medical centre’s waiting areas?”

Appendix 7: Participants’ suggestions of things that would make it easier to see a doctor or other medical services
SUMMARY

Fifty-five Aboriginal people, consisting of 20 young Aboriginal adults aged 16-25 years (10 male, 10 female), 20 Aboriginal adults aged 26-45 years (10 male, 10 female), and 15 Aboriginal senior adults aged 46 years or more (5 male, 10 female), were interviewed to determine what difficulties, if any, Aboriginal people face in accessing health care services in the Macarthur area (south-west Sydney, Australia).

The majority of participants perceived their health as being average, thought a lot about their health, and felt their health was important to them. There was more variation in the extent to which they were concerned about their health. Slightly less than half had at least one medical problem, of which high blood pressure, eye problems and diabetes were the most common. The majority smoked tobacco, drank alcohol, and slightly over a quarter drank alcohol to excess. The majority were happy with the amount of exercise they completed. Approximately a quarter were not happy with the type and amount of food they ate and did not eat enough healthy food.

Some participants, due to fortunate circumstances, encountered fewer barriers in accessing health care services. However, most participants faced a large number of barriers. The majority of participants felt that it was a good idea to see a doctor when they were healthy, however, only one-third had done this. Although slightly more stated that they sought treatment straight away, a large number left it as long as possible before seeing a doctor, or seeking help for a toothache. Four adults took dentistry into their own hands by using cigarette ash for pain, or removing teeth with pliers, their hands, or having a friend help them by purposely punching them in the jaw. A major determinant of the speed with which participants sought help, whether for a toothache or a medical problem, was the degree of pain. The greater the pain, the more likely a participant was to seek help.

The majority of participants did not feel intimidated, nor out of place in medical centres and more individuals said they felt comfortable waiting to see the doctor, than uncomfortable, or slightly uncomfortable. Unfortunately, a number of individuals mentioned racism, and being stared at in medical centres. Thus, it is not surprising that many felt more comfortable in Aboriginal medical centres. Overall, most participants indicated that they were relatively happy with the service they received from receptionists, although views concerning the service they received were evenly distributed between very good and poor. No participant felt that they received poor service because they were Aboriginal, although they did mention that some receptionists were not friendly and should pay more attention to customers. However, thirteen individuals felt that they were treated differently all the time, or at least some of the time, by receptionists because they were Aboriginal. Approximately one in five said that they refused to go to a medical centre due to the
way a medical receptionist had treated them. However, upon inspection, the reasons why the participants said they were boycotting some medical centres did not appear to be due to the manner or behaviour of receptionists, but rather medical centre procedures. The majority felt that their visits to doctors had been positive experiences and most of the remainder considered their visits at worse to have been ‘okay.’ More than half had never had a bad experience with a doctor. A third had experienced at least one problem with a doctor, but such episodes were rare. Most participants who reported a bad experience with a doctor never returned, although they might see a different doctor in the same medical centre.

Participants were divided between those individuals who were not concerned about which general practitioner they saw and those who chose to see a specific doctor. The later group did so because it was their usual doctor, they wanted to see someone of the same sex, or needed specialist knowledge. Some participants said they would prefer to see an Aboriginal doctor because they would feel more comfortable talking to another Aboriginal person, who would be able to communicate more effectively, and would be more familiar with Aboriginal culture. The majority, however, stated that it did not matter what race, age, or gender the doctor was, although a third said that they preferred older doctors because they were more knowledgeable and some preferred same-sex doctors for full body examinations.

Nearly one in every five individuals said that they would not attend early in the morning (e.g., 9.00 am). The major reasons cited for not attending this early were that the family came first, that they did not like to rush and they did not get out of bed early enough to go at such a time.

A large number of individuals said they used bush medicine and felt that it is a good thing to use, and more than a quarter had been treated by their parents or guardians with it. Approximately three-quarters said that they had not used bush medicine at the same time as western medicine; however, some did not think that there was any possibility of interactions between both drugs. Furthermore, two-thirds have never told a doctor that they use bush medicine. Typical reasons were that they did not think it would be necessary to tell a doctor, and that bush medicine should be kept secret to only Aboriginal people. The majority of individuals who have told a doctor that they use bush medicine stated that the doctor’s reactions have been less than favourable. The reluctance of telling doctors about using bush medicine did not appear to be related to perceived likelihood of being punished. Unfortunately, only one-third of the individuals asked about this issue felt that western trained doctors would understand bush medicine. Thus, only a quarter of individuals said that they would ever go to a doctor specifically to discuss bush medicine when prompted.

There were four major barriers impacting on participants’ abilities to access health care services. These were financial, transport, communication, and shame. Slightly over half the participants said that they usually did not, or sometimes did not, have enough money to pay for transportation to a medical service. Likewise, almost half said that they usually do not have enough money to pay for the medical service fee,
especially when they need to see a specialist. This would be higher if it was not for the fact that almost three-quarters said that they only go to doctors who bulk-bill. Slightly over half did not have enough money to pay either the transportation cost to a medical service and medical service fee, or the cost of medications at a chemist on the day of the interview. Some participants simply accepted this. Others were more resourceful and went to St. Vincents for help, or committed criminal acts (catching trains without paying) so as to receive medical care. Surprisingly, three-quarters said that they usually had enough money to buy medications. An analysis of the participants’ comments revealed that these individuals simply acted resourcefully by planning for such situations, or asked friends, family members, or relatives to help out. One Aboriginal woman explained how her chemist helped her by allowing her to pay the pharmacy at a later date. Similarly, five participants mentioned that their general practitioner would provide them with free medication, such as free antibiotics.

There are three reasons why transportation should not be a major problem: (a) most participants, or a close family member, have a motor vehicle, (b) the public transport system is close to most participants’ homes and the medical centre they usually attend, (c) and Tharawal Aboriginal Corporation provides a free transportation service. Unfortunately, a substantial number of individuals mentioned that they either did not use Tharawal’s transportation service because they found it less than reliable or desirable, or they used it and had to suffer the consequences. Others simply walk to the medical centre, but with some medical conditions this is not possible. Thus, if one disregards those who said that they walk to the medical centre and those that use Tharawal’s transportation service, slightly more participants have transportation problems than those who do not.

Less than half of the participants had access to a telephone at home with which they could make calls to a health care facility. Slightly less than half have also had, or sometimes had, difficulties making telephone bookings for a medical appointment. The major difficulty was feeling uncomfortable talking on the telephone. Not surprisingly, a significant number of individuals prefer to simply turn up and wait for a medical appointment, rather than make a telephone booking ahead of time. The major reason was convenience and the fact that they just happened to be there. A few said they always got someone else to ring up for them because they had difficulties understanding receptionists. Unfortunately, a few individuals said they would rather wait until someone visited their home and then ask them to ring and make the booking, rather than call themselves. One third of individuals had difficulties, or sometimes had difficulties, understanding receptionists and slightly less than half had difficulties, or sometimes had difficulties, understanding doctors. The difficulties encountered included accents, not understanding the information content, and the health professionals’ speaking pattern. One third said that they could not read, or could read but had some problems. One fifth had difficulties reading the yellow pages to find a telephone number for a doctor. Similarly, one quarter said that they had, or sometimes had, difficulties reading health pamphlets.
The biggest barrier for many Aboriginal people noted in this study was shame. Even if all the other barriers were eliminated, some participants probably will still not access health care services readily, if at all, because of these feelings. Aboriginal people have encountered approximately 200 years of oppression and racism. This has caused many Aboriginal people to have low self-esteem and apathetic views about their health and many other aspects of their life. Their resulting behaviour in response to various forms of neglect and abuse has lent itself to further racism. These findings are consistent with a model put forward by Feiring, Taska, and Lewis (1996, p. 767) which, while it focused on sexual abuse, proposed that “abuse leads to shame through the mediation of cognitive attributions about the abuse, and shame, in turn, leads to poor adjustment.” Thankfully, the future looks brighter in that none of the 20 young adults in this study stated that they felt shame. However, for many older Aboriginal individuals, shame is so entrenched that they refuse to seek help until it is too late. One of the many ways in which shame acts as a barrier is with those who cannot read or write well. For instance, one Aboriginal woman always brought her husband with her whenever she visited a doctor, so that he could help her fill out the forms. This woman felt that there were other Aboriginal individuals who would not go to medical centres because they would be required to fill out forms and would be embarrassed by their inability to do so. Although participants were evenly distributed between those who would not be affected at all and those who would be affected negatively if Aboriginal medical centres (mainly referring to Tharawal) were closed down, it is clear that for some participants, the integration of Aboriginal people into mainstream health care will not be the most effective strategy in the short-term. As Aboriginal people gain more pride, self-confidence, and self-esteem, then they will feel more comfortable in using the mainstream health care system.

Having reported the barriers that the Aboriginal participants in this study faced, this article then concluded by making a recommendation as to how some of the barriers in the Macarthur area could be reduced. It is recommended that the empowerment of Aboriginal people, both at the individual level and the community level be pursued. A mechanism by which empowerment can be implemented, the ‘Empowerment Bus’, is then discussed.
INTRODUCTION

The health of Aboriginal individuals in Australia (Richmond & Harris, 1998) and the area in which this study was conducted (South West Sydney Area Health Service, 1997) is sub-optimal. Hoy (1998, p. 1038) suggests:

“the health of Aboriginal people in the Northern Territory of Australia is among the worst in the world, with mortality rates increased in every ‘disease-specific’ category and averaging overall approximately five-fold those of non-Aboriginal Australians.”

A comparison with so many ailments suggests that Aboriginal individuals suffer much more than non-Aboriginal individuals. For instance, Aboriginal people, compared with non-Aboriginal people have a higher incidence of acute lower respiratory tract infection (Torzillo, et al., 1999; Williams, Gracey, Smith, 1997), back pain (Honeyman & Jacobs, 1996), cardiovascular disease (Hoy, et al., 2000), caries (Seow, et al., 1999), diabetes (Cameron, Moffitt, & Williams, 1986; Sellers, et al., 2000), end-stage renal disease (Cass, Gillin, & Horvath, 1999; Hoy, et al., 2000), hypertension (Hoy, et al., 1998), otitis media and hearing loss (Morris, 1998), and pregnancy-induced hypertension and urinary tract infection (de Costa & Child, 1996). Alarmingly, Aboriginal population suffer the highest incidence worldwide of infection with group A streptococci, which can result in rheumatic fever and rheumatic heart disease (Brandt, et al., 2000). Not surprisingly, Aboriginal people have a higher incidence of rheumatic heart disease than non-Aboriginal people (Carapetis, Currie, & Mathews, 2000; Carapetis, Wolff, Currie, 1996).

Aboriginal people experience many other health problems. For instance, immunisation levels of Aboriginal children are low (Hamdorf, et al., 1996). Additionally, although HIV incidence is similar among Aboriginal and non-Aboriginal Australians, Guthrie et al. (2000, p. 266) suggest “the lack of a recent decline in incidence and the higher proportion of Indigenous people exposed to HIV by heterosexual contact indicate the need to intensify interventions to prevent HIV transmission among Indigenous people.” Probably the bleakest depiction of the state of Aboriginal health in the beginning of the 21st century is depicted by Bridge (1999, p. 7):

“Australian Aboriginal women have twice the number of still born babies as Australian non-Aboriginal women and have babies who are five times more likely to die within the neonatal period. The perinatal mortality rate

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3 For a more thorough review of Aboriginal health the author suggests that the interested reader look at the following three internet sites:
   (This site contains a list of recent theses relating to Aboriginal health)
   (This site contains a list of links to journal articles relating to Aboriginal health)
   (This site contains a list of links to Aboriginal organisations)
is three times higher and the infant mortality is more than five times the overall rate for babies of Australian Aboriginal women compared to Australian non-Aboriginal women. These are the stark statistics compiled by the Midwives' Notification System in Western Australia (1998).”

Despite the fact that a substantial number of primary health care programs have been designed to specifically improve Aboriginal health (Couzos, Wronski, Murray, & Cox, 1998; Kruske, Ruben, & Brewster, 1999; Miller, Torzillo, & Hateley, 1999; Wakeman & Field, 1998), the majority of Aboriginal individuals in Australia still experience poor health, especially compared with non-Aboriginal individuals. Torzillo and Kerr (1986, p.31) go so far as to say that, “many Aboriginal people still live in conditions comparable to those experienced now in developing countries or a century ago in developed countries.”

It is important, however, to distinguish the differences between rural Aboriginal health and urban Aboriginal health. For instance, Duffy, Morris, and Neilson (1981) report an incredibly high prevalence (19%) of diabetes mellitus in the outer island area of the Torres Strait region. Likewise, O’Dea, et al. (1990) assessed 122 adults greater than 17 years of age in a small rural Aboriginal community in northern Australia and noted, “this small isolated Aboriginal population from northern Australia had an unexpectedly high frequency of diabetes (in view of their relative leanness) [11.5%] in association with a high frequency of metabolic abnormalities indicative of insulin resistance (hyperinsulinemia, IGT, hypertriglyceridemia)” (p. 830). However, the prevalence of diabetes in Aboriginal people in two predominantly Aboriginal communities in eastern New South Wales was substantially lower (6.7%; Williams, et al., 1987). Furthermore, their body composition was substantially different from the population reported by O’Dea, et al. (1990) in that 53% of the women and 27% of the men were obese.

Such urban-rural differences in the severity of Aboriginal health are not confined to diabetes. For instance, Chang, et al. (2000) has reported a high proportion of persistent asthma in the Torres Straits community in comparison to urbanised Australia. The prevalence of caries in Aboriginal people is lower in areas where fluoridation levels in the water are higher (Martin-Iverson, et al., 2000). Hence caries is lower in urban areas.

Variation in urban-rural Aboriginal health differences is not simply a matter of problems that are specific to the far northern regions of Northern Territory, Queensland and Western Australia. Instead they occur in other areas in Australia, as noted by Crowe (1995): “Central Australian Aborigines have a wide variety of medical illnesses which differ in incidence and severity from elsewhere in Australia.” However, such differences are not uniform. Instead, Henderson and Gray (1994, p. 1) suggest “Aboriginal and Torres Strait Islander people live in very diverse environments throughout Australia, where the causative factors of ill-health and the prominence of specific health problems vary.” A good example of the differences faced by health professionals in providing health care to rural Aboriginal communities is presented by McLaren (1995) who discusses the provision of
psychiatric services to Aboriginal people in the Kimberley. This region is approximately twice the size of Victoria, consists largely of empty wilderness, and has a permanent population of only 22,000. A casual comparison between Melbourne (the capital of Victoria), which would not make up even 1% of the land mass of the Kimberley, but has a population more than 100 times that of the Kimberley, would suggest not only are the health services and access to such services different in the two areas, but they need to be.

McDermott, Plant, and Mooney (1996, p. 589) explain how “one of the stated aims of Australia’s health care system is to achieve equity of access to health care according to need for all Australians, with the ultimate goal of moving toward statistical equality of good health for all.” To achieve such equity in access to health care a working party, consisting of 14 Aboriginal and Torres Strait Islander individuals and 5 non-Aboriginal individuals, submitted a final report to the Commonwealth, State and Territory Ministers responsible for Health and Aboriginal Affairs. The outcome was the establishment of the Aboriginal Health Development Group (AHDG). The AHDG, however, did not have Aboriginal representation and thus the Aboriginal Health Advisory Group (AHAG), which had representatives from Aboriginal health services, was established. In June 1990, the above-mentioned Ministers agreed to the National Aboriginal Health Strategy (NAHS). The overall aim of the NAHS was to “ensure that by the year 2001 all Aboriginal and Torres Strait Islander people have the same level of access to health services and facilities as all other Australians (National Health Strategy, 1992, p. 9). As a result, the Commonwealth Government announced in December 1990 that it would provide an extra $232 million over five years to implement aspects of the NAHS.

In 1991 the report from the Royal Commission into Aboriginal Deaths in Custody (1991) was tabled. This had a substantial impact. The Federal Government, in consultation with the Aboriginal community, launched two packages. On the 31st March 1992, it was announced that $150 million would be spent to address immediate legal, justice, alcohol, and substance abuse issues. On the 24th June 1992, it was announced that an additional $250 million would be spent concentrating on reducing dependency, increasing employment and income generation, and on young people.

The priorities identified by the Royal Commission into Aboriginal Deaths in Custody were similar to the conclusions of the working party that established the NAHS. The National Health Strategy (1992) suggested that there were five broad areas requiring action: (1) involving Aborigines and Torres Strait Islanders in their health, (2) reducing structural problems (unemployment, poor education, inadequate housing, water supply), (3) improving service provision and access to services, (4) providing

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4 It should be pointed out that such difficulties are not confined to psychiatry. Two authors, Grzybowski (1998) and McLean and Condon (1999) have discussed the problems associated with providing obstetrical and mammography services respectively for Aboriginal people in rural and remote areas.

5 This was in addition to the estimated, at the time, $1.3 billion, which would be provided by the Commonwealth for Aboriginal health and related services.
information about health and monitoring improvements, and (5) providing better support in the areas of education and training.

Since 1992, a variety of initiatives have been pursued. For instance, in August 1996, the Minister for Health, the Aboriginal Health Resource Co-operative Ltd, the Commonwealth Minister for Health and Family Services, and the chairperson of the Aboriginal and Torres Strait Islander commission signed an agreement with the aim to improve health outcomes for Aboriginal and Torres Strait Islander peoples by three methods. One of these was methods to improve access to both mainstream and Aboriginal and Torres Strait Islander specific health and health related programs. Another example of a partnership comes from Victoria. The Victorian Aboriginal Community Controlled Health Organisation Inc (VACCHO) and the General Practice Divisions Victoria (GPDV) developed a Memorandum of Understanding in July 2000 “to provide the framework for support to divisions of general practice in working effectively with Aboriginal communities” (Victorian Aboriginal Community Controlled Health Organisation Inc and General Practice Divisions Victoria, 2000, p. 3).

Of particular importance to this study was the development of the Strategic Plan for Aboriginal Health in South Western Sydney (1993). The plan created a partnership between the South Western Sydney Area Health Service, Tharawal Aboriginal Corporation, and the New South Wales Department of Health. Seven goals and 45 strategies were set. A review of the plan was conducted in 1998 (South Western Sydney Area Health Service, 1999) and concluded that 17 of the strategies were fully implemented, 19 partly implemented, and 9 not implemented at all. Of the seven goals, only one (“To improve the accessibility and appropriateness of mainstream health services to Aboriginal people in partnership with Aboriginal communities”) did not achieve any of the strategies to the level of full implementation. Reasons cited for this lack of success were: “the lack of a clear Aboriginal infrastructure until recently, high turnover of Aboriginal and mainstream staff within SWSAHS and in external organisations and problems of engaging mainstream health services in taking action to improve Aboriginal health” (South Western Sydney Area Health Service, 1999, p. 2).

The aim of this study is to assess what difficulties, if any, Aboriginal people have in accessing primary health care services in the Macarthur area. The findings of this study will then be used to design a health promotion program to improve access, if it is determined that there are barriers to accessing health facilities. This report consists of 3 sections. Section A (Current Health) assesses the participants’ perceived health status, the degree to which they think and are concerned about their health and how important their health is to them. Section B (Health Maintenance) consists of two sub-sections. The first sub-section (Preventative Measures) examines issues such as immunisation, exercise, and nutrition. An important part of this sub-section is the focus on check-ups. The second sub-section (Curative Measures) focuses on health care measures that have been used, including western medicine and traditional Aboriginal bush medicine. To a certain extent, Sections A and B are designed to ‘set the scene’. They provide the reader with an insight into what kind of
individuals the participants are, with a particular focus on their health beliefs and behaviours. Section C (Access to Health Facilities) consists of three sub-sections and focuses solely on access issues. The first sub-section (Medical Practices and Staff) examines the participants’ experiences and feelings about seeing doctors and receptionists. The second sub-section (Access Problems) examines difficulties such as transport, finances, and language. An important part of this sub-section is a discussion on shame. The third sub-section (Making Health Access Easier) examines the participants’ responses to five possibilities for improving access.

Unlike many reports, a substantial amount of discussion occurs in the results sections. The author chose to do this for two reasons: (1) the sheer volume of material and topics discussed would have meant a discussion that was excessively long and not focused on the most important findings of the study, and (2) the author wished to discuss suggestions to improve Aboriginal individuals access to health care.
The fifty-five participants in this study consisted of 20 young Aboriginal adults aged 16-25 years (10 male, 10 female), 20 Aboriginal adults aged 26-45 years (10 male, 10 female), and 15 Aboriginal senior adults aged 46 years or more (5 male, 10 female). The participants had a mean age of $34.31 \pm 15.12$ years (range = 16 to 91 years). Further information about the characteristics of the sample participants can be seen in Table 1. The sample size was determined using Goering and Streiner’s (1996) recommendations. Goering and Streiner suggest that qualitative researchers should sample until informational redundancy is reached. That is, interviews are conducted with as many people as necessary until saturation of responses occurs. They suggest that 15-20 interviews are sufficient for most studies to reach saturation. They note a smaller sample would result in a lack of understanding, whereas a larger number is unmanageable, unnecessary, and could prevent full in-depth understanding of individuals, as there wouldn’t be enough time. Since the aims of this study included a comparison of the three age groups and a comparison between the sexes, it was desirable to have sufficient and equal representation in each category. The aim was to have 10 males and 10 females in each age category and this was achieved for all categories except male senior adults. The reason(s) for failing to obtain 10 male senior adults can only be surmised since most of the individuals who declined to participate in the study were not approached directly by the researcher. Nevertheless, the total number of participants interviewed in this study was more than sufficient to address the goals of the study and was two to three times the number required according to Goering and Streiner.

Table 1: Mean age of participants, separated by gender and age category (n=55)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>Gender</th>
<th>N</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young adults (16-25)</td>
<td>Male</td>
<td>10</td>
<td>16</td>
<td>24</td>
<td>19.40</td>
<td>2.99</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>10</td>
<td>16</td>
<td>23</td>
<td>19.30</td>
<td>2.41</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td>Male</td>
<td>10</td>
<td>30</td>
<td>45</td>
<td>36.00</td>
<td>5.48</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>10</td>
<td>26</td>
<td>44</td>
<td>34.10</td>
<td>6.44</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td>Male</td>
<td>5</td>
<td>47</td>
<td>91</td>
<td>58.60</td>
<td>18.45</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>10</td>
<td>47</td>
<td>58</td>
<td>50.60</td>
<td>3.20</td>
</tr>
</tbody>
</table>

* The high refusal rate by the male Aboriginal senior adults is an interesting result in itself and will be discussed at a later point in the report.
7 To give an indication of the level of difficulty that the researcher faced in obtaining male senior adults in this study, it is worth noting that one of the female Aboriginal adults the researcher interviewed was kind enough to make 12 telephone calls to male Aboriginal senior adults she knew in the area. Only 1 of the 12 gentlemen was willing to take part in the study.
8 Due to the smaller representation of male senior adults, 2 of the 5 were approached again about various issues. Furthermore, some of the last participants to be interviewed (male and female) were also asked why they felt male Aboriginal senior adults in the area would be unwilling to be involved in the study and what health issues might be of particular concern to them.
In order to be reasonably assured that participants would have used, or could be in a position to, use health care facilities in the Macarthur area, the sampling strategy required that a participant in this study had to both: (a) fulfil the two criteria of the definition of an Aboriginal person as outlined on page 4 and (b) live, work, and/or be visiting someone who either lives or works in the catchment area covered by the Macarthur Division of General Practice.

METHODOLOGY

The author consulted a variety of people during the two-months prior to the commencement of this study in order to develop a set of general (“umbrella”) questions that could be used as a basis for semi-structured qualitative interviews. Representatives of Tharawal Aboriginal Corporation, Macarthur Division of General Practice, and the University of Western Sydney Macarthur played a significant part in developing some of the questions. From such discussions, and the results of a recent study completed by the author (McInman, 2000), a set of questions was created (see Appendix 1). These general (“umbrella”) questions were not regarded as an exhaustive list, but rather a skeletal guide. Thus, responses from these questions often led to the researcher asking additional and more probing questions. The questions focused on three areas: the perceived health status and health concerns of the participants; the perceived use of and comfort in using health care facilities; and possible problems accessing health care facilities.

Seventeen semi-structured interviews were conducted in June and July 2000 using the above-mentioned general (“umbrella”) questions. These participants (12 males, 5 females, mean age = 36.8 ± 12.4 years) were recruited with the help of staff at Tharawal Aboriginal Corporation. All interviews lasted approximately 60 minutes and were tape-recorded. As a consequence of these interviews, a number of important discoveries were made concerning the general health and health access issues of these participants. After

9 The author wishes to acknowledge the helpful suggestions for questions provided by Ms. Sandra Keogh, a former Manager of the Centre for Health Outcomes and Innovations Research (UWSM).
10 The researcher used a substantial number of probing questions. This was considered essential as it was anticipated that a number of the participants would find some of the questions confusing, there might be unexpected differences in understanding due to cultural differences, and some of the questions were of a very personal nature and therefore some participants may be tempted to answer them incorrectly. An excerpt shows an example of the need for probing from an interview conducted with an Aboriginal adult woman (aged 26-45 years). Initially she said she had no problems making telephone bookings, but after two more questions she revealed that she did have such difficulties:
   I: Do you have difficulty making a phone booking for a medical appointment?
   “Um, no.”
   I: What are you like on the phone? Are you nervous and jittery and all that?
   “Yeah, yeah.”
   I: So do you make the appointments yourself, or do you get other people to do it for you?
   “Um, I get me, me sisters normally do it. But sometimes if I get brave enough, I'll do it, but other times my sister will do it.”

11 These participants included Aboriginal males at a male-only community bush setting, Aboriginal females preparing to go on a female health workshop, Aboriginal patients after visiting a General practitioner, paediatrician, or dentist, Aboriginal people visiting the centre socially, Aboriginal health workers, and Aboriginal adults in their homes.
all 17 interviews had been conducted and transcribed, the author developed a far more extensive set of general (“umbrella”) questions. This expanded list of “umbrella” questions was used as the basis for all subsequent interviews (see Appendix 2). Due to the extensive number of questions, not all of these questions were asked of every subsequent participant. This was especially the case with elderly participants.

The author was acutely aware of the need to use more than one source when recruiting participants, thus the remaining 38 participants came from a variety of sources. The staff at Tharawal Aboriginal Corporation helped recruit some further participants, both at their centre and in participants’ homes. Five participants were recruited from Hoxton Park Community Medical Centre. The remainder were recruited by the author directly approaching individuals in the community at: residential homes in Claymore, the shopping area in Campbelltown, bus stops in Campbelltown, Bradbury TAB, residential homes in Bradbury, the shopping area in Airds, a sporting venue in Airds, and residential homes in Airds.

A major objective of this study was to obtain the viewpoints of the Aboriginal people in their own words. The traditional qualitative approach, whereby the interviewer “should talk or ask questions only under certain conditions” (Shouksmith, 1968, p. 36) was not considered the most effective method for achieving this objective as a number of the participants were not particularly articulate. Instead, the interviewer not only asked and listened, but also fully interacted by clarifying, discussing and telling (Chase, 1996). In this way, confusion was decreased and clearer answers obtained.

### NOTE CONCERNING ANALYSES

The interviews were semi-structured in nature and included a large number of probing questions in order to elicit a variety of responses. Because the researcher was concerned to let the participants speak for themselves, their answers vary greatly in terms of levels of understanding, articulation, and breadth of material discussed. To best comprehend the range and depth of information provided by the participants concerning their health and access to health care, most answers were categorised. These categories were not determined prior to the interviews, but were developed after the completion and transcription of all interviews. From a quantitative point of view, such categorisation is subjective and open to criticism. However, the categories emerged from a careful summary of themes proffered by participants and closely reflect their comments. Due to the potential for inaccuracy caused by subjectivity, tables of such categories are not provided in this report, except where subjectivity clearly was not an issue.
RESULTS

Section A: Current Health

Section A assesses the participants’ perceptions of their health. For instance, participants’ views were canvassed about how healthy they thought they were and whether they had any medical problems. They also indicated to what extent they thought about their health, the degree to which they were concerned about their health and to what extent their health was important to them. This section is especially important because the reader can compare the types of viewpoints the participants had about their access difficulties with their perceptions about their health. This section concludes with an examination of age and gender differences of these five variables. This final topic (age and gender differences) also serves as a summary of Section 1.

1. Perceived Health Status

1.1 Perceived health

All participants were asked: “How healthy would you say you are?” Fifty-two of the 55 participants were able to answer the question in a meaningful manner (see Appendix 3 for a list of all the participants’ responses). Slightly more than fifty percent of these individuals believed they were of average health. Such individuals were very likely to use the words: “pretty healthy.” A typical response was:

A: “Not too healthy, but not unhealthy, just a bit in the middle.”
I: What does that mean?
A: “To me, that I can still get up in the morning, stretch and go for a run and whatever and I don’t get too puffed out, or I don’t get sick from a cold.”

(Aboriginal Man, Young Adult: 16-25 years)

Even some participants who had suffered a severe medical problem could be classed as having an average health self-perception:

A: “Um, well, I feel pretty good, considering what did happen and what I have been through, all of my experiences. But at the moment I feel very good.”
I: Can you explain what you mean by ‘really good’?
A: “Um well I am ready to go back to work and at home, here, I’m that good, I’m just cooking and just cleaning. I feel very good.”
I: Do you mind telling me what happened to you?

12 “A:” = Aboriginal participant
13 “I:” = Interviewer

What Aboriginal people think about their access to health care.
A: “I’m a diabetic. I have been for nearly 30 years. I’m on insulin and what happened was that my kidneys got infected. I’m on dialysis... I’m not sure where it was, but I kicked my toenail on my big on my right leg and that got all infected. Um, well the nail came off and I was dressing it and within two days it deteriorated and I thought that it would be a slow process, but it wasn’t. It was just two days and then the toe got all black and gangrene. At first I went to the hospital and they just cut the top of it. Then that just didn’t seem to be healing up, so they debribed it about three times. After that I just said go just above the knees. I want to get on with my life. You know I have been in theatre so many times I’ve just about had it.”

(Aboriginal Woman, Senior Adult: 46+ years)

However, other individuals with medical problems, felt their health was poor:

A: “At the moment I’m not healthy at all.”
I: Why is that?
A: “I'm overweight. And because I'm overweight, it causes a lot of, you know, to do with blood pressure. And I’ve got diabetes. And I really didn't look after myself properly, because I thought, you know you don't have to, because you’re not on tablets, so that's cool. But then I found out, that I have a lot of problems. Because I've had feet problems, you know, because of the diabetes.”

(Aboriginal Woman, Senior Adult: 46+ years)

For other individuals who could be classified as believing they were not healthy, it was not so much because of medical problems, but rather behavioural problems:

A: “Um, not really healthy, I get a bit windy because I smoke a lot. Um, I breakout with a lot of boils, a lot of time, because I have been drinking a fair bit and that. But when I am off the grog, my skin is all right, but once I am on it, um, I break out in boils. Just a scratch will turn out into a boil.”
I: How much do you drink?
A: “Mainly weekends, Friday, Saturday, you know, and Sunday at the football, I drink a fair bit eh.”
I: What’s a fair bit?
A: “Till I’m pretty well drunk. Sometimes I go a bit too far overboard, or the pub may chuck me out.”
I: Are you unconscious?
A: “Sometimes I do, like I, be at this place and I’ll snap out of it and say ‘what am I do here?’ I’ll have a little blackout, sort of.”

(Aboriginal Man, Adult: 26-45 years)

There were only 10 participants who could be classed as believing they were very healthy, in contrast to 15 who believed they were not healthy. It is worth noting that of the 10 participants who could be classed as believing they were very healthy, just as many mentioned positive health behaviours as negative health instances:

“Healthy. I eat a lot of fruit, food, vitamins, walk a lot, just had a baby recently.”
(Aboriginal Woman, Young Adult: 16-25 years)

“Extremely healthy. I do do a cigarette. I'm a little unfit, but I’m healthy. Extremely healthy.”
(Aboriginal Woman, Young Adult: 16-25 years)
1.2 Medical problems

Fifty-three of the 55 participants responded to the question of whether they had any medical problems such as diabetes, high blood pressure, epilepsy, or eye problems. Twenty-two (41.5%) of these individuals replied that they had at least one medical problem. Eight of the 22 (36.4%) individuals reported more than one medical problem. Table 2 lists the number of medical conditions that the 22 individuals reported. Common ailments were high blood pressure, eye problems and diabetes. These three are common medical ailments of Aboriginal people (Hoy, 1998, Hoy, et al., 1998, Hoy, et al., 2000). However, the prevalence of these ailments is not representative of Aboriginal society. For instance, of the 15 individuals aged 45 years and over who responded to this question, 5 (33%) reported having diabetes. This is three times the prevalence reported by Henderson and Gray (1994) in the same area. The author believes that the extremely high prevalence of diabetes reported in this study is simply due to the sampling method employed. As noted earlier, random sampling was not deemed appropriate for this study. Instead a purposive sample was obtained. Thus prevalence rates are not representative of the area. Nevertheless, the author believed that providing the reader with an understanding of the medical conditions the participants had, would provide them with a better framework to understand the difficulties, if any, they face in accessing medical facilities.

Table 2: Number of reported medical problems reported (n=53)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>2</td>
</tr>
<tr>
<td>Arthritis</td>
<td>1</td>
</tr>
<tr>
<td>Asthma</td>
<td>4</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>1</td>
</tr>
<tr>
<td>Chest pain</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5</td>
</tr>
<tr>
<td>Dialysis</td>
<td>1</td>
</tr>
<tr>
<td>Ear problems</td>
<td>1</td>
</tr>
<tr>
<td>Eye problems</td>
<td>5</td>
</tr>
<tr>
<td>Heart attacks/problems/bypass</td>
<td>4</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>7</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>1</td>
</tr>
<tr>
<td>Legs amputated</td>
<td>2</td>
</tr>
<tr>
<td>Retinopathy</td>
<td>1</td>
</tr>
<tr>
<td>RSI</td>
<td>1</td>
</tr>
<tr>
<td>Throat cancer</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>

Note this is 45 years and over, not 46 years and over. This alteration was made so as to allow a comparison with Henderson and Gray (1994).
All participants were asked: “To what extent do you think about your health?” Forty-nine of the 55 participants were able to answer the question in a meaningful manner. Responses to this question were highly skewed with 22 (44.9%) of the 49 individuals responding that they think about their health a lot. A minority thought about their health in a proactive manner:

“Oh yeah. I always worry about, like um, if I eat something that is unhealthy, if it is going to affect me in the long run. Like I hardly ever drink milk, but I have as much cereal as I can. It’s supposed to be good for your bones or something. My eyes, I’m sort of a bit, is it long distance… I can’t really see things to far away. And I try and eat as many vegetables as I can.”

(Aboriginal Man, Young Adult: 16-25 years)

However, the majority thought about their health as a consequence of something happening in their life:

“I think about it a lot, because of sugar [diabetes]. A lot of old people pass away because of their sugar. They’re not old, but they should have lived to be a lot older.”

(Aboriginal Man, Adult: 26-45 years)

A: “A lot, especially since the operation. Um, any sort of chest pains, I sort of, where I generally ignored it before, I’m quite aware and I let other people know who are around me. Um, I let them know about what they should do in case of. Um, and especially the fact that I don’t come from New South Wales. I’m from the Northern Territory, so I don’t have any family down here. So that’s why it is important for me.”

I: Why would you not, prior to the operation, tell people about your chest pains?
A: “Just totally ignored it.”

I: Was it a case of just wanting to deny it?
A: “Didn’t think there was anything to worry about. I didn’t think that I actually fitted into, um, the sick type person.”

I: And what is the sick type person?
A: “Well, um, where I was living out in xxxxx, people live out unhealthy lifestyles, as in drinking, drugs, bad eating habits, um, violence.”

(Aboriginal Man, Adult: 26-45 years)

“Think about it a lot, especially as I get older.”

(Aboriginal Woman, Senior Adult: 46+ years)

Nine individuals responded in a manner suggesting that they did not think about their health:

“I don’t. As long as I am walking, talking, breathing.”

(Aboriginal Man, Adult: 26-45 years)

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To maintain anonymity, xxxxx has been substituted whenever a participant has mentioned something that might indicate who they are, or who they are talking about.
A further 4 individuals responded that they did not think about their health unless they were sick:

“Depending if I’m sick or anything. Otherwise I don’t really think about my health, no.”
(Aboriginal Woman, Young Adult: 16-25 years)

“Every time I get a pain.”
(Aboriginal Woman, Adult: 26-45 years)

The later example, of the woman who only thought about her health when she was in pain, is a key finding of the study. It appears that for a lot of people in this study, it is only when an ailment becomes obvious, either by an external indicator, or pain, that they will think about their health, let alone do something about it. This finding will be discussed further.
1.4 Concerns about health

All participants were asked: “To what extent are you concerned about your health?”. Fifty-one of the 55 participants were able to answer the question in a meaningful manner (see Appendix 4 for a list of all the participants’ responses). This question elicited a wide variety of responses. The author categorised the responses into 4 categories: 12 ‘not concerned’, 7 ‘a little concerned’, 15 ‘concerned’, and 10 ‘very concerned’.

The following three responses, all from individuals who were categorised as being ‘very concerned’, reveal a great diversity of reasons for feeling the way they do:

“Me, I’m really concerned about it, because um, especially with my diabetes because it runs in the family. Like, you know, it does run in the family, and I’m really concerned about my own, um, diabetes, my own health I should say. I go to the doctors, if I’ve got appointments to go see a doctor, then I’ll go see him. It doesn’t matter if I am working or not, you know. If I have an appointment, I’ll go and see him, especially if it comes to my health… I gave up drinking. The last drink I had was after my 18th birthday. After my 18th birthday I, I wake up next morning, you know how you wake up and you feel real hangover from the grog. Well that was me. And I was spewing and I was crook as anything, so I went straight to the doctors and he sent me down to have these tests done. I found out that I had ulcers. Come back and he said you have to give up smoking and drinking. Fair enough. I gave up drinking, but I couldn't give up me smoking. I tried and I tried and I tried to give up smoking, but I couldn't... Then I was smoking and smoking and then one day I had a medical test... [and the doctor] asked me to have a sleep study done. So okay, fair enough, I'll do that. Once I found out I had sleep apnoea, then the other doctor told me I had to do two things. One was to give up smoking and lose weight, because if I don’t as the years get by it's going to get worse and I'll have to sleep with a machine. Now that's one thing, that's another thing, I worry about my health, because I don't want to sleep with a machine, you know. I'd rather sleep with my Mrs than sleep with a machine. I couldn't see myself doing that and that's why I gave up smoking.”

(Abboriginal Man, Adult: 26-45 years)

I: Anything else you are concerned about your health?
A: “Yeah, just as long as I don't end up with sugar diabetes, you know, or any other disease. You know, I'm pretty happy with it.”

(Abboriginal Man, Adult: 26-45 years)

A: “Very concerned. My mother passed away xxxx years ago so that leaves me and my brothers and sisters as the oldest generation. Um, as it is fairly important to pass down history. We have to get history recorded.”

I: Tell me a little about that?
A: “Well, like my great grandfather was born of xxxx parents in xxxx. Now, although we know where he died, we don’t know when and we don’t know exactly where he is buried. The oldest brother was a SIDS case, so I don’t know where he is buried. I just feel that those sorts of things, plus my father’s side of things, he being born in xxxx. I just feel it’s important for the next couple of generations… for them to know.”

(Abboriginal Man, Adult: 26-45 years)
Individuals who had been categorised as being not concerned about their health tended to also view themselves as healthy:

“Happy as I am. Not really concerned.”
(Aboriginal Man, Adult: 26-45 years)

“I'm not really concerned actually. Like health is a big thing, but I don't really think about it until I'm sick or something is going on.”
(Aboriginal Woman, Young Adult: 16-25 years)

A: “No, not really.”
I: Why do you reckon that is the case?
A: “I’m healthy.”
(Aboriginal Man, Young Adult: 16-25 years)

An additional two individuals reported that their health was fine and thus they were not concerned about their health. Four individuals reported that they were concerned about medical issues, but they found it impossible to determine, or did not mention, to what extent they felt this way. One individual replied they were only concerned about their health when they were sick.
1.5 Importance of health

All participants were asked: “Is your health all that important to you?” Fifty-one of the 55 participants were able to answer the question in a meaningful manner. Three individuals felt their health was not important to them, but this was a rare viewpoint:

“As long as I can walk and talk and breathe that’s important. Other than that I don’t worry about it.”
(Aboriginal Woman, Adult: 26-45 years)

Triple the number of individuals who felt their health was not important felt their health was very important, as the following two quotes portray:

“Very important. If you don't exercise and you don't eat the right thing, your health will just go down hill.”
(Aboriginal Man, Adult: 26-45 years)

“It's a very important, because I want to keep on surviving, but like I say, I'm not looking around, I'm not frightened of death, if you get what I mean. If I die right now, I’m dead. And if a doctor comes to me and says, ‘xxxx [his name] you have two months to live’, I wouldn't be frightened of it, I wouldn't be crying about it, you know. I'd be rushing around trying to do the two things in the two months that I really want to do. You know, tell me love ones that I love them, and tell me enemies to get ready to come with me. You know, um, that's, that's, that's what I want to do. You know. I'm not frightened. But the health and well-being of a person’s mind is, is, is, is most important. That's, that's the ultimate. While ever you can lay back with two broken, or with no legs, or with no arms, but you still have a healthy mind and be able to think things through, you know, and see things, with, or without your eyes, you can see things in your mind, um, you’ve still got an existence. You can still tell yourself that you are still alive, even though you don't have limbs, or whatever. Ultimately, like, no one wants to be that way, but I'm saying the mind is the, is the thing…”
(Aboriginal Man, Senior Adult: 46+ years)

However, the majority of these individuals (68.7%) were categorised as believing their health was only ‘important’ to them:

A: “Important enough to stay alive, you know. I don’t want to sort of, although I never think about dying, or anything like that because of my health, but I sort of like to, sort of, I don’t know, stay alive, instead of dying, you know. Just things I see, like I said, it runs in the family and, um, just to see the family, um, how badly they have be treated with their health and I sort of don’t want to go that way.”
I: When you say “badly they have been treated with their health”, what do you mean?
A: “Like, what I mean by that is, um, like when they go into hospitals, have operations and stuff like that, I’ve been there, I’ve seen it all. Um, that’s with all diabetes, you know, um, especially cancer. Um, what I mean is, one of the family did have cancer, um, plus he’s got diabetes, um, and I’ve seen him, you know, it’s just. That’s why I sort of worry a lot about my health, you know.”
(Aboriginal Man, Adult: 26-45 years)
A: “Oh yeah.”
I: Why is that?
A: “Frightened of dying.”
I: Are you seriously frightened of dying?
A: “Oh yeah... I went to nine funerals (of Aboriginal people) in the last week.”
(Aboriginal Woman, Senior Adult: 46+ years)

A: “Yeah.”
I: Why is that?
A: “Just so I don't be sick all the time.”
I: Any other reasons?
A: “Just to live longer.”
(Aboriginal Woman, Young Adult: 16-25 years)

Three individuals noted that the importance they attach to their health varies from time to time:

A: “Yep. I want to be healthy, but sometimes I don’t give a damn, you know.”
I: Why is that?
A: “Just with life sometimes, it gets me down. Just with the problems in life and I turn to grog and you know take it away for a little while.”
(Aboriginal Man, Adult: 26-45 years)
1.6 Age and gender differences

The majority of responses provided by the individuals canvassed (69.8%) could be categorised as either believing they were healthy or very healthy. This is similar to the results of the 1994 National Aboriginal and Torres Strait Islander Survey (Cunningham, 1996b) which found that most people thought they were in good, very good, or excellent health (82.7% for males, 63.1% for females). The survey indicated that “older people were more likely than younger people to say their health was fair or poor” (p.1). The same trend was also found in this study, although the trend was more pronounced for females.

As with self-perceptions of health, there was an obvious age trend with medical problems. The majority of young adults did not have, or report, medical problems. Only one male young adult and two female young adults reported medical conditions, whereas 9 out of 9 female senior adults and 2 out of 4 male senior adults reported medical conditions.

There was not, however, an association between medical problems and self-perceptions of health. This was partially alluded to in Section 1.1, where it was shown that just as many of the 10 participants who could be classed as believing they were very healthy, mentioned positive health behaviours as negative health instances\(^\text{16}\).\(^\text{17}\)

There were no obvious age or gender differences with regard to the extent to which participants thought about their health. There were also no relationships found between the extent to which participants thought about their health and either self-perceptions of health or whether they reported any medical problems.

There was a definite age trend associated with concerns about health (see Table 3).\(^\text{18}\) Only 1 of the 17 young adults were ‘very concerned’ about their health, whereas 4 of the 9 senior adults were ‘very concerned’ about their health. Furthermore, 10 of the 17 young adults were categorised as being ‘not concerned’ or ‘a little concerned’, whereas none of the senior adults were categorised in this manner.

\(^\text{16}\) This result does not support that of Cunningham, Sibthorpe, & Anderson (1996b, p. 3) who found that “people were also more likely to say their health was poor or fair if they said they had a long-term health condition, such as heart problems, kidney problems or diabetes.”

\(^\text{17}\) The reason for this result cannot be determined from this data. However the author suspects that a social psychological theory known as the ‘big fish-little pond’ effect may explain this. The interested reader is directed: Marsh, H. W., Kong, C.-K., & Hau, K.-T. (2000). Longitudinal multilevel models of the big-fish-little-bond effect on academic self-concept: Counterbalancing contrast and reflected glory effects in Hong Kong schools. Journal of Personality and Social Psychology, 78(2), 337-349.

\(^\text{18}\) The 7 individuals who answered this question, but who could not be categorised into the 4 categories of ‘not concerned’, ‘a little concerned’, ‘concerned’, and ‘very concerned’ were not included in this analysis.
A relationship between concerns about health and medical problems was noted (see Table 4). There were a wide range of views regarding the extent of concern about health for individuals who responded that they did not have a medical problem. However, for individuals who responded that they did have a medical problem, they tended to be 'very concerned' (7 out of 18; 38.9%) or ‘concerned’ (6 out of 18, 33.3%). It can hypothesised that these participants have varying views about the extent to which they are concerned about their health if they don't have a medical problem, but as soon as they develop one, then their level of concern increases. However, there are exceptions as the following two examples illustrate:

A:  “Well not too concerned as you can see.”
I:  What do you mean by ‘as you can see’?
A:  “For myself I don't feel 100 percent fit, but probably 50/60. The size of me is pretty big.”
   (Aboriginal Man, Young Adult: 16-25 years)
A: “I suppose ending up in hospital, that would be it, just ending up in hospital. Like I said, next heart attack I have I hope I am straight to the morgue, there’s no stop off at the hospital and trying to revive me. Because I don’t want no needles stuck in me to keep me alive.”

I: Is that what had to happen in the past?

A: “Well they have done that for the last three heart attacks I’ve had. And for every pain in the chest I’ve got stuck in an ambulance, they kept on wanting to stick needles into me to. Most of my elders, including my brothers and sisters and cousins, the ones that have died in the last five years have all died from being in the care of doctors. And it is the continual years that they have messed around with their bodies until they are just dead.”

I: Just so I understand, if you have another heart attack and no one helps you, you’ll probably die, would that be right?

A: “Yes.”

I: But if they get help quick enough and get you to a hospital, they could possibly keep you alive?

A: “Yes, might, yes.”

I: But you don’t what that?

A: “No, not really, because like I said, doctors have been poking around with my relatives, you know, for the last five years you could say, and members of my family have died.”

I: But if they save your life by putting you in an ambulance, taking you to hospital and doing what they have to do [interrupted by interviewee]?

A: “And then killing me. No, no. I don’t feel like going to the doctor no more. I’ve had enough of them. They want to do blood tests. They want to do, and they already have all that information, um, but it’s just like continual paperwork. I hate continual paperwork. Medicine is the same way too. On top of that I would like to use the bush medicine.”

(Aboriginal Man, Senior Adult: 46+ years)

There were no obvious age or gender differences with regard to the extent to which participants felt their health was important.

A relationship between concerns about health and importance of health was noted (see Table 5). There were a wide range of views regarding the extent of concern about health for individuals whose responses were categorised as being either ‘not important’ or ‘important’. However, for individuals who considered their health ‘very important’, they tended to be ‘very concerned’ (5 out of 9; 55.6%) or concerned (2 out of 9, 22.2%).

Table 5: Relationship between the degree of concern about health and the importance of health (n=40)
A relationship between thinking about health and importance of health was noted (see Table 6). Individuals who considered their health to be ‘very important’, tended to think a lot about their health (6 out of 8, 75%). However, individuals who only considered their health was ‘important’ or ‘not important’, tended to have diverse views about their health. This study has practical ramifications because, the greater the extent to which a person thinks about their health, the more likely they will believe their health is important. As it has already been pointed out that the more a person views their health as important, the more concerned they will be with their health, promoting greater thinking about ones health may have beneficial outcomes, especially as it was also shown that there was a relationship between concerned about health and having a medical problem.

Table 6: Relationship between the degree of thinking about health and the importance of health (n=40)

<table>
<thead>
<tr>
<th></th>
<th>Don't</th>
<th>Not that much</th>
<th>Some times</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your health all that important to you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not much</td>
<td>2</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Is important</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Very important</td>
<td></td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>6</td>
<td>6</td>
<td>20</td>
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</tbody>
</table>
Section B: Health Maintenance

This section consists of two sub-sections. The first (Preventative Measures) examines issues such as immunisation, exercise, and nutrition. An important part of this sub-section is the focus on check-ups. The second sub-section (Curative Measures) focuses on health care measures that have been used. These include western medicine and traditional Aboriginal bush medicine.

2. Preventative Measures

This sub-section addresses eight health topics (obtaining health information, health pamphlets, immunisation, check-ups, alcohol, smoking, exercise, and nutrition). Wherever possible, emphasis focuses on the prevention of health problems. Due to the findings of the study, check-ups receive special attention. This sub-section concludes with two further topics. An examination of the relationships between check-ups and some of the other variables is made. This is followed by an examination of age and gender differences. This final topic (age and gender differences) also serves as a summary of Section 2.

2.1 Obtaining health information

The majority of the 50 individuals, who provided meaningful responses to the question “Where do you get your health information from?”, suggested that it was via the media and/or written sources (see Table 7). These included such things as television, radio, internet, newspapers, health pamphlets, written material, and even completing a school health exam. Two examples demonstrate why they prefer these sources:

I: “Where do you get your health information from?”
A: “Mainly sitting around, um, in medical clinics reading their pamphlets.”
I: “So you get more information from that than your mother and father, or your other family members, or TV?”
A: “Yeah, because, um, by reading it, it gets in more than what it does by watching it.”
(Aboriginal Woman, Adult: 26-45 years)

19 It should be pointed out that although the variables chosen in Section 2 were considered important on their own, they also have an important accumulative effect. For instance, Berlit (2000, p. 231) explains how “a significant risk reduction for ischemic stroke is possible with at least 30 minutes of physical activity twice a week, cessation of cigarette smoking, and treatment of hypercholesterolemia with statins. Dietary measures should include a reduction of animal proteins, normalization of body weight and a large amount of fruit and vegetables; small amounts of wine are allowed.” All of these variables, except weight control have been examined in this section. Weight control was not examined specifically as the two main mechanisms used for weight control (exercise, nutrition) were examined.
I: “Where do you get your health information from?”
A: “I suppose it is just listening to the news…”
I: Do you get more information from TV than from your friends and family?
A: “Oh yes. I do, because, um, the family is just like me, checking things out.”
I: What about your elders?
A: “Well, their source is bush medicine. That’s about it. Health, um, among, health reasons among Aboriginals with the elders has got a lot more to do with bush medicine than anything else.”

(Aboriginal Man, Adult: 26-45 years)

Table 7: Frequency of sources of health information (n=52)

<table>
<thead>
<tr>
<th>Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>All places</td>
<td>2</td>
</tr>
<tr>
<td>Doesn’t</td>
<td>1</td>
</tr>
<tr>
<td>Family and friends</td>
<td>14</td>
</tr>
<tr>
<td>Aboriginal elders</td>
<td>1</td>
</tr>
<tr>
<td>Written material</td>
<td>6</td>
</tr>
<tr>
<td>Health pamphlets</td>
<td>13</td>
</tr>
<tr>
<td>Newspapers</td>
<td>1</td>
</tr>
<tr>
<td>TV</td>
<td>10</td>
</tr>
<tr>
<td>Radio and internet</td>
<td>2</td>
</tr>
<tr>
<td>Doctors</td>
<td>14</td>
</tr>
<tr>
<td>Aboriginal medical facilities</td>
<td>7</td>
</tr>
<tr>
<td>Chemist and naturopath</td>
<td>2</td>
</tr>
<tr>
<td>Praying</td>
<td>1</td>
</tr>
<tr>
<td>School health exam</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
</tr>
</tbody>
</table>

The next substantial source of information was from health professionals (doctors, Aboriginal medical facilities, chemists, naturopaths). For instance, one Aboriginal woman said she obtained her information from doctors:

“Um, most from the doctors. If I want to know anything, I'll ask them, and no matter which doctor, their pretty good. They'll sit down and explain everything to you. And then if I can get some pamphlets, I'll take them home.”

(Aboriginal Woman, Senior Adult: 46+ years)

A substantial number of people obtained their information from friends and family members. One young woman mentioned that she obtained health information by praying and a young male felt that he did not obtain health information:

I: Where do you get your health information from? Is it from parents, friends, pamphlets, TV, radio, the internet, doctors, or other sources?
A: “Nothing really. Just play football all day and hang around with me mates.”

(Aboriginal Man, Young Adult: 16-25 years)
Two individuals specifically mentioned that they did not obtain their health information from just one source. In fact, a large number of individuals mentioned they used a variety of sources to learn more about health. The following two individuals’ responses indicate this:

I: Where do you get your health information from? Is it from parents, friends, pamphlets, TV, radio, the internet, doctors, or other sources?
A: “Off the TV.”
I: So you think you get more information of the TV than you do get off your friends?
A: “Yeah, the TV, the news, and you hear about it by ear, and off friends and that. Like this fella’s got Hep B or something. Like I’ve got one friend, he was playing football and he found out that he had Hep B and he had to leave football and that, because body to body contact sport. So he quit, plus he just come to train to stay fit… You just hear it by ear and that, you no.”
I: So are you more likely to get more information about your health from TV or from your friends?
A: “Both.”
I: And what about from pamphlets and magazines and newspapers?
A: “Yeah, same, yeah.”
I: So would you get more information from TV or from written type sources?
A: “I reckon, written type.”
I: Yeah?
A: “Yeah.”
I: But it’s just that you have not mentioned it? And when you look at a pamphlet, you quickly look at it, and then you chuck it back, but you still reckon [interrupted by the interviewee]?
A: “Yeah, oh, I suppose, yeah, like, because if you went to a doctors’ surgery, they are all in front of you and that. Like, yeah, if you do not go to the doctors and that, you just don't pay attention to it. But see, when you see it on TV, it sort of gets you going and that.”
I: It gets you what?
A: “It gets you going, like you look at it and you go ‘oh yeah’, because they advertise a lot of things about health and that – smoking and diabetes and all that, you know. The main things in, I don't know, the main sickness going around, or something.”

(Aboriginal Man, Young Adult: 16-25 years)

A: “The elders. Mainly the elders and the old people. And some will come from the kids.”
I: Are you saying that your kids teach you something?
A: “Oh yeah, oh yeah, same thing.”
I: What about TV end pamphlets?
A: “Some from my sisters, not from hospitals, but from the elders down home.”
I: You were talking about headaches?
A: “If I wake up with a hangover or a migraine. I don't have migraines, but if I get a headache, I get two raw eggs and Worcestershire sauce. It works quicker.”
I: And what about if you've got a headache, but it's not because of grog?
A: “… I'd put my hand like that [places thumb and index finger on an acupuncture point in the webbing between the thumb and index finger].”
I: Do you ever use the egg mixture if you've got a headache, but it's not because of grog?
A: “No.”
I: Where did you learn the pressure point?
A: “Kick-boxing.”

(Aboriginal Man, Adult: 26-45 years)
After the first 17 interviews were analysed, the author decided to ask 4 additional questions regarding obtaining health information to subsequent interviewees. For instance, participants were asked: “Can you get all the health information that you require?” The majority of individuals (72.7%) definitely believed they could. However, a sizeable proportion believed that at one time or another, they definitely couldn’t. After listening to these individuals respond to this and other questions, the author couldn’t help but wonder if in fact there were more than 27.3% of the individuals having difficulties obtaining health information. The following four responses are representative of the viewpoints of individuals who had difficulties:

“Sometimes frightened to talk about diseases.”
(Aboriginal Man, Adult: 26-45 years)

“Would like to know more.”
(Aboriginal Man, Young Adult: 16-25 years)

“Basically most stuff, but can’t get every single thing.”
(Aboriginal Woman, Young Adult: 16-25 years)

A: “No.”
I: And why is that?
A: “Because I don’t know who to go to. I don’t know who to ask.”
(Aboriginal Man, Young Adult: 16-25 years)

Further evidence that a greater percentage of individuals in the population actually had difficulties obtaining health information, is due to the fact that 10 out of the 29 (34.5%) individuals asked, felt embarrassed asking about health issues at one time or another. A number of women felt embarrassed asking about ‘womens’ issues’. Examples from individuals who responded that they were embarrassed about asking about health issues are presented below:

I: Do you find it embarrassing asking about health issues?
A: “Sometimes. If my doctor isn’t there I feel embarrassed, but if my doctor’s there then I will just ask him straight out.”
(Aboriginal Man, Adult: 26-45 years)

I: Do you find it embarrassing asking about health issues?
A: Depends, always embarrassed about woman’s issues”
(Aboriginal Woman, Senior Adult: 46+ years)

I: Do you find it embarrassing asking about health issues?
A: “No, except about woman’s issues to a male doctor.”
(Aboriginal Woman, Senior Adult: 46+ years)
The reader, however, should not forget that the majority of participants did not feel embarrassed asking about health issues, as the following two quotes portray:

I: Do you find it embarrassing asking about health issues?
A: “No.”
I: A lot of people your age do?
A: “What's there to be embarrassed of?”
I: Why do you think you feel like that, opposed to a lot of people your age who do feel embarrassed?
A: “I don't know. Probably everyone’s different.
(Aboriginal Woman, Young Adult: 16-25 years)

“No, there is nothing to be embarrassed about.”
(Aboriginal Woman, Young Adult: 16-25 years)

Thus it is not surprisingly that the majority (72.4%) of individuals asked, found it easy to obtain health information, opposed to those who only found it easy sometimes (17.2%), or who did not find it easy (6.9%). One additional person (3.4%) found it easy to obtain basic health information, but struggled with information regarding womens’ health.

“General information is fine, but about getting information about womens’ health is harder.”
(Aboriginal Woman, Senior Adult: 46+ years)

Similarly, 82.4% of individuals asked, felt they did not have ‘problems’ obtaining the health information they required, as exemplified by an Aboriginal woman:

I: Do you have problems obtaining the health information you require?
A: “No as you can always find someone to help you.”
(Aboriginal Woman, Senior Adult: 46+ years)
2.2 Health pamphlets

Almost all of the participants read health pamphlets. For instance, 44 of the 50 (88%) individuals who provided meaningful responses to the question “Do you ever read health pamphlets?”, said they did. As noted in the following quote from a young Aboriginal man, individuals tended to read them while waiting to be seen by a health professional:

“Oh yeah, when I’m waiting for a doctor, to see a doctor, there’s pamphlets all out there.”
(Aboriginal Man, Young Adult: 16-25 years)

Individuals were not asked why they read health pamphlets. Nevertheless, a variety of reasons were provided why individuals read health pamphlets:

I: Do you ever read health pamphlets?
A: “Oh yeah, yeah.”
I: Why is that?
A: “To be on the safe side.”
(Aboriginal Man, Adult: 26-45 years)

“Sometimes. Only when they have something about Kooris on them. That's about the only time.”
(Aboriginal Man, Senior Adult: 46+ years)

“I generally pickup pamphlets whenever I go to the doctor's surgery, because I think it's important being a parent xxxxx, um, yeah, I've always thought it important.”
(Aboriginal Man, Adult: 26-45 years)

After the first 17 interviews were analysed, the author decided more than one question needed to be asked about health pamphlets. Thus a further 7 questions were asked. For instance, participants were asked: “Do you find health pamphlets worth reading, or do you simply read them to pass time while you are waiting?” Twenty-nine meaningful responses were elicited. The majority (65.5%) of these individuals felt they were worth reading:

I: So is it just to pastime?
A: “No, no. To tell your kids. To share it with your kids and the younger ones and that. Teach them to be cleaner.”
(Aboriginal Man, Adult: 26-45 years)

“Worth reading. Attracts my eye, especially if they have the artwork.”
(Aboriginal Woman, Senior Adult: 46+ years)
An additional 20.7% of individuals asked, suggested they were both worth reading and a way to pass time:

I: Do you find health pamphlets worth reading, or do you simply read them to pass time while you are waiting?
A: “Both.”
I: What do you mean?
A: “Well, I usually read them just to pass time, and sometimes they interest me, because sometimes I might see some of the symptoms and think I’ve got it.”

(Aboriginal Man, Adult: 26–45 years)

“If I have a problem, then I find them good. Otherwise, they are just a way of passing the time. But it’s good to have them, especially if I don’t want to ask someone.”

(Aboriginal Woman, Young Adult: 16–25 years)

The remaining individuals considered health pamphlets were, at best, a means of passing time while waiting to see a health professional. Unfortunately, 6 of the 42 (14.3%) individuals asked, did not realise that they could take health pamphlets from doctors’ surgeries home with them:

I: Do you know that you can take the health pamphlets from doctors’ surgeries home with you?
A: “No. I thought you just had to put them back in there, you know.”
I: So you never take them home then?
A: “No.”

(Aboriginal Man, Adult: 26–45 years)

Obviously, if some Aboriginal people do not know that they can take health pamphlets home with them, then some are barred from accessing health information that other people take for granted. Of the 36 individuals who did know that they could take the pamphlets home, 32 (88.9%) had actually done so (see Table 8). For example, individuals reported:

“Um, sometimes I do. The ones that I am interested in, STD, diabetes, um, domestic violence ones as well. I do take them home. I read them and show them to my kids. Show my kids the STD ones and the violence ones and that it, domestic violence, to show me kids what can happen in and out the home.”

(Aboriginal Man, Senior Adult: 46+ years)

“Um, I have taken one on broken bones. Taken one home and stuck it on the fridge on a magnet.

(Aboriginal Man, Young Adult: 16–25 years)

“Ah, yeah, sometimes I do to. Um, diabetes one I took home. I did a lot of reading on that because it runs through my family and that. And heart disease, and that’s what I’ve got.”

(Aboriginal Man, Adult: 26–45 years)
Table 8: Number of individuals who have taken health pamphlets home, separated by gender and age category (n=46)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>Male</th>
<th>Female</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young adults (16-25)</td>
<td>3</td>
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<td>Adults (26-45)</td>
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<td></td>
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<tr>
<td>Senior adults (46+)</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

One Aboriginal man explained how the type of pamphlets he now takes home are different from what he took home in the past:

I: Which ones are you more likely to take home, opposed to those you are less likely to take home?
A: “Right now in this era. Um, well, see like, when I was young kid, I would be picking up things about crab lice, um, the pox and what other things, because that was the theme of the time that, that, the kids in my group were always talking about. Whatever. Later on, when we became adolescents, it would be, um, pictures of, um, sheilas, um, um, with their tits hanging out having a breast, because that was the theme then. Today, it's heart problems, you know, it's mental problems, it's mainly also where you can access what departments you get this information from. I like to go for the names and addresses of places where you can get, like you know, the Heart Foundation for heart, the Diabetic of Australia for more general information about diabetes.

(Aboriginal Man, Senior Adult: 46+ years)

Although it became clear after interviewing only a small number of participants, that the majority of individuals read health pamphlets and thought they were worth reading, it was nevertheless considered important to understand what other views they had about them. Thus, 24 individuals were asked: “Do you find health pamphlets enjoyable to read?” Two-thirds (66.7%) of the individuals asked, felt they were, and another 20.8% felt that some were. The following two individuals’ responses indicate how some individuals found only some of the health pamphlets enjoyable to read:
I: Do you find health pamphlets enjoyable to read?
A: “Some are like that. They have those little cartoon ones. I reckon they are the better ones, because they make it more fun. Instead of, like, in the other ones they make it look like a bit scary. In a cartoon it makes it more relaxing. Oh, well for the kids anyway, not for me.”

I: Not for you?
A: “Yeah, for the little ones too, because you show them a doctors book, if you show them all the scary things, but if you show them in a different way, they won’t be so frightened.”

(Aboriginal Man, Adult: 26–45 years)

I: Do you find them good?
A: “Yeah, the majority of them are. Some of them are hard to read, because they are hard to understand, because of the terminologies they put in them, you know? Um, the average person is, um, you know, they are not all up onto a lot of the medical terms. You know like, um, we hear a lot about things such as mengiococcal. You know, what is mengiococcal?, what does it look like?, you know, I don't need a whole range of things to sort of say 'yes, the first symptoms of mengiococcal is like a rash or whatever.' That's what people can understand…”

(Aboriginal Man, Senior Adult: 46+ years)

Although 4 of the 22 (18.2%) individuals asked “Do you find health pamphlets well written?”, said they were not, and a further 5 (22.7%) said that only some were well written, the majority felt they were well written. Some individuals found that the words used in pamphlets were sometimes too difficult:

I: Do you find health pamphlets well written?
A: “Not all. They need to cut down the words more better.”
I: What do you mean by that?
A: “Shorten the letters down.”

(Aboriginal Woman, Young Adult: 16-25 years)

When individuals were asked: “Is there anything that could be done to make health pamphlets better?”, this suggestion was reiterated by many people:

“There's lots of big words in them.”

(Aboriginal Woman, Adult: 26–45 years)

By far the most common suggestion, however, was to design the pamphlets in cartoon format:

I: Is there anything that could be done to make health pamphlets better?
A: “Yeah, just upgrade it for the little ones, so they can understand it and make it more enjoyable for them.”
I: How do you upgrade them?
A: “Draw little cartoons and have the words smaller. You know, not like in big words. Smaller so they can understand it. Yeah.”

(Aboriginal Man, Adult: 26–45 years)
I: Is there anything that could be done to make health pamphlets better?
A: “Pictures.”
I: Tell me a little bit about that?
A: “Well a lot of Aboriginal people cannot read and write and I've seen it as I've had to help people fill out forms and that. If they had signs and pictures, they would be able to understand a bit better.”
I: What do you think about the idea of having health pamphlets designed in cartoon format?
A: “Yes that would be good, because a lot of kids can read cartoons and they like to see those things, and as they read them they can take in the information.”
I: As someone who can read well, would you feel embarrassed reading a health pamphlet which is done in cartoon format?
A: “No way.”
(Aboriginal Man, Adult: 26-45 years)

I: Is there anything that could be done to make health pamphlets better?
A: “Put cartoons in them.”
I: Would you be embarrassed if there was cartoons in the health pamphlets?
A: “No.”
(Aboriginal Woman, Young Adult: 16-25 years)

As so many participants suggested that health pamphlets should be presented in a cartoon format, 19 individuals were asked whether they would be embarrassed if health pamphlets were designed in such a manner. All, but two said yes. One suggested that she would feel embarrassed reading them due to her age:

“Would not read them as I am an older person.”
(Aboriginal Woman, Senior Adult: 46+ years)

The other person initially felt she would be embarrassed because:

“This would be more degrading for Aboriginal people.”
(Aboriginal Woman, Adult: 26-45 years)

However she later suggested that if the pamphlets did not depict Aboriginal people, then she would read the pamphlets and would not feel embarrassed. An example from a young Aboriginal woman who did not think she would be embarrassed by the approach is typical of most individuals not embarrassed by the idea:

I: Do you think it's a good idea?
A: “Yep.”
I: Why is that?
A: “A lot of people they look at cartoons and like it shows sometimes in detail what's happening like if you've got a baby with measles and it could show a picture. If you show an actual baby, they turn off it and they won’t look at it. But if it's just like a cartoon picture, then they think okay this is what's going on and they might want to read up on about it.
(Aboriginal Woman, Young Adult: 16-25 years)
2.3 Immunisation

Immunisation is the standard approach (Sarkin, 2000; Traynor, et al., 1996) used to prevent many highly contagious diseases (Butenandt & Weiss, 1999). Childhood immunisation has been found to be safe, well tolerated, and immunogenic for diphtheria (Holt, et al., 2000), measles (Kaplan, et al., 1992), mumps (Christakis, et al., 2000), polio (Schmitt et al, 2000), rubella (Asahi et al, 1997), and tetanus (Holt, et al., 2000). Unfortunately, immunisation rates in Australia are not optimal and in fact in some Aboriginal communities they are quite a concern (Hamdorf, et al, 1996). As immunisation is an important mechanism by which serious illness can be avoided, the participants in this study were asked 7 related questions. The majority (74.4%) of individuals who provided meaningful responses to the question “Do you understand what child immunisation is?” replied in the affirmative (see Table 9). The level of understanding among those who felt that they knew what immunisation was, however, varied considerably, as the following five quotes depict:

I: Do you understand what child immunisation is?
A: “Yeah.”
I: What is it?
A: “Mainly looking after youngins and make them grow healthy and strong. Sort of keep them away from disease and all of that.”
(Aboriginal Man, Adult: 26-45 years)

I: Do you understand what child immunisation is?
A: “Yes.”
I: What is it?
A: “It's, um, it's, it's, um, early warning system that's put in place to stop these kids from catching these terrible diseases - whopping cough, whatever, measles, you know. Um, and to stop them from them spreading it, you know.”
(Aboriginal Man, Senior Adult: 46+ years)

I: Do you understand what child immunisation is?
A: “Yeah”
I: Tell me a little about it?
A: “It's for hepatitis and things like that. You get three needles or something for one thing. Because I remember when I was a young fella, I use to come up here and we'd get needles. Like, one in the butt every week or something.”
(Aboriginal Man, Young Adult: 16-25 years)

A: “Yes.”
I: What is it?
A: “Well it's, um, you know, it is a preventative measure to, you know, to try and stop the children from annihilation, but also as they progress through the rest of their life to, um, ward off any form of digging up any diseases or viruses or that, that may be xxxxx.”
(Aboriginal Man, Senior Adult: 46+ years)

“Yes, to make sure baby don’t get sick from chicken pox etc.”
(Aboriginal Woman, Young Adult: 16-25 years)
Table 9: Number of individuals who know what immunisation is, separated by gender and age category (n=43)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>Do you know what child immunisation is?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Young adults (16-25)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
</tr>
</tbody>
</table>

It is worth noting that a number of individuals who said that they did not know what immunisation was, actually had some idea:

“Is that the needle thing?”

(Aboutiginal Man, Young Adult: 16-25 years)

Participants were definitely in favour of immunisation. In fact, the percentage of individuals who responded positively to the question: “Do you believe child immunisation is a good thing?” was greater (93.9%) than the percentage of individuals who thought they knew what it was (74.4%). It appeared that, even if individuals only had a rudimentary understanding of what immunisation was and how it worked, they were nevertheless positively inclined towards it:

I: Do you believe child immunisation is a good thing?
A: “Yeah.”
I: Why is that?
A: “Well it’s going to prevent them from getting sick, because they are only kids.”
I: How does it prevent them from getting sick?
A: “Oh, oh, I know nothing about immunisation. But I would just say if it's supposed to be good for the kids, then I would get it done.”

(Aboutiginal Man, Young Adult: 16-25 years)

I: Do you believe in child immunisation?
A: “What's that?”
I: You know, when kids have needles etc for preventing polio etc?
A: “If they got it, yeah.”
I: Do you know what it is?
A: “No. No, I don't know what it is. Whatever they talking about, I still reckon that they should, all kids should get it done.”

(Aboutiginal Man, Adult: 26-45 years)
Of 38 individuals asked, 24 (63.2%) have had children. All of these 24 parents, had their children immunised. The reasons given for having their children immunised varied considerably. 10 of the 38 (35.7%) individuals suggested reasons that could be categorised as protecting from ill-health. Examples of this include:

I: And why did you do that?
A: “Because I didn't want them to get sick all the time. I know that it didn't actually stop them from getting measles, and whatever, but I don't think they would have got as severe a case of it.”
( Aboriginal Woman, Senior Adult: 46+ years)

“To protect them from all the germs that are going on. Like things been happening with all the measles and them things that are coming out. There's a lot of new stuff that have been coming out for the little ones.”
( Aboriginal Woman, Adult: 26-45 years)

“To protect them from all the germs and everything.”
( Aboriginal Man, Adult: 26-45 years)

The next most common reason suggested was that it was considered ‘the thing to do’:

“Because it’s the done thing to do and to protect kids. Went along with everyone else.”
( Aboriginal Woman, Senior Adult: 46+ years)

“Because it was the, you know, the thing to do. You know, I had to protect them the best I could. So it was just like feeding; something you had to do. You know?”
( Aboriginal Woman, Senior Adult: 46+ years)

Other reasons included: due to health promotion campaigns, personally been affected by not being immunised, due to the law, and felt that it was a good thing to do. One young Aboriginal male did not want his children immunised, but his wife did, so he relented and the children were immunised.

Due to recent governmental changes aimed at increasing immunisation rates, the following question was asked, Do you realise that the government pays parents to have their children immunised? Approximately equal numbers of individuals knew about this (51.6%) opposed to didn’t know about this (see Table 10), as the two following quotes depict:

“Um, the last year or so, yeah, know the last two years.”
( Aboriginal Woman, Adult: 26-45 years)

“Yes, did do it, but not for the money.”
( Aboriginal Woman, Young Adult: 16-25 years)
Table 10: Number of individuals who know that the government pays parents to have their children immunised, separated by gender and age category (n=31)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>Male</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young adults (16-25)</td>
<td>Male</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td>Male</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td>Male</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>16</td>
<td>15</td>
</tr>
</tbody>
</table>

This question, however, caused a few people to be offended as the following person’s response indicates:

I:  Do you realise that if a parent gets their child immunised, they can receive money for doing so?

A:  “I, I, that might be right, that might be wrong, I have been a health worker here for xxxxx years. I have never, ever, heard of an Aboriginal mother, father, ever putting a dollar into any particular treatment that they have, ever. And I suppose that even goes down to selling blood, or whatever. I’ve never heard that. Um, I have no wish to hear that either. Um, I don’t know of any, I don’t know of any other, I don’t know of any Aboriginal people whose in this community, and none of my family members would, or people that I know in other communities, would for the sole purpose of getting a few bob, take their child in to be immunised. Even if it was a few dollars, I don’t think there’s an Aboriginal person around who would do that for that. I think they would have their child immunised because they know the importance of it. And if they don’t have their child immunised, it’s because they haven’t received enough information in relation to it. I, I’ve have never heard of an Aboriginal women yet, or an Aboriginal person say ‘my children are not going to be immunised’.”

(Aboriginal Man, Senior Adult: 46+ years)

Such a response was also elicited when participants were asked: “Do you think there are some Aboriginal people who have their children immunised only because of the money on offer?” The majority, however, 56.5% felt that some Aboriginal people would do this. Nevertheless, many were quick to respond that they felt that such behaviours were not confined to Aboriginal people:

“Yes, not just Aboriginal people. Also white people.”

(Aboriginal Woman, Senior Adult: 46+ years)
2.4 Check-Ups

Seventeen (36.2%) out of 47 participants reported going to a doctor when they were healthy. The major reason given for this behaviour was to have a check-up. Sometimes such a check-up would be required as part of applying for an employment position. Two typical responses of participants who felt that it was a good idea were:

A: “Yep.”
I: Why is that?
A: “To make sure... To make sure that I haven't got anything. Haven't got any diseases, or anything like that.”
I: And when was that?
A: “About eight months ago.”
(Aboriginal Man, Adult: 26-45 years)

A: “Yes.”
I: And why did you do that?
A: “To get a check-up.”
I: Do you think many Aboriginal people would do that?
A: “No, not really.”
I: And why is that?
A: “Because they don’t care.”
(Aboriginal Woman, Young Adult: 16-25 years)

Other reasons given for attending while being healthy included liking the doctors and thus it was something to do, while being pregnant to have the baby checked, or a spur of the moment decision, as the following participant mentioned:

A: “Yes.”
I: Why did you do that?
A: “It was just a spur of the moment, spur of the moment thing. I was at the medical centre and for no particular reason I went and had a check up, I think. Just a half hour check up. I didn't feel sick, didn't feel anything. It was just the spur of the moment thing. Um, he was quite pleased that I did ask him. I wasn't, I wasn't due for a check up for eight months, eight months for my annual check up. But he was there and I was there at the right time. And he had some spare time and it only took half an hour.”
(Aboriginal Man, Senior Adult: 46+ years)

Those who had not been to a doctor when they were healthy tended to volunteer their opinion that such an action would be a waste of time:

A: “See I've got friends as doctors and I go in there for just a bit of a yarn and inevitably a health issue will come up, but that doesn't directly concern me.”
I: Would you purposely go there, be it a booking or not a booking [interrupted by interviewee]?
A: “No, no. Never. I'm, I'm not into wasting my time or wasting their time.”
(Aboriginal Man, Senior Adult: 46+ years)
Forty-two participants answered whether they felt it was a good idea to see a doctor when they were healthy or whether such an action was a waste of time. The majority (61.9%) felt that this was a good idea. The typical reason by this group of individuals was one of reassurance:

“Well I think it's a good idea to go see a doctor even though you are healthy, or even if you are not healthy, to make sure that everything is ticking. At least you would be prepared if you do come down with something. The alternatives will be there.”

(Aboriginal Woman, Senior Adult: 46+ years)

A: “Um, regular check ups I think is very good to be able to. You definitely need them.”
I: Why is that?
A: “One is that, um, you may have something that, um, is not, well you believe it is not, it could turn out to the something quite dramatic. Um, I have friends and relatives who let things go and also they're on, um, you know, deaths knocking on the door. You know, it's a small thing, 'well don't worry about it, we'll fix up tomorrow' sort of thing. Ah, or try and treat it themselves, you know. I suppose, in one way I'm a bit of a prime example where small knocks and a couple of small breaks in my fingers years ago, as a young bloke, you know, big and tough, 'I can handle it'. Today I am suffering because of it.”

(Aboriginal Man, Senior Adult: 46+ years)

“I just volunteered. I get it done once in a blue moon. Say just make sure my cholesterol is normal. Sugar is normal and all that. You don't want to get it too high. Blood pressure, you don't want to get it too low.”

(Aboriginal Man, Adult: 26-45 years)

Unfortunately, the percentage of participants who agreed that such action was a good idea was substantially larger than the percentage of participants who had actually been to a doctor when they were healthy. For instance, although a participant might see the point in going to see a doctor, even though they were healthy, in reality they were not likely to go:

A: “Oh, it could be a good idea.”
I: And why is that?
A: “Just in case anything is wrong with you, or anything.”
I: Could you imagine yourself ever doing it? Going along when you think you are healthy?
A: “Oh yeah one day.”
I: Do you reckon you would do it in the next five years?
A: “Probably, I don't know.”
I: In reality, do you think you would go in the next five years, or not really?
A: “No, not really.”

(Aboriginal Woman, Young Adult: 16-25 years)

Similarly, a participant who could not see the point in going, was also not likely to go see a doctor when they were healthy:
A: “Just a waste of time, I reckon.”
I: \textit{Why is that?}
A: “Well there's nothing really wrong with you, so they're looking for like nothing really. They're trying to find if there is any thing wrong with you, but there isn't. Your just getting a check up done.”
I: \textit{So you can't see any advantage by actually having a check up.}
A: “No, I mean it would be good if I did, but I really wouldn't take the time out to do it.”
I: \textit{So why would it be good?}
A: “Just to, if they pick up something early. Like, um, your just starting to get some sort of cancer, or AIDS even, anything like that.”
I: \textit{So you don't want to know if you're getting cancer, you'll just wait till you get it?}
A: “I'd like to know. Yeah, I would like to know. But, um,”
I: \textit{You can see what you are doing. You say I'd like to know, but I wouldn't take the time to do it. So which is it?}
A: “I'd probably wait until it was too late. It wouldn't be my choice but.”
I: \textit{It wouldn't be your choice?}
A: “No.”
I: \textit{Can't you just, right this moment say I have had enough of the interview and go off and see a doctor? Could you not do that?}
A: “Yeah I could.”
I: \textit{So whose choice is it?}
A: “It's really mine.”
\textit{(Aboriginal Man, Young Adult: 16-25 years)}

Discouragingly, many participants who thought that going to see a doctor when they were healthy was a waste of time, really had a lot of difficulty seeing any point in doing so:

A: “Um [long pause], waste of time I think.”
I: \textit{Why is that?}
A: “Um, well, when I was playing sports and that I was feeling all right, you know, and I'm breathing and everything. I just, you know, I just feel fit and that.”
\textit{(Aboriginal Man, Adult: 26-45 years)}

“Well it would be a waste of the doctors time as well as my time if I'm healthy. Because if I'm healthy I wouldn't have to go see a doctor, because what for, you know, what for, what do you want to go see a doctor.”
\textit{(Aboriginal Man, Adult: 26-45 years)}

A: “Um, yeah, I don’t know. I suppose it would be silly. You probably only go see a doctor if you are real crook or something.”
I: \textit{Can you think of any time that you might go if you were healthy?}
A: “Um, no. Probably if you, I don't know, no not really. There's no point going to the doctor if you are healthy and stuff. I suppose you would if you were starting a family or something.”
I: \textit{So why would you do that?}
A: “See if your wife is alright.”
\textit{(Aboriginal Man, Young Adult: 16-25 years)}

There was some indication that participants who felt it was a good idea to see a doctor when they were healthy, were more likely to be concerned about their health,
in contrast to those who saw it as a waste of time. For example, out of 22 participants who felt that it was a good idea to see a doctor when they were healthy, approximately a third (31.82%) were very concerned about their health, whereas of the 14 participants who felt that it was a waste of time to see a doctor when they were healthy, only 2 (14.29%) indicated that they were very concerned about their health.

Table 11: Relationship between concern about own health and whether going to a doctor when healthy is a good idea or a waste of time (n=36)

<table>
<thead>
<tr>
<th>To what extent are you concerned about your health?</th>
<th>Good idea</th>
<th>Waste of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not concerned</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>A little concerned</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Concerned</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Very concerned</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>9</td>
</tr>
</tbody>
</table>

Throughout this report, the activity of having (or believing in) a check-up with a doctor has been examined with regard to several other variables. Such relationships are important because one of the outcomes of the study is the need for Aboriginal people to be encouraged to have check-ups. Other research has also indicated the need for regular check-ups. For instance, an anonymous author (1992, p. 321) has suggested:

“In many communities [not Australia], over 50% of diabetes was undiagnosed prior to the survey. It is concluded that a substantial proportion of abnormal glucose tolerance during pregnancy will go undetected in the absence of screening programmes.”

Another example of the importance to have check-ups comes from the research conducted by Miller, Torzillo and Hateley (1999). They introduced a program designed to improve access to, and delivery of, diagnosis and treatment on prevalence of gonorrhoea and chlamydial infection in remote Aboriginal communities. They were successful in reducing the prevalence of gonorrhoea (from 14.3% in 1996 to 7.7% in 1998) and chlamydia (from 8.8% in men and 9.1% in women in 1996 to 7.2% in both men and women). The authors felt their success was due to three things: increased testing activity, advances in diagnosis, and reduced interval to treatment.

Due to the importance of check-ups, a number of participants were asked about three relevant screening tests often conducted in regular check-ups (blood pressure for hypertension, blood sugar testing for diabetes, cholesterol for cardiovascular disease), while female participants were asked an additional question (mammograms for breast cancer).
2.4.1 Check-Ups: Blood pressure

Hypertension is a serious condition (Julius, 2000). High blood pressure is a cause of cardiovascular morbidity and mortality (Hermansen, 2000), stroke (Berlit, 2000), and some forms of cancer (Xie, et al, 1999). One difficulty is that hypertension frequently coexists with obesity and this increases the risk of morbidity (Holmwood, 2000). Thus many health promotion campaigns have been designed to reduce the incidence of hypertension by way of nutritional, exercise, and drug therapy (Belmin, 2000; Julius, 2000). For instance, Berlit (2000, p. 231) suggests “the treatment of arterial hypertension, with optimal values around 135/85 mmHg, reduces the risk of stroke by 50%.” As a preventative measure, many screening programs have been developed (Hensrud, 2000). Such screening is very important because as Colhoun, Dong and Poulter (1998, p. 747) suggest “there is considerable scope for improving the treatment and control of hypertension.”

Virtually all (94.2%) of the 52 participants asked: “Have you ever had your blood pressure measured?”, said they had (see Table 12).

Table 12: Number of individuals who have had their blood pressure measured, separated by gender and age category (n=52)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>Have you ever had your blood pressure measured?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Young adults (16-25)</td>
<td>Male</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>10</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td>Male</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>10</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td>Male</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>49</td>
</tr>
</tbody>
</table>
2.4.2 Check-Ups: Blood Sugar

Diabetes is a major public health problem, with enormous personal and societal costs, especially when not controlled (Glasgow, et al., 1999). Individuals who have diabetes have to control their blood glucose levels so that they do not develop short-term problems associated with low blood sugar levels: hypoglycemia (Solter & Sekso, 1979), and long-term problems associated with high blood sugar levels: microvascular diabetic complications such as peripheral sensory neuropathy (Culleton, 1999), retinopathy (van Ballegooie & van Everdingen, 2000), and nephropathy (Loebstein et al., 1998); all of which can cause severe health difficulties and decrease life expectancy (Coppini, et al., 2000). Thus screening for diabetes is of paramount importance. To test blood sugar levels, relatively cheap urine (Halloran & Bennitt, 1999) and blood (Christensen, et al., 1985) tests can be conducted, although formal diagnosis requires more expensive HbA1c testing. Likewise, for those individuals found to have diabetes, diabetes complication screening needs to be conducted. Donaghue, et al. (1999, p. 185) suggest that “screening should commence after five years of duration in young children, and after two years of duration in adolescents.”

Most (75.9%) of the 54 participants asked: “Have you ever had your blood sugar measured?”, said they had (see Table 13).

Table 13: Number of individuals who have had their blood pressure measured, separated by gender and age category (n=54)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>Have you ever had your blood sugar measured?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Young adults (16-25)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
</tr>
</tbody>
</table>
2.4.3 Check-Ups: Cholesterol

Total cholesterol concentration is a strong predictor of mortality from cardiovascular and coronary heart disease (Emond & Zareba, 1997; Monique & Kromhout, 1995), while low high-density lipoprotein cholesterol levels are associated with hyperinsulinemia (O'Dea, et al, 1990). Low cholesterol concentrations, however, are not associated with increased mortality from non-cardiovascular causes (Monique & Kromhout, 1995). Thus, five Finnish surveys, with 27,721 randomly selected men and women aged 30 to 59 years, not surprisingly found that the risk of coronary heart disease among individuals with cholesterol greater than or equal to 8.0 mmol/L was approximately five times that of those individuals having a cholesterol level less than 5.0 mmol/L (Jousilahti, et al., 1998). Similarly, the Oxford Vegetarian Study of 6,000 vegetarians and 5,000 non-vegetarian controls, found mortality from ischemic heart disease was positively associated with estimated intakes of dietary cholesterol (Appleby, et al., 1999). There is some evidence, however, which suggests that the importance of lowering cholesterol levels in the elderly is debateable (Belmin, 2000; Krumholz, et al., 1994). For instance, Chyou and Eaker (2000) suggest:

“An increased ratio of total cholesterol to high-density lipoprotein appears to be associated with an increase in risk for all-cause mortality in men aged 65 and over, while an elevated level of high-density lipoprotein, considered alone, seems to be protective against mortality from all causes in men aged 65-74 years, but this effect diminishes over the age of 75.”

As all the participants in this study were less than 60 years of age, except for one man aged 91 years, the screening of a similar population would be appropriate. Slightly more than half (54.5%) of the 33 participants asked: “Have you ever had your cholesterol measured?”, said they had (see Table 14). The reliability of this result, however, must be questioned as two individuals did not know what this test was and hence it is possible other individuals may have said they had been tested for cholesterol when in fact they had not.

Table 14: Number of individuals who have had their cholesterol measured, separated by gender and age category (n=33)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>Have you ever had your cholesterol measured?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Young adults (16-25)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
</tr>
</tbody>
</table>
2.4.4 Check-Ups: Mammography

Mammography, one of the three most common methods of detecting breast cancer (Dean & Pamilo, 1999), has some problems. It does not pick up rapidly growing and aggressive tumors (Gilliland, et al., 2000) and the majority of women find the procedure moderately to extremely uncomfortable (Dullum, Lewis, & Mayer, 2000). The procedure can also produce ‘false positives’ which oftentimes causes anxiety as such results require further ‘unnecessary’ examinations. Thus, Tubiana (1998, p. 1593) argues that “screening is worthwhile only if the increase in human life outweighs the economic and social costs (anxiety, going to appointments) that it may produce.” Nevertheless, as “breast cancer continues to be the most common and lethal cancer in women today” (Crymes, 1979, p. 1), the majority of health professionals recommend that physicians should refer their patients for screening mammography to reduce breast cancer mortality (Costanza & Edmiston, 1997; Pisano & McLelland, 1991). With this in mind, it is encouraging to note that all 7 of the 7 (100%) woman in the 46+ age category who were asked: “Have you ever had a mammogram?”, said they had. Not surprisingly, none of the 10 woman aged 16-25, had been tested with a mammogram, and only 2 of the 8 (25%) woman aged 26-45 had been tested. Also encouraging is the fact that, all but one of these woman had their last mammogram within the last 3 years (see Table 15).

Table 15: Years since last mammogram (n=9)

<table>
<thead>
<tr>
<th>Years since last mammogram</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>1</td>
</tr>
<tr>
<td>1.5</td>
<td>1</td>
</tr>
<tr>
<td>2.0</td>
<td>3</td>
</tr>
<tr>
<td>3.0</td>
<td>3</td>
</tr>
<tr>
<td>4.0</td>
<td>1</td>
</tr>
</tbody>
</table>

The other two are breast physical examination and breast self-examination.

What Aboriginal people think about their access to health care.
2.5 Alcohol

The majority (70.4%) of the 44 participants, when asked about their alcohol drinking status, indicated that they drank alcohol (see Table 16). Their incidence of alcohol consumption is similar Australian Bureau of Statistics’s (1996a) survey which reported that among Indigenous people aged 15 years and over living in New South Wales, 68.4% drank alcohol in the last year. Similarly, Henderson and Gray (1994) found that 79% of Aboriginal adults in southwest Sydney drank alcohol.

Table 16: Number of alcohol drinkers, by age category and gender (n=44)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>Do you drink alcohol?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Young adults (16-25)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
</tr>
</tbody>
</table>

Although alcohol consumption has been linked to numerous health conditions such as road injuries, cirrhosis of the liver, suicide and stroke (Unwin, Thomson & Gracey, 1994), it is not the percentage of individuals that drink alcohol that is of primary concern. Rather, it is the percentage of individuals that drink alcohol to excess. This point is reiterated by the fact that a number of authors have found a higher proportion of non-Aboriginal people who drink than Aboriginal people (Healey, 1997; McLennan & Madden, 1999). Twenty-six of the participants who drank alcohol were asked: “Do you drink too much alcohol?” Clearly alcohol over-consumption is a problem, as 27% said they drank too much (see Table 17). The percentage of participants who drank to excess is similar, but slightly higher, than a figure of 22% reported by Healey (1997). Clearly the conclusions of this study are similar to those of McLennan and Madden (1999, p. 55), who suggest:

“despite the lower proportion of Indigenous adults who drink, alcohol continues to be of concern for Indigenous people because those who do consume alcohol are more likely to consume it at hazardous levels.”
Table 17: Incidence of Aboriginal participants who drink alcohol to excess, by age category and gender (n=25)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young adults (16-25)</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>19</td>
</tr>
</tbody>
</table>

The Macarthur Health Needs Assessment survey (South Western Sydney Area Health Service, 1997) found alcohol use, along with smoking and illegal drug usage[^21], were concerns in the Macarthur area in both the youth and adult populations. One of the six groups this survey suggested were at greatest risk were Aboriginal and Torres Strait Islanders. An Australian study by the Australian Bureau of Statistics (1995) suggested that three-quarters of all adults thought alcohol was a common problem in their area. Torzillo and Kerr (1991, p. 326) note: “there is a clear and unequivocal relationship between violence and alcohol in Aboriginal communities and this alone is sufficient to make alcohol a major public health issue.” Participants in this study also clearly articulated that drug usage, especially alcohol and illegal drugs, were a major health problem in the area:

[^21]: The author was fully aware of the increasing use of illegal drugs by Aboriginal people in Australia (Patterson, et al., 1999) and Sydney (Forero, et al., 1999), however, he decided not to ask participants about such illegal behaviour, except where appropriate, so as not to offend or cause participants to cease the interview. In some cases, the researcher did ask about illegal use:

A: “Oh when I end up in hospital mainly. I know my limits when I drink and that. See I am able to pull up when I have had enough. I am not everyday, but once a fortnight I have a drink, that’s about all.”

I: Do you smoke?
A: “Everyday, but with my alcohol say every fortnight.”
I: Touch any other stuff, but we won’t mention what it is?
A: “Oh, once in a blue moon. I’m not addicted to it.”
(Aboriginal Man, Adult: 26-45 years)

I: What about the dreaded weed [indicating marijuana], do you touch that stuff?
A: “Now and again, you know. I used to be when I was younger, but now I just have it, just to be sociable with the boys when they are sitting around, you know.”
I: Without mentioning anything, do you touch other stuff?
A: “No. Oh once I did when I was in jail, because I was a bit down and out and that and I tried a bit of heroin.”
(Aboriginal Man, Adult: 26-45 years)
I: *How big an issue is alcohol with Aboriginals in this area?*
A: “It's one of the main ones, in this area. Um, um, with drugs as well.”
I: *Which is the bigger problem?*
A: “Mainly the alcohol, because it's so easy access. You find that mainly the people around here, they, like the Aboriginals, that's where they go, it's just over the pub. Always see their kids out the front.”
I: *And why do they go to the pub?*
A: “Because they’ve got nothing better to do. Like they won’t go out and get a job. Oh there is a lot of Aboriginals that do work. I’m not saying that everybody, all Aboriginals are bad, but the majority are, like into the alcohol and drugs.”
I: *This study will only be useful if practical ramifications arise from it. What would your recommendations be with regard to the alcohol issue?*
A: “Close the pub down here. And the liquor store. And then they’ve got further to go for their alcohol… Try to stop the sell of alcohol around here, because that's the main problem. And try and get a bit more entertainment out here too.”

(Aboriginal Woman, Adult: 26-45 years)

Torzillo and Kerr (1991, p. 326), when addressing the topic of Indigenous alcohol consumption, argue that “colonisation and racism is at the root causes of alcoholism” and that while “alcohol abuse is clearly a consequence of colonisation and oppression… health planners must always base their analysis on this important factor.” However, these authors quote another author (who has written a separate chapter in the same book, Brady, 1991), who disagrees. Brady suggests “It is time to stop interpreting alcoholism as some kind of helpless result of cultural clash. Rather we should be seeing it for what it is. That is: the deliberate distortion of tradition for the sake of fulfilling an individual physical desire for alcohol. It is time to stop portraying the contemporary Hopevale alcoholic as a passive victim of colonisation. Rather we must consider how he has actively created his own problem” (p. 173). Such a focus on the individual being actively involved in their alcohol consumption destiny is clearly articulated by one of the participants who gave up on the advice of a doctor:

“I gave up drinking. The last drink I had was after my 18th birthday. After my 18th birthday I, I wake up next morning, you know how you wake up and you feel real hangover from the grog. Well that was me. And I was spewing and I was crook as anything, so I went straight to the doctors and he sent me down to have these tests done. I found out that I had ulcers. Come back and he said you have to give up smoking and drinking. Fair enough. I gave up drinking, but I couldn't give up me smoking.”

(Aboriginal Man, Adult: 26-45 years)
2.6 Smoking

The majority (60.4%) of the 48 participants asked about their smoking status indicated that they smoked (see Table 18). This incidence of smoking is similar to, or slightly higher than that reported by the Australian Bureau of Statistics (ABS) in 1994, which reports that among Indigenous people aged 15 years and over living in New South Wales, approximately 50.8% smoked (Australian Bureau of Statistics, 1996a). In a separate document, detailing smoking status for all Indigenous people in Australia in 1994 aged 15 years and over, the ABS reported that 56% of males and 48% of females smoked (Cunningham, 1996a), compared with 68% of males and 54% of females in this study.

Table 18: Incidence of smoking among Aboriginal participants, by age category and gender (n=44)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>Do you smoke tobacco?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Young adults (16-25)</td>
<td>Male</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>6</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td>Male</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>6</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>19</td>
</tr>
</tbody>
</table>

The level of smoking in this sample was approximately 2.5 times higher than the national average of all Australians (including Indigenous people). For instance, in the 1995 National Health Survey, 27% of males and 20% of females aged 18 years or more said they smoked (Australian Bureau of Statistics, 1999).

The negative health effects of smoking are well documented (Cox, et al., 2000; Jarvis, et al., 2000; Juel, 2000) and yet a number of the participants in this study were not aware of, or did not want to believe, that there are severe health risks associated with smoking:

I: You say you don't do anything to abuse your body, but you smoke?
A: “I smoke because right now my mind tells me, I'm addicted to smoking and I see a benefit in having a cigarette, because I know what it psychologically does to me and I know what physically it does to me. In my mind, it's like dope, marijuana, if it's used properly it's like alcohol, if it's used properly it can be used for a meditative, meditative way. The doctors will soon tell you that themselves. Like it is only when you abuse it. Now, I smoke 20 cigarettes a day. Maybe I should be smoking only one cigarette a day and maybe I should be smoking only
one milligram a day, instead of the 16 milligram strength that I smoke and 20 plus a day. You know, and perhaps cigarettes will kill me. That's something I'll have to accept... If a doctor ever says to me, 'xxxxx [interviewee’s name] you are going to die if you have a smoke, then I'll have to make that decision seriously of giving it up properly.’”

I: Can I just clarify something you said, you said you drink a little bit of alcohol and that can be good for you. If you have a little bit of marijuana, that can be good for you. Too much of either of those can be negative. Are you saying if you have a little bit of a cigarette that can be good for you?

A: “Yes. For the simple reason, it's an education thing. And I'm not the world's smartest person, but I have in my memory of Randolph Scott handing his fellow cowboy mate whose lying in the dust with a bullet in his chest, coughing, he's dying, and Randolph Scott rolls him a cigarette and puts it in his mouth and lights it up. And he has a couple of puffs and says ‘ooh that was good.’ Or a war hero, has his last smoke before he dies, ‘that was good.’ Um, it's like someone giving you a kiss before you die. This is been inbred, I'm no less of a memory than I have, ah, as when I was a kid, when I used to see these heroes. And that was the thing that I grew up with. Now it's not my fault that I have a, a, a mechanism in my brain that tells me that smoking is bad for you, but it does relax you. Like I say, if a doctor can medically get me to accept that smoking is no good for you period, why is the government getting an excise tax from cigarettes. BILLIONS and billions of dollars these bastards, these ones don't want smoking tobacco, um, go finished here in Australia. They don't. It's the government. It's, it's, it's like, they're allowing it.”

(Aboriginal Man, Senior Adult: 46+ years)

This finding is similar to a 1994 survey, reported in Cunningham (1996a) which found that approximately 1 in 3 urban Indigenous people said they believed it was safe to smoke a pack or more of cigarettes a day.

On a more positive note, some of the non-smokers indicated that they were ex-smokers. Participants who did not smoke were not initially asked if they were ex-smokers, but in later interviews this additional information was sought. Hence it is likely that the percentage of non-smokers who admitted that they were ex-smokers is a conservative figure. Nevertheless, at least 24% of all the non-smokers in this study used to smoke. This figure is similar to a finding of Henderson and Gray (1994, p. ix) who found that 34% of Aboriginal adults in southwest Sydney who had “been smokers at one-time or another had given up smoking.” No data was collected as to why these individuals gave up smoking. Nevertheless, it is suggested that resulting ill-health may have been a major cause, because the youngest ex-smoker was 35 years of age. The other ex-smokers were older than 40 years of age.
2.7 Exercise

Exercise and sport have a positive impact on health, both physiologically (Coats, Adamopoulos, & Meyer, 1990; Galloway & Jokl, 2000; Kokkinos, et al., 2000; Lemura, von Duveillard, & Mookerjee, 2000) and psychologically (Berger & McInman, 1993; McInman, 1997a; 1997b; 1997c; McInman & Berger, 1993; McInman & Grove, 1991). Furthermore, physical activity behaviours are significantly related to self-perceptions of health (Piko, 2000). Exercise has also been suggested (Belmin, 2000; McDermott, et al., 2000) and successfully used as a health promotion strategy (see Bauman & Smith’s, 2000, review). Bauman and Smith (2000, p. 88) suggest that exercise is in fact “the second most important area for risk factor reduction, after tobacco use,... in terms of its contribution to the overall burden of disease for Australia.” Unfortunately, it tends to be the last choice of treatment or prevention by many health professionals (Bauman & Smith, 2000), including general practitioners. Galloway and Jokl (2000, p. 37) note the lack of exercise prescription with middle-aged and older patients:

“Physicians caring for middle-aged and older patients frequently overlook the importance of regular physical activity. Exercise on a routine basis is an important component of successful aging. It has been shown that many age-related declines in musculoskeletal function can be markedly reduced by participation in some form of regular exercise.”

The development of questions for this study is another good example of how exercise can be overlooked by health professionals. There were no exercise-related questions in the initial general ‘umbrella’ questions. It was only after the first 17 interviews had been transcribed that this oversight was noted. Subsequent participants were asked 6 questions. For instance, individuals were asked: “Are you happy with the amount of exercise you do?” The majority (65.7%) of individuals, stated that they were happy with the amount of exercise they did (see Table 19). There was an important age trend for this question. For instance, 87.5% of young adults said they were happy with the amount of exercise they did, whereas only 50% and 42.9% of adults and senior adults respectively were happy about their exercise participation rate. Such a trend was seen for many other exercise questions (see Section 2.10). It is important to note that a few, usually older individuals, did not exercise:

“I was a man of football see, and then I wouldn’t mind getting back into it, but you know, the grog and alcohol always seem to, grog always seem to not let me get there. I’ve got my kid now, um, to charred up to go to training and that. So you just give up and then you don’t know what, then you don’t feel yourself, you just want cigarettes. If I’ve got nothing to do, I’ll just sleep in the day time for hours and then night comes I might sit up till all hours and then I’ll go sleep all through the day and that. Sort of vampire, you know. Come out at night.”

(Aboriginal Man, Adult: 26-45 years)

---

22 It appears that a significant reason why healthcare professionals do not prescribe exercise is that they “do not feel adequately prepared to design and prescribe exercise programs for their patients” (Christmas & Andersen, 2000, p. 318). However, their ignorance does not explain why they do not refer their patients to healthcare professionals trained in exercise prescription.

23 This lack of exercise prescription is true for all age ranges.
Table 19: Degree to which Aboriginal participants are happy with the amount of exercise they do, by age category and gender (n=35)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>Are you happy with the amount of exercise you do?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Young adults (16-25)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
</tr>
</tbody>
</table>

The level of perceived frequency of exercise participation was very high (see Table 20). For instance, 20 out of 30 individuals participated in exercise every day and a further 8 (26.7%) individuals participated between 2-6 days per week. This finding appeared to be reliable as 72.7% indicated that they had exercised either on the day of the interview, or the previous day.

Table 20: Frequency with which Aboriginal participants exercise, by age category and gender (n=30)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>How frequently do you exercise?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Every day</td>
</tr>
<tr>
<td>Young adults (16-25)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>

An interesting finding was that even with such high frequency of exercising, 11 out of 30 (36.7%) individuals felt that they exercised too little. One possible reason for this finding was indicated by two other individuals who were asked the question. They could not answer it because they did not know how much was the right amount of exercise to participate in:

“I don't know how much is the right amount.”
(Aboriginal Woman, Adult: 26-45 years)
Another explanation for the result revolves around participants’ uncertainty as to whether walking was exercise. Some individuals did not consider walking exercise, or noted that they did a lot of walking as an after-thought:

*I:*  *How frequently do you exercise?*
*A:*  “Not much, but walk everywhere.”
*(Aboriginal Woman, Young Adult: 16-25 years)*

Other participants were more educated with regard to exercise and knew that even an every day activity such as walking up stairs was exercise:

*I:*  *When was the last time you exercised?*
*A:*  “Two weeks ago I walked up some stairs.”
*(Aboriginal Woman, Senior Adult: 46+ years)*

Encouragingly, 25 out of 29 (86.2%) individuals said they enjoyed exercising. The type of exercise performed by the 30 individuals who provided a meaningful response can be seen in Table 21.

Table 21:  Kind of exercise Aboriginal participants participate in (n=30)

<table>
<thead>
<tr>
<th>Exercise</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk</td>
<td>26</td>
</tr>
<tr>
<td>Jog/run</td>
<td>8</td>
</tr>
<tr>
<td>Football</td>
<td>7</td>
</tr>
<tr>
<td>Aerobics</td>
<td>1</td>
</tr>
<tr>
<td>Weights</td>
<td>2</td>
</tr>
<tr>
<td>Play with kids</td>
<td>2</td>
</tr>
<tr>
<td>Dance at club</td>
<td>1</td>
</tr>
<tr>
<td>Walk up stairs</td>
<td>1</td>
</tr>
<tr>
<td>Cycle</td>
<td>4</td>
</tr>
<tr>
<td>Basketball</td>
<td>2</td>
</tr>
</tbody>
</table>


2.8 Nutrition

An individual’s degree of health, or disease, determines his or her nutritional needs (Williams, 1982). Likewise an individual’s nutritional status has an impact on his or her health. Nutrition impacts on atherosclerosis (Connor, 1968), caries and periodontal disease (Martin-Iverson, Phatouros, & Tennant, 1999), obesity (Guest & O’Dea, 1992), and triglycerides (Brown, 1971). Thus, a variety of nutritional health promotion campaigns (Lee, et al., 1995; McDermott, et al., 2000) have been implemented. For instance, Ashton and Ball (2000) investigated the effect of a month long diet on serum lipoprotein concentrations, which required lean meat to be replaced with tofu. They obtained a decrease in total cholesterol and triglycerides. Similarly, male employees from local worksites participated in a low-intensity, short-term nutrition program (Braeckman, et al., 1999). At the end of the study the participants improved significantly in nutritional knowledge, had a net reduction in caloric intake and percentage of energy from total fat, and among participants with hypercholesterolemia there was a significant reduction in blood cholesterol. Furthermore, Reynolds, et al. (1998) has shown that children in a school-based program (“High 5”), designed to increase fruit and vegetable consumption for cancer risk reduction, can increase their knowledge about the modification of nutrition behaviour and cancer risk. Of even more importance is the health prevention work by Plancoulaine, et al. (2000) who found evidence for the validity of very early nutritional prevention. They report how an appropriate “diet in infancy may have longstanding effect[s] on lipid metabolism” (Plancoulaine, et al., 2000, p. 114).

As with exercise, there were no original “umbrella” questions on nutrition. As a consequence of transcribing the tapes of the first 17 interviews, it was decided that nutritional questions should be added. Thus 8 questions were subsequently asked. The results were alarming. As can be seen in Table 22, nearly one quarter of individuals asked were not happy with the type of food they ate. Of more concern was the fact that more than one quarter of the individuals reported both not being happy with the amount of food they ate and not eating enough healthy food. Some of these individuals were not eating in this negative manner by choice, as indicated by the fact that only 1 of 32 individuals stated that they did not enjoy eating in a healthy manner. For some individuals, lack of finances caused them to eat cheap less nutritious food, have smaller meals than required, or simply miss meals altogether:

*I: Do you eat enough healthy food?*  
A: “Try to. I know the healthy foods, but when I can’t afford something...”  
(Aboriginal Woman, Adult: 26-45 years)

However this same woman stated that she had enough to eat at other times:

*I: Are you happy with the amount of food you eat?*  
A: “No eat too much.”  
(Aboriginal Woman, Adult: 26-45 years)

---

24 Unlike most research in the area, however, HDL-C was also significantly lower on the tofu diet, although the LDL-C: HDL-C ratio was similar.
Thus in this woman’s case and many other participants situations, finances were not the only cause of the nutritional problem. Instead the causes were often the result of the individual’s attitudes or behaviours. With better organisation, attitudes, or behaviours some of the nutritional problems could have been controllable by the individuals. The following quotes add weight to such a hypothesis:

*I:* Are you happy with the type of food you eat?
*A:* “No. I share with someone who eats junk.”
(Aboriginal Woman, Adult: 26-45 years)

“No, constantly dieting.”
(Aboriginal Woman, Senior Adult: 46+ years)

*I:* Like, are you careful with your diet, or do you just eat anything?
*A:* “I just eat anything.”
(Aboriginal Man, Adult: 26-45 years)

“No, I eat too much fatty food.”
(Aboriginal Man, Adult: 26-45 years)

*I:* Are you happy with the type of food you eat?
*A:* “No. I don’t always have three meals a day. Life’s too hard to do it. Not enough brains.”
*I:* Do you eat enough healthy food?
*A:* “No, but I would like to it eat more healthier foods, and like, get, you know, like to get more healthier fruit and stuff.”
*I:* And why don't you? Is that because of money?
*A:* “No, it's because I ain't got no where to live mate. I just live everywhere I go everywhere. And then I move on.”
(Aboriginal Man, Young Adult: 16-25 years)

Table 22: Perceptions concerning nutrition

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Are you happy with the type of food you eat?”</td>
<td>33</td>
<td>21.2%</td>
<td>12.1%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Are you happy with the amount of food you eat?</td>
<td>33</td>
<td>27.3%</td>
<td>3.0%</td>
<td>69.7%</td>
</tr>
<tr>
<td>Do you eat enough healthy food?</td>
<td>32</td>
<td>28.1%</td>
<td>6.3%</td>
<td>65.6%</td>
</tr>
<tr>
<td>Do you enjoy eating in a healthy manner?</td>
<td>32</td>
<td>3.1%</td>
<td>3.1%</td>
<td>93.8%</td>
</tr>
</tbody>
</table>

25 The reader may be interested to read the answer to the next question asked of this young man:
*I:* Do you live on the streets?
*A:* “No, I just live at anyone's house. I don't live on the street.”

A number of other participants were asked about homelessness in the area. The question was asked as homelessness has severe health consequences. However from all accounts, Aboriginal people in this area do not suffer homelessness. The reason suggested by the participants for this lack of homelessness was due to the extended family system of Aboriginal people.

What Aboriginal people think about their access to health care.
Such a belief that the negative nutritional situation of a minority of individuals is partially supported by the fact that slightly over the majority of individuals felt that they sometimes ate too much sugary food, sometimes drank too many sugary drinks, and sometimes ate too much fatty food (see Table 23).

Table 23: Perceptions concerning types of food eaten

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you eat too much fatty food?</td>
<td>36</td>
<td>44.4%</td>
<td>41.7%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Do you eat too much sugary food?</td>
<td>36</td>
<td>41.7%</td>
<td>58.3%</td>
<td></td>
</tr>
<tr>
<td>Do you drink too many sugary drinks?</td>
<td>36</td>
<td>44.4%</td>
<td>55.6%</td>
<td></td>
</tr>
</tbody>
</table>

The difficulties of such a minority in the community must be acknowledged and addressed if substantial improvements in health are going to be made. Nevertheless, it is important not to lose sight of the fact that the majority of individuals were happy with the type of food they ate, happy with the amount of food they ate and ate enough healthy food. Examples portraying this are provided to present equal coverage:

```
I: Are you happy with the type of food you eat?
A: "Yes."
I: What sorts of food do you eat?
A: "Salad and a bit of steak and that."
(Aboriginal Man, Young Adult: 16-25 years)
```

```
I: Do you eat enough healthy food?
A: "Yes."
I: Are you sure?
A: "Yeah. Like sometimes, I eat junk, but I eat a lot of healthy food."
(Aboriginal Woman, Young Adult: 16-25 years)
```

```
I: Do you eat enough healthy food?
A: "Try to balance it out. Don’t have sugar and cut down the amount of salt she uses."
(Aboriginal Woman, Senior Adult: 46+ years)
```
2.9 Relationships with check-ups

As noted earlier, the health of Aboriginal people in Australia is generally recognised as less than desirable. Slightly less than half of all the participants in this study had medical problems, some of which were life-threatening and/or had serious implications. Furthermore, more participants considered themselves unhealthy than very healthy. This situation was despite the fact that a number of the participants, especially the older individuals, spent a lot of time thinking about their health and/or were concerned about their health. On the basis of findings such as these, some health professionals have proposed that Aboriginal people should be encouraged to use healthcare facilities more frequently than they presently do. Unfortunately, this study noted a degree of apathy towards health care and a lack of proactive behaviour. An example of the indifference many of the participants had concerning their health care is provided in an answer by an Aboriginal man when he was asked, ‘Do you have difficulty making a phone booking for a medical appointment?’ He responded by saying:

A: “No I don't do it. No I don't do it.”
I: Can you do it?
A: “Well I suppose, if I haven't got any money, I won't worry about it. If I have got money, it's, um, I'd ring up, but, um, it doesn't bother me really.”

(Aboriginal Man, Adult: 26-45 years)

Similarly, another Aboriginal man was reluctant to use a certain form of medical service, even though he was very positive towards medical facilities in general:

“I have a personal thing about fillings. I think fillings are a waste of time. If you are not going to continue a health hygiene on your teeth, because ultimately another tooth is going to break down. You are better off getting it taken out and having dentures in, or something, because that pain is going to be a continuous thing. And that's going to be more of a problem later on in life with abscesses.”

(Aboriginal Man, Senior Adult: 46+ years)

More drastic were the actions taken by two Aboriginal men:

I: If you have a tooth problem, would you prefer to go to a doctor, dentist or the hospital?
A: “Last time it was me operating on me teeth.”
I: And how did you operate on your teeth?
A: “I got hold of a pair of pliers and pulled out those two bottom ones, because they were knocked loose by one of my nephews. So rather than go to a dentist, because it was too far away, too much of a hassle, I just got hold of a pair of pliers, stood in front of a mirror and jerked them out.”
I: So they were too far away, too much of a hassle, was there any other reason why you didn’t go?
A: “No. It was just too far away. Too much of a hassle. And like there was a pair of pliers in the house.”
I: So the teeth are gone and you got rid of the roots as well?
A: “Yep… It hurt a lot, but I still had to have them out. I couldn’t eat and chewing was absolutely murder, so I had to pull them out.”

(Aboriginal Man, Adult: 26-45 years)
I: If you have a tooth problem, would you prefer to go to a doctor, dentist or the hospital?
A: “None. I hang out with the problem and pain and I just use old bush remedies on the tooth and work it out me self; work it loose. Then try and do it harder and just try and pull it off the gum and that.”
I: So how do you pull it out?
A: “With my tongue and fingers.”
I: Do you ever use pliers?
A: “No. that would just grind the teeth.”
I: How many teeth have you done that to?
A: “I’ve done that to most of them.”
I: How many teeth do you reckon you have done that to?
A: “To my teeth, I reckon about six of them have come out that way.”
I: You’ve pulled out six teeth?
A: “Yeah. Well sometimes if it’s really loose I’ll get someone to hit me in the head and it will loosen it more.”
I: How many times do they hit you?
A: “Once is enough.”
I: And do you have to drink anything before this to be able to handle it?
A: “No, I just hope.”

(Aboriginal Man, Adult: 26-45 years)

Another example of an extreme approach to health taken by many of the participants in this study is the case of an Aboriginal man who saw a doctor for a foot condition. He understood the doctor’s instructions to use up all the medication, but the patient stopped doing this as soon as his foot began to look better and eventually suffered further complications:

A: “I was up in the country and I was chipping and I got a ‘burr’ in my foot and, um. Um, I had it for about a month and I’ve picked a hole in my foot and it started getting infected around the area and then it started moving up to my ankle. Like it was only on the bottom, but it came to my ankle, the redness of it. And, um, I was walking around on, hopping around on one foot for about a month before I decided to go to the doctor to get some tablets.”
I: How did that go?
A: “He told me to do the full packet, but I never, once I started being able to walk on my foot, I didn't worry about taking the rest of the tablets. When I take my shoes off it still hurts. It’s still tender and that.”
I: Why didn’t you take the rest of the packet?
A: “Because I could walk on my foot.”
I: Did the doctor tell you to take the whole packet?
A: “Yeah.”
I: Do you think it was a stupid thing for him to say that?
A: “No, not really. Sort of, I’ve always been like that, you know. Like doctors they, ‘finish the whole packet’, I don't care if it’s better or not, just so you will know you’ll be right, but. Once my sores were gone, I don't worry about it…Like, I’ll have a boil on me and once the boil has started to go away, I’ll stop taking the tablets.”

(Aboriginal Man, Adult: 26-45 years)

With such apathetic behaviour it is not surprising that only one-third of the participants have gone to a doctor when they were healthy. What is more discouraging is the fact that approximately 40 percent of the respondents felt that it was a waste of time to do so.
This study found that there was a relationship between going to see a doctor while healthy and whether doing so was considered to be a good idea or a waste of time. All but 1 of the 16 participants who thought that going to see a doctor when they were healthy was a waste of time, had not done so (see Table 24). Unfortunately, 12 of the 24 participants who felt that going to a doctor when they were healthy was a good idea, had not done so either.

Table 24: Relationship between going to a doctor when healthy versus beliefs that going to a doctor when healthy is a good idea or a waste of time (n=40)

<table>
<thead>
<tr>
<th>Have you ever gone to a doctor when you're healthy?</th>
<th>Good idea</th>
<th>Waste of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>16</td>
</tr>
</tbody>
</table>

No significant differences were found between the subgroups of individuals who did think it was a good idea and who had or had not gone to a doctor when healthy, with regard to age category, medical problems suffered, perceptions of personal health, concerns about health, and importance of health. There was evidence of a sex difference, but the number of participants was too small to fully evaluate this. There may also have been a difference between the two groups in terms of the degree to which they think about their health. It is possible that individuals who think that going to a doctor while healthy is a good idea and who have done this are more likely to think about their health more frequently (see Table 25).

Table 25: Relationship between participants who believe that going to a doctor when healthy is a good idea, separated by if they have gone to a doctor when healthy or not, versus extent of thinking about health (n=20)

<table>
<thead>
<tr>
<th>To what extent do you think about your health?</th>
<th>[Is a good idea] and [been/not been]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;Good idea&quot; and &quot;Has gone&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;Good idea&quot; and &quot;Not gone&quot;</td>
</tr>
<tr>
<td>Don't</td>
<td>2</td>
</tr>
<tr>
<td>Not that much</td>
<td>1</td>
</tr>
<tr>
<td>Some times</td>
<td>3</td>
</tr>
<tr>
<td>A lot</td>
<td>4</td>
</tr>
</tbody>
</table>
Since the belief that going to a doctor while healthy is closely related to actual visits when healthy, an attempt was made to determine whether any other variables were related to this belief. This analysis revealed no relationship between the positive and negative beliefs, actual visits and perceived health status measures (e.g., importance of health, perceptions of personal health, medical problems, concerns about health, think about health). Although none of these comparisons are significant, there appears to be a trend for more participants who believed it was a good idea to see a doctor to think a lot about their health compared with those who thought it was a waste of time to see a doctor when they were healthy (see Table 26). This finding should be pursued further in future research as there may be practical implications for preventative programs and interventions. For instance, it was earlier established that these individuals have a relationship between the importance they put on their health and the amount of thinking they do about their health. Thus, if Aboriginal people are helped to consider their health as being more important and taught the importance of thinking about their health, they may be more likely to visit a doctor in a proactive manner. Facilitating such a mindset change is considered the major solution to reducing the access difficulties in the area and is discussed in detail in the discussion section of this report.

Table 26 Relationship between beliefs that going to a doctor when healthy is a good idea or a waste of time versus extent of thinking about health (n=36)

<table>
<thead>
<tr>
<th>To what extent do you think about your health?</th>
<th>Is it a good idea to see a doctor when you're healthy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't</td>
<td>Good idea</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Not that much</td>
<td>2</td>
</tr>
<tr>
<td>Some times</td>
<td>5</td>
</tr>
<tr>
<td>A lot</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
</tr>
</tbody>
</table>

Additional analyses revealed no relationship between the belief that going to a doctor while healthy was a good idea or waste of time and responses to the alcohol, smoking, 3 of the 4 exercise, and 6 of the 7 nutrition questions. As the two significant findings (1 exercise, 1 nutrition) could have occurred simply due to chance, further analysis have not been conducted.
2.10 Age and gender differences

A substantial number of participants obtained their health information from a variety of sources. The three most common sources utilised were from the media and/or written sources, health professionals, and friends and family members. The majority of participants: (a) believed that they could get all the health information they required, (b) found it easy to do so, and (c) felt they did not have ‘problems’ obtaining the health information they required. Nevertheless, a sizeable proportion believed that at one time or another, they definitely couldn’t get all the health information they required. Some of the reason for this may be due to the fact that slightly more than one third of participants felt embarrassed asking about health issues at one time or another. This was especially the case with women asking about ‘women’s issues’. There were no obvious age or gender differences with regard to any question concerning obtaining health information.

Almost all of the participants read health pamphlets, especially while waiting to be seen by a health professional. The majority of participants felt they were worth reading. Two-thirds of the participants felt that health pamphlets were enjoyable to read. Thus it is not surprising that the majority felt they were well written, although some individuals found some of the words were too difficult. To solve this problem, many participants suggested that the design of pamphlets should be in cartoon format. Only 2 out of 19 individuals felt they would be embarrassed if health pamphlets were designed in such a manner. Unfortunately, 14.3% of those individuals asked, did not realise that they could take health pamphlets from doctors’ surgeries home with them. Obviously, if some Aboriginal people do not know that they can take health pamphlets home with them, then some are barred from accessing health information that other people take for granted. Of the individuals who did know that they could take the pamphlets home, the majority had actually done so. There were no obvious age or gender differences with regard to answers provided about health pamphlets.

The majority of participants believed they understood what child immunisation was. However, the degree to which they actually understood varied considerably. In fact, some of the individuals who said that they did not know what immunisation was actually had a better idea than those who did not know what it was. Participants were definitely in favour of immunisation, even if they only had a rudimentary understanding of what immunisation was and how it worked. The majority of participants had children and all children had been immunised. The reasons given for having their children immunised varied considerably. The most common reason was to protect from ill health. Other reasons were: ‘it was the thing to do’, due to health promotion campaigns, personally been affected by not being immunised, due to the law, and felt that it was a good thing to do. Only one participant, a young male, did not want their children immunised. His wife, however, did want to have their children immunised and thus he relented. Approximately half of the individuals knew about the recent governmental changes aimed at increasing immunisation rates, whereby parents are paid to have their children immunised. The
majority of participants felt that some Aboriginal people would have their children immunised, only because of the money on offer. Many also felt that non-Aboriginal people were likely to do this. An age difference was observed for understanding what child immunisation is. Specifically, there were more young adults who reported that they did not know what immunisation was than adults or senior adults. With regard to the reasons why parents immunised their children, it was noted that the two individuals who cited having been personally affected by not being immunised were senior adults. It is conceivable that as immunisation rates are improving and no-one in this sample did not immunise their children, this reason is less likely to be mentioned by young adults or adults. No other age or gender differences with regard to answers provided about immunisation were noted.

Approximately one-third of participants reported going to a doctor when they were healthy. The major reasons stated for this behaviour were: (a) to have a check-up, (b) liking the doctors and thus it was something to do, (c) while being pregnant to have the baby checked, and (d) a spur of the moment decision. Those who had not been to a doctor when they were healthy tended to believe that such an action would be a waste of time. There may be an age/gender difference for going to a doctor when healthy, however, there is insufficient data to be certain. The majority of individuals felt that it was a good idea to see a doctor when they were healthy. The most common reason cited was for reassurance. Unfortunately, the percentage of participants who agreed that such action was a good idea was substantially larger than the percentage of participants who had actually been to a doctor when they were healthy. Similarly, many participants who thought that going to see a doctor when they were healthy was a waste of time really had a lot of difficulty seeing any point in doing so. There was a definite age difference for beliefs regarding going to a doctor when healthy. The majority of young adults felt that it was a waste of time to go to a doctor when they were healthy, whereas the majority of adults and especially senior adults felt that it was a good idea. There was some indication that participants who felt it was a good idea to see a doctor when they were healthy, were more likely to be concerned about their health, in contrast to those who saw it as a waste of time. The percentage of participants who had been tested for blood pressure, blood sugar, and cholesterol was 94.2%, 75.9%, and 54.5% respectively. There was an age difference for testing of blood glucose and cholesterol. The percentage of senior adults and adults who had been tested was higher than young adults. All senior women asked, had received mammography testing, whereas only 25% of female adults and no young adults had participated in such testing. Only one of the women had not had their last mammogram in the last 3 years.

The majority of participants drank alcohol. There was a definite age difference for alcohol consumption. The percentage of senior adults who drank was lower than adults, who had a lower percentage of alcohol consumption than young adults. Slightly over a quarter of participants drank to excess. Participants in this study also clearly articulated that drug usage, especially alcohol and illegal drugs, were a major health problem in the area. There was an age difference with regard to excessive consumption. There were a greater percentage of young adults who drank to excess than adults or senior adults.
The majority of participants smoked. Furthermore, at least 24% of all the non-smokers in this study used to smoke. There was an age/gender difference with regard to smoking in that the majority of young adults and adults smoked, whereas although the majority of male senior adults smoke, the majority of female senior adults do not smoke.

The majority of individuals were happy with the amount of exercise they completed. There was an age difference in that the majority of young adults (87.5%), compared with adults (50%) and senior adults (42.9%), were happy with the amount of exercise they completed. The level of perceived frequency of exercise participation was very high. Likewise, the majority of individuals had participated either on the day of the interview or the previous day. There was an age/sex difference for both the level of perceived frequency of exercise participation and last exercise day. Specifically, there was no difference between male and female young adults and adults for these two variables. However female senior adults exercised far less frequently than male senior adults. Even with such high frequency of exercising, slightly more than one third of individuals felt that they exercised too little. Reasons for this finding include not knowing how much is the right amount of exercise to participate in and participants’ uncertainty as to whether walking was exercise. Encouragingly, virtually all individuals said they enjoyed exercising.

Approximately a quarter of individuals asked were: (1) not happy with the type of food they ate, (2) not happy with the amount of food they ate, and (3) did not eat enough healthy food. Some of these individuals were not eating in this negative manner by choice, as indicated by the fact that only 1 of 32 individuals stated that they did not enjoy eating in a healthy manner. Lack of finances, individual’s organisation, attitudes and/or behaviours, were the major reasons cited why some individuals were eating cheap less-nutritious food, having smaller meals than required, or simply missing meals altogether. Such a belief that the negative nutritional situation of a minority of individuals is partially supported by the fact that slightly over the majority of individuals felt that they sometimes ate too much sugary food, sometimes drank too many sugary drinks, and sometimes ate too much fatty food. The difficulties of such a minority in the community must be acknowledged and addressed if substantial improvements in health are going to be made. Nevertheless, it is important not to lose sight of the fact that the majority of individuals were happy with the type of food they ate, happy with the amount of food they ate and ate enough healthy food. An age change was noted for eating too much fat, eating too many sugary foods, and drinking too many sugary drinks. Senior adults consumed less fat and sugar than adults, who consumed less fat and sugar than young adults.
3. Curative Measures

This sub-section addresses five health topics (last medical treatment, preferred medical facilities, bush medicine usage, speed to seek help, frequency comparisons about seeing a doctor). The emphasis in Section 3, unlike Section 2, is on solving a health problem once it has arisen and not on the prevention of health problems. This sub-section concludes with an examination of age and gender differences. This final topic (age and gender differences) also serves as a summary of Section 3.

3.1 Last medical treatment

There was substantial variation among the participants in terms of when they last sought medical treatment of any kind (see Table 27). Such variation is clearly seen in the following two quotes:

I: When was the last time you sought medical treatment of any kind?
A: “Um, I go to one every second or third day to have my blood pressure checked.”
I: Do you go to the same GP?
A: “My local GP for my blood pressure and health and the other GP for my toenails. I don’t get them clipped I just get them pulled out.”
(Aboriginal Woman, Senior Adult: 46+ years)

I: When was the last time you sought medical treatment of any kind?
A: “Four years ago.”
I: Four years ago?
A: “Oh, I think I went and got some aspirin. That’s about it.”
I: Why didn’t you go to a chemist?
A: “I was in here and I just said can I get some aspirin and they give it to me. But, um, yeah four years back the last time I was like in a doctor thingo, getting a blood test and that and I had to be rushed off to the hospital because he said I had an infected blood or something.”
(Aboriginal Man, Young Adult: 16-25 years)

Just over a quarter of the individuals (26.9%) had sought medical treatment in the last week and an additional 32.7% had attended in the last month. Thus, the majority (59.6%) had attended a health professional in the last month. The majority of such visits were to a doctor (76%). The other visits were to dentists (12%), hospitals (6%), chemists (4%), and a specialist (2%). Reasons for the visits varied from simple to complex issues and involved both standard and non-traditional treatments. The following five quotes from Aboriginal people responding to the question, “when was the last time you sought medical treatment of any kind?”, is testimony to this:
“Three weeks ago, three weeks ago. That was at Tharawal. [I had] a sore knee... I fell down some stairs.”

(Aboriginal Man, Senior Adult: 46+ years)

“I went to a dentist about two and a half months ago. Had a tooth pulled out the back.”

(Aboriginal Man, Young Adult: 16-25 years)

“It was a doctor. I actually went to a medical service on Saturday. I thought I had giardia and needed to get some treatment.”

(Aboriginal Man, Adult: 26–45 years)

“To do hypnosis.”

(Aboriginal Woman, Senior Adult: 46+ years)

A: “I was in hospital recently because of my ears. I had a hole in my ear drum, but I’ve got all that fixed up. That would be six years ago, seven years ago. That was like the only serious time that I have been to the doctor for anything serious, like when I am sick I just stick it out and drink tea and sweat it and that, but.”

I: When was the last time you reckon you went to a chemist?

A: “About four years ago when I had a bad cough and I still have it.”

(Aboriginal Man, Young Adult: 16-25 years)

Table 27: The last time medical treatment of any kind was sought, by age category and gender (n=52)

<table>
<thead>
<tr>
<th>Age categories</th>
<th>When was the last time you sought medical treatment of any kind?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Today</td>
</tr>
<tr>
<td>Young adults (16-25)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
</tr>
<tr>
<td>Adults (26-45)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
</tr>
<tr>
<td>Senior adults (46+)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
</tr>
</tbody>
</table>

Not surprisingly, as most of the recent visits to a health professional were to a doctor, there was substantial variation in the participants’ answers in terms of when they last sought medical treatment with a general practitioner. A quarter of the individuals (27.1%) had seen a general practitioner in the last week and an additional 29.2% had attended in the last month. Thus, the majority (56.3%) had attended a general practitioner in the last month.

The reasons why participants choose to go to the medical centre they went to are displayed in Table 28. As can be seen in this table, there were two major reasons why these participants choose to go to the medical centre they attended. The most frequently cited reason was because the patient’s family or personal doctor happened
to be based there. The second reason was a more practical reason; the medical practice was close to where they were at the time.

I: Why did you choose to go to that medical centre and not another medical centre?
A: “Oh, I’ve been going to the one medical centre for years. And what’s the use, you know, swapping and changing, having medical records all over every medical centre, when you can just go to one normal one and see the doctor there all the time.”
(Aboriginal Man, Adult: 26–45 years)

A: “It was a small country town and it was like the closest to my house.”
I: Any other reasons?
A: “No. Not because it was a specific medical centre. It was because it was the closest.”
(Aboriginal Man, Young Adult: 16–25 years)

One participant mentioned both these reasons. However, it was obvious that other issues were just as important in his decision:

A: “Well, um, it is close to my home and it’s, the yeah, it’s 5 minutes from my home and it’s more convenient for me to go to the Aboriginal medical centre, instead of going to the hospital, because I feel more comfortable going there, because I have known him for a fair while and I don’t want to uproot my medical history from one place to another. Um, it is not that I am frightened to go to another doctor, or GP, or whatever. I feel more comfortable where, where, people sort of know me for what I am. Know me from my medical history. I’m not a psycho, or anything. I’ve got a good rapport with Tharawal. Not only with the doctor, but all the people who work there.”
I: You mentioned comfort. Do you feel less comfortable at other medical centres?
A: “No, I’ve done it for six, going on seven years, um, I feel more in a family environment. I feel more at ease. It’s a family oriented medical centre… There’s no hassles with them. If you’ve got a hassle, we’ll sit down and talk about it.”
A: “… There’s a lot of private questions that I will ask within the medical centre, Aboriginal medical centre, where I wouldn’t ask in the hospital.”
I: Why is that?
A: “The doctor at Tharawal, he will ask you questions and if you don’t feel comfortable, you can tell him. If I was to go to a hospital and ask me the same question and you don’t want to answer it, they sort of get a little bit pissed off… It’s the way they should ask you a question. With my local doctor it’s always xxxxx [his first name] this and xxxxx that, ‘what is the problem?’ I went to the local hospital and it is ‘what?’, ‘what?’ ‘what?’”. That’s the primary word, ‘what’, you know. With my local doctor it is ‘what is the problem?’ and it is a simple straight out conversation ‘what’. You go to the hospital and it is a demeaning way of ‘what’, you know. I find that sort of, um, degrading, you know. Because I am there for a problem. If I can’t answer them. It’s like I said I could be having a hypo, or something, and I do talk in riddles at times, I have a small speech impediment and they can’t understand, can’t understand. It works both ways. It pisses them off and it pisses me off, you no. I can understand it, but when it comes to the question of ‘what can I do for you?’ That one little word. It’s a four letter word ‘what’ and you know it’s sort of degrading.”
(Aboriginal Man, Senior Adult: 46+ years)
Table 28: The reasons why participants choose to go to the medical centre (n=30)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/personal doctor works here</td>
<td>19</td>
</tr>
<tr>
<td>Live close by</td>
<td>13</td>
</tr>
<tr>
<td>Because I like the doctor there</td>
<td>2</td>
</tr>
<tr>
<td>Thought the treatment would be better. Not just send on way</td>
<td>1</td>
</tr>
<tr>
<td>Been going there for years</td>
<td>3</td>
</tr>
<tr>
<td>I found it more relaxed/comfortable</td>
<td>3</td>
</tr>
<tr>
<td>More by mistake than anything</td>
<td>2</td>
</tr>
<tr>
<td>Pretty friendly people</td>
<td>1</td>
</tr>
<tr>
<td>Don't have to book</td>
<td>1</td>
</tr>
<tr>
<td>Her doctor said they are only interested in making money so</td>
<td>1</td>
</tr>
<tr>
<td>Only doctor about</td>
<td>1</td>
</tr>
<tr>
<td>It's easier</td>
<td>1</td>
</tr>
<tr>
<td>Due to their transport service</td>
<td>1</td>
</tr>
<tr>
<td>They had just opened and wanted to test them out</td>
<td>1</td>
</tr>
<tr>
<td>Get a second opinion</td>
<td>1</td>
</tr>
<tr>
<td>Been before for same thing</td>
<td>1</td>
</tr>
<tr>
<td>Is an Aboriginal medical centre</td>
<td>1</td>
</tr>
<tr>
<td>Never been before</td>
<td>1</td>
</tr>
<tr>
<td>Open early</td>
<td>1</td>
</tr>
</tbody>
</table>

While pursuing the reasons behind why participants choose one medical centre opposed to another, two alarming findings were noted:

“I was going to Dr. xxxxx down there [another medical centre], um, he was really good, but you had to make an appointment and you had to sit there for hours. Like, he actually told me one day, because we started to get on pretty good, and he said, um, their services down there, they are only interested in making money. And then I felt, well, I don't, but, he, um, he treated, medicated, everything was okay. But when he said that, I thought ‘Oh you know. I wonder if you go there one day and he's in a hurry and, you know, and so, because you don't have to make an appointment up here [Tharawal], oh well you can, but very few people [do]. And, um, so I get straight in there and up there, he was someone who really got me onto all these xxxx [a medical service] and everything happening at xxxx hospital.’

(Aboriginal Woman, Senior Adult: 46+ years)

I: Are there other doctors around this area?
A: “I know there is one xxxx [indicates location], but people think he’s not real good.”

I: Tell me a little about that. What do they say about him?
A: “Um, I heard that a lady took her baby there and he just said that he [the baby] had a cold, when in fact he had pneumonia. He ended up dying a couple of days later.”

(Aboriginal Woman, Young Adult: 16-25 years)
A large number of participants did not mind which general practitioner they saw:

_I:_ Why did you choose to go to that GP and not another GP?
_A:_ “No. I wouldn’t care really. I just trust them and that.”

_I:_ Why don’t you care what doctor you see?
_A:_ “Because, um, I don’t know, because they’re a doctor I suppose.”

(Aboriginal Man, Young Adult: 16-25 years)

In some cases they had no choice as the medical centre was a single doctor practice, or the doctor they saw might be the only one available on the day. Patients who did ask to see a specific doctor, provided a variety of reasons for doing so. Essentially, however, there were three main reasons: (1) the doctor knew the patient’s personal history, (2) personal characteristics of the doctor, and (3) the patients felt comfortable with the doctor.
3.2 Preferred medical facilities

To appreciate what kind of health services the participants believe they use, six scenarios were presented (see Table 29). The six scenarios were:

1. In general, would you prefer to go to a doctor, chemist, or the hospital for medical problems?
2. If you are not well, would you prefer to go to a chemist, doctor, hospital, or seek alternative medical treatment?
3. If you have the flu who would you seek for help: a chemist, doctor, or the hospital?
4. If you had a rash who would you seek for help: a chemist, doctor, or the hospital?
5. If you mildly burnt yourself who would you seek for help: a chemist, doctor, the hospital, or bush medicine?
6. If you have a tooth problem, would you prefer to go to a doctor, dentist or the hospital?

The questions vary in terms of the answers available. For instance, Question 1 involved a comparison between using a doctor, chemist, or hospital services, whereas Question 2 compared these three services and an additional group (alternative medical practitioner). Thus comparisons between questions are not strictly available. Where participants have suggested a different response from that provided, these have been recorded.

Three-quarters of the individuals (73.5%), who provided a meaningful answer to the question concerning response to medical problems (n=49), suggested they would utilise the services of a doctor. Three individuals (6.1%) said they would go to a hospital. Another three individuals said they would go to a chemist if the complaint was not bad, but if it was more serious they would go to a doctor. It is very interestingly to note that only one individual said they would not seek help. See Appendix 5 for an explanation of the reasons why participants would use the services they stated they would utilise.

Two-thirds of the individuals (68%), who provided a meaningful answer to the question concerning not being well (n=50), suggested they would utilise the services of a doctor. This question provided the possibility to seek alternative medical treatment. Three individuals (6%) said they would have used such services. This was the only question where this option was suggested as an alternative. Thus it is possible that the responses to some of the other questions are not truly representative of the actions participants would make if confronted by the situation. A significant number of individuals said that they would go to the hospital if they were not well. Part of the difficulty of this question is that being ‘not well’ is a very broad statement. Thus, what one person perceived ‘not being well’ might be, differed considerably from what another person perceived it as being. Thus, it is impossible to state with any degree of certainty whether 14% of the participants answering this question needed to go to hospital.
Table 29: Preferred health facilities of participants for various health conditions

<table>
<thead>
<tr>
<th>Alternative medical treatment</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bush medicine</td>
<td>1</td>
</tr>
<tr>
<td>Chemist</td>
<td>10</td>
</tr>
<tr>
<td>Dentist</td>
<td>1</td>
</tr>
<tr>
<td>Doctor</td>
<td>36</td>
</tr>
<tr>
<td>Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Tharawal</td>
<td>1</td>
</tr>
<tr>
<td>Chemist or doctor</td>
<td>1</td>
</tr>
<tr>
<td>Dentist or doctor</td>
<td>1</td>
</tr>
<tr>
<td>Treat it myself</td>
<td>1</td>
</tr>
<tr>
<td>Initially treat it myself, then chemist</td>
<td>1</td>
</tr>
<tr>
<td>Initially treat it, then doctor</td>
<td>1</td>
</tr>
<tr>
<td>If not bad chemist, if bad doctor</td>
<td>3</td>
</tr>
<tr>
<td>If not bad chemist, if bad doctor, if serious hospital</td>
<td>1</td>
</tr>
<tr>
<td>If not bad doctor, if serious hospital</td>
<td>1</td>
</tr>
<tr>
<td>Anywhere</td>
<td>1</td>
</tr>
<tr>
<td>No-one/Nothing</td>
<td>1</td>
</tr>
</tbody>
</table>
The majority of the individuals (60%) who provided a meaningful answer to the question concerning response to having the ‘flu’ (n=50) suggested they would utilise the services of a doctor. A significant number of individuals stated that they would go to a chemist (20%). These two health professionals were definitely seen as the most appropriate as the next common response provided by the participants was to see a chemist if the situation was not severe and a doctor if the complaint was more serious.

Of all the scenarios, having a rash was the one which had the largest percentage of individuals (74.5%) stating they would seek the services of a doctor. The only other health professional that the participants (n=51) felt they would approach in any numbers was a chemist (15.7%).

Responses to ‘mildly burning yourself’ were a lot more varied than for any other scenario (n=51). A possible reason for this may be due to perceptual differences as to what constitutes mildly burnt. The most common answer was to seek a doctor (39.2%). It is possible that this response was slightly inflated, because it was the fifth scenario presented and thus some individuals may not have put so much thought into their answer. The two other common responses were to seek help at a hospital (21.6%) or to treat it themselves (15.7%).

Of all the scenarios, the last one concerning response to tooth problems produced the most agreement (n=50); 80% of individuals said they seek the services of a dentist. Five individuals (10%) said they would go to a doctor. Reasons suggested for seeing a doctor usually revolved around pain removal:

A: “At the hospital you wait for hours, then at the doctor and the dentist you mightn't get in and that.”
I: So you might go to a doctor for a tooth problem?
A: “Yeah, anything for pain.”
(Aboriginal Man, Adult: 26-45 years)

“Doctor for aspirin.”
(Aboriginal Man, Young Adult: 16-25 years)

“Doctor of course.”
(Aboriginal Man, Senior Adult: 46+ years)

“Doctor, because can tell you what is problem. Dentists just give you fillings and on you way.”
(Aboriginal Man, Young Adult: 16-25 years)
“Well, I'd actually go to a dentist, but if, if we are talking about overnight, I would have to go to the doctors, because there is no dentist's open overnight. Where I reckon it’s wrong, because a lot of people do suffer with bad toothaches and stuff like that. Where they should have a clinic open for the public if they do have like a bad toothache, or whatever, can go in there. Fair enough, okay, you can go to a doctor and tell him that you, you’ve got a real bad toothache, he's only, he can only prescribe you, um, a little stuff to put on your tooth until in the morning, but is that going to help you. It might, but then again it mightn’t. But to me, I reckon they should have at least a medical dentist open overnight, um, like these, um, medical centres.”  
(Aboriginal Man, Adult: 26-45 years)

Further support for the hypothesis that pain is a significant motivator for Aboriginal people to access health services is seen in the following comment by a participant who suggested that she would utilise the services of a chemist for tooth problems:

A: “I'd go to the Chemist and I'd go to the dentist as the last, last, last resort, because I am scared of the dentist. I just about vomit thinking about it.”  
I: So why do go to the chemist?  
A: “Well he gives me something for the pain and hopefully I talk myself into believing, that once the pain goes, everything else will go, you know.”  
(Aboriginal Woman, Senior Adult: 46+ years)

Of major concern is the fact that three adults took dentistry into their own hands and even went to the extent of removing some of their own teeth. Two of the instances are reported in Section 2.9 (Relationships with check-ups). The other is presented below:

A: “Well if I had a problem like just a loose tooth or something. Like, over the years, dads just gone, 'Okay, come and sit down'. Sit on his lap, get the pliers and it's gone. Like, you don't even feel it, but if it's worse than that, then I go to the dentist.”  
I: So how old were you approximately when that was happening?  
A: “From about whenever my teeth started getting going till probably about 15.”

As dentistry can be quite expensive, it is worth noting that only one person said they would not do anything.
### 3.3 Bush medicine usage

A large number of individuals (39.5\%\(^{26}\)) said they used bush medicine. The following three accounts are from individuals asked about their bush medicine usage. The first two indicated that they used bush medicine, while the third person instead acknowledged how she used old wives’ tales:

**I:** Do you use bush medicine?
A: “Um, now and again if one of the ones show me something, see this here try this here stuff out.”

**I:** Do you know how to do it yourself?
A: “A few of them I do.”

**I:** So what sort of stuff would you use it for?
A: “Um, well I had, um, um, some plants for boils and that, rashes and sores.”

*(Aboriginal Man, Adult: 26-45 years)*

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**I:** Do you use bush medicine?
A: “When I am out bush, yes.”

**I:** What is the effectiveness of it like?
A: “Um, all I know, I have sort of been sick, um, I have been brought up, in you know the normal white society, but, um, there have been occasions where I have been very sick and I have had relatives who still live the tribal, sort of lifestyle. Who have gone out and picked some things, plants and what have you, made some sort of brew, or food, or something and it’s fixed me up. I’ve had them show me various things, but, um, like what things to eat and what things not to. What to touch and what not to, um, yeah.”

*(Aboriginal Man, Adult: 26-45 years)*

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**I:** Do you use bush medicine?
A: “Yes, I use some old wives’ tales, of wives tales’ remedies.”

**I:** What are they?
A: “And I like herbal remedies and things like that.”

**I:** What are the old wives’ tales?
A: “Well you know they reckon pissy-nappy it gets rid of conjunctivitis. And you know when you have got a pig-stie, you rub a gold ring on it and it takes the pig-stie away. Lavender is supposed to relax the mind. It’s supposed to be relaxing.”

**I:** Tell me the nappy one?
A: “Babies pissy nappy, wipe their eyes when they have got conjunctivitis.”

*(Aboriginal Woman, Young Adult: 16-25 years)*

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\(^{26}\) Although not fully comparable, as this study only enquired whether participants use bush medicine and did not state a time frame, this figure of 39.5\% is substantially higher than that supplied by the Australian Bureau of Statistics (1995) who report that one in ten Aboriginal people used bush medicine to treat a health related problem in the last 6 months. One reason for the difference might be the method of data collection. Participants might have felt more comfortable talking about using bush medicine due to the interview method employed.
However, by far the majority of individuals did not use bush medicine:

“No. See I live in the city, so I have no access.”
(Aboriginal Woman, Adult: 26-45 years)

I: Do you use bush medicine?
A: “No way in the world.”
I: Why?
A: “I'm a black city girl.”
(Aboriginal Woman, Adult: 26-45 years)

I: How often do you use it?
A: “I don't use it at all.”
I: Never?
A: “No, because I haven't been brought up the Aboriginal way, um, I wouldn't know what to look for in bush medicine. So I wouldn't really try in case I end up poisoning myself.”
(Aboriginal Woman, Adult: 26-45 years)

More than a quarter (29.7%) of the individuals had been treated by their parents or guardians and one individual (2.7%) was treated by their relatives (not by their parents or guardians) with bush medicine. For instance, the following woman was treated using bush medicine and what would best be described as home remedies:

“Dad use to bath us with a bush for itches. He also use to slice up soap and use it for constipation. Saturday was castor oil clean out day.”
(Aboriginal Woman, Senior Adult: 46+ years)

The majority of the individuals (59%) who provided a meaningful answer to the question “do you feel that it is a good thing to use bush medicine?” (n=39) said that it was a good thing to use:

“Yes, good for mind and spirit.”
(Aboriginal Woman, Adult: 26-45 years)

“Yes, better than drugs.”
(Aboriginal Woman, Young Adult: 16-25 years)

I: Do you use bush medicine?
A: “You're not waiting in line at the medical centre. You're not waiting in line for the chemist. You go straight to the bush and pick it. You don't need a prescription for it see.”
(Aboriginal Man, Adult: 26-45 years)
I: Does it [bush medicine] work?
A: “Yep.”
I: How effective is it?
A: “Pretty effective. The bush medicine up in xxxxx. I was two days into a flu, um, heading for bed. Me next door neighbour said he had some bush medicine. Um, I sent my cup over. Um, he filled it up. Um, it probably took me about half a day to drink that little cup, but the next day I was right. Um, I suppose if, um, I was feeling really down in me body, um, I'd go out and get me own bush medicine and start chucking it in me tucka. And yeah it does work, because, um, like I said, I had alcoholic poisoning, um, for three weeks and things were not going too good for the first two weeks. Well I went out into the bush and grabbed some stuff to chuck into the pot, and everything started to come good.”
I: So were you using Western medicine in the first two weeks?
A: “No, I wasn't using any white man's medicine. I wasn't using any medicine at all.”
I: How did you know that you had alcoholic poisoning?
A: “Um, because um, the jitters, um, the colour of my piss. That’s usually the big teller - the colour of my piss.”
I: Did you go to the doctor to check that you did have alcoholic poisoning?
A: “No, didn't have to. I've had enough of it. Yeah, I no what it’s like.”
I: Have you ever used it for your heart problem?
A: “No. No I haven't used it for my heart problem yet.”
I: What about your diabetes?
A: “Um, no. I haven't used any bush medicine for me diabetes... there are a few other members of the family who have got it too [diabetes] and, um, they're using white man's medicine and it is taking too long to heal. One of them has lost a toe and it looks like he is going to go his father’s way and start losing parts of his limbs and like our grandfather went the same way.”
I: Are they using bush medicine to treat their diabetes?
A: “Yeah, yeah. Well, one of them is. I don't know about the other two members.”
I: I'm a bit lost, he's actually taking it for the diabetes?
A: “It's more like the cure of, um, losing toes. You know, repairing skin…Um, the only reason I use the bush medicine is because I wasn't going anywhere near white man's medicine. That was mainly it. I wasn't going anywhere near white man's medicine, so I got into the bush medicine.”

(Aboriginal Man, Adult: 26-45 years)

There was also partial support for it by another 5 (12.8%) individuals who thought it was some times useful, while at other times they felt it was of no use:

A: “… I know a little bit. Like there’s, um, this thing up north near xxxxx and that, if you mix it with water and you can put it on sores and that and that it goes away. And, I don't know, some other stuff they reckon you can just put your hands on you where you are sick and it will go away. That's just, um, believing in it. Like getting better and that.”
I: What do you think of that?
A: “Um, crap.”
I: What do you think of some of the other things you mentioned?
A: “Yeah, some, like, just good for the skin and that, but things for inside the body is a bit out, far-fetched. But things like, yeah, um, oils and stuff they get are good. Are good for the skin and some things if you have got real dried skin and they mix with ants and leaves and all that and put it on your skin. Like stuff like that. It has the real strong eucalyptus smell and that.”
I: And you think that's good?
A: “Yeah, just for your breathing and go through your skin and that, you know.”

(Aboriginal Man, Young Adult: 16-25 years)
I: Does it work?
A: “Oh yeah, some do and some don’t. Um, for cuts and that I, um, I use vinegar. I just sort of put a dab, dab vinegar into a cotton wool, dab it on the cut, and then there is a certain type of leaf, my mum knows about it, and you put a little cut in the middle of the leaf, but you don’t like cut it in half, or anything. It’s like a hole and you just put a cut into it and put it over the cut, put a bandage around it and it heals over within about two days. If it is a deep cut, I, um, pinch the skin and… put one of those butterfly bandages on it and dab it with vinegar and put the leaf over the band-aid. So, but that’s it, I don’t really, I never really think about am I going to die from this, or.”

I: Do you call it bush medicine, or what do you call it?
A: “I just say, ‘is there any way, bush way, of bush medicine’. It just depends.”

I: So what do you say to your mum?
A: “Mum, is there any sort of way that you can cure this without me going to the doctor?’”. And she’ll say, ‘Yeah.’”

I: So why do you want to use that [bush medicine] instead of going to the doctor?
A: “There's no reason really. I just, I'd rather, like, not go to the doctor.”

I: And why is that?
A: “Don't know, because the doctors just too much out of the way, when I can just take care of it myself, I guess.”

I: They’re out of the way, you can take care of yourself, what else?
A: “Because they want me to take like days off work, or anything like that, or if they, um, put me into see a specialist, or anything. I mean if it's getting bad and it's starting to go green, or whatever, then I'll go see a doctor.”

(Aboriginal Man, Young Adult: 16-25 years)

Similarly, one person added a proviso: he felt that it was a good thing, but only if its use was supervised:

A: “Supervised, yes. You know, like, there's some things, I've done a lot of reading about bush medicine actually, bush foods and that. Some of them are quite toxic. So they’ve got to be prepared in the right way. Um, a lot of Aboriginals today have been urbanised, so they don't know the full extent of how to prepare it. So if they going to use it, is got to be prepared properly, otherwise it may end up causing more harm than good.”

I: Have you ever heard of anybody actually having more harm than good?
A: “Some of the things in the sixties with datdra [hallucinogenic drug]. Aboriginal people used it, but it was only used in ceremonies in a certain way. And of course if it is not prepared and used in the right way it causes blindness and insanity.”

(Aboriginal Man, Senior Adult: 46+ years)

Six individuals stated that they did not know a great deal about bush medicine:

“Even though I am Aboriginal, I don't know much about bush medicine.”

(Aboriginal Man, Senior Adult: 46+ years)

“I don't know much about that. It's just what I’ve heard about there’s different berries and different leaves and that you boil up.”

(Aboriginal Woman, Senior Adult: 46+ years)

Only one person believed that bush medicine was not a good thing.
3.4 Speed to seek help

As noted earlier in Section 2.9 (Relationships with check-ups), a degree of apathy towards health care and a lack of proactive behaviour was noted in this study. This indifference some participants had concerning their health care was examined in greater detail. Participants were asked two questions. Forty-six individuals provided meaningful answers to the question: “Do you see a doctor immediately, or do you leave it as long as possible before seeing a doctor?” The response to the question varied considerably (see Table 30). A large number of individuals (39.1%) stated that they sought the assistance of a doctor straight away:

A: “I go immediately when I feel sick, or I don't feel well, I go to my local GP. Um, I don't wait until I get sick. If I feel sick, I go to my local doctor at Tharawal. But that is the only place I will go if I am not terminally ill, or anything like that, I'd go to my local doctor.”

I: If you couldn’t go to Tharawal, would you leave it a bit longer before you went to the doctor, or would you go immediately?

A: “I'd go to the casualty. I'd go to the hospital.”

I: Why not the doctor?

A: “I don't know why, but I'd go to the hospital…. I'd feel more comfortable. I'd feel more secure, because if I go to the hospital that I usually go to, they'll have my medical history, whereas if I go to a different GP, well I have to go through the whole procedure again of my date of birth, where were you born, and all of this, and yet at the hospital it is all on computer. You know, I just go in and say here is my Medicare card and um, I’m there for whatever time, whatever period and if I go to a different GP, I could be there a couple of hours and then get referred to the hospital for another three or four hours.”

(Aboriginal Man, Senior Adult: 46+ years)

Six (13%) individuals left it a day or two before seeing a doctor, and one individual (2.2%) left it 3 days to 2 weeks before seeing a doctor:

A: “When I have a medical problem I usually leave it for a couple of days and see if it fixes itself. If it doesn't I’ll go to the doctor.”

[Then she was asked something 20 minutes later in the interview:]

I: Have you ever been frightened to go to the doctor?

A: “There was one time there when I actually had, um, pneumonia, borderline pleurisy, and it got to the stage where I had to go, but I didn't really want to go.

I: And what happened?

A: “I ended up in hospital for three to four weeks.”

I: How old where you then?

A: “30-38 [Note: approximate age to keep anonymous].”

I: So how long did you put up with it before you went to see the doctor?

A: “I went and saw the doctor when it got to the stage of borderline pleurisy.”

I: So you put up with it for how long?

A: “I put up with it, like, the pneumonia for about two weeks. Them my body just said ‘No, I’ve had enough’.”

I: So why did you leave it so long?

A: “I don't know. Just didn’t feel like… Working, looking after the family.”

I: Are you sure that’s the only reason?

A: “Yep. Well, mainly it was that I was too busy with work and the family, and um, at the time, everybody was going on holidays and that, and there was nobody here. At the time, the new boss had just started as well. And me health just started going down hill, because I wasn't looking after myself properly.”

(Aboriginal Woman, Adult: 26-45 years)
“Um, I don't necessarily, you know, see him straight away, but, um, I don't let it linger on, you know. It may be within say 24 hours at the outside. If I think it is a problem, then I will be straight into the doctor.”

(Aboriginal Man, Senior Adult: 46+ years)

An almost equally large number of individuals (30.4%) leave it as long as possible before seeing a doctor:

“I leave it about a month or so, you know. I think, I’ll fix it up with xxxxx, you know. I try to fix myself up first, but if I can't, I'll go see a doctor then.”

(Aboriginal Man, Adult: 26–45 years)

A: “I’d just leave it until I really have to go.”
I: Has that been the case all your life?
A: “Yes.”
I: Has what has happened to you more recently changed things? Do you go see them more urgently or [interrupted by interviewee].
A: “Um, no not really, because, um, I usually try to diagnose myself [laughs].”
I: You try to do what?
A: “[Still laughing] Diagnose myself.”
I: Are you trained, as far as you are concerned, to diagnose yourself?
A: “Yeah. I think I am. I think I am. Sometimes I go to the doctor and tell him what's wrong with me.”
I: Just so I understand, what are your qualifications?
A: “Assistant nurse…passed the health workers course at Macarthur.
I: And you feel that you are sufficiently trained, experienced, etc, to be able to diagnose?
A: “I'm not, I'm not, spot on all the time, but I’m close enough.”

(Aboriginal Woman, Senior Adult: 46+ years)

Five (10.9%) individuals said their response depended upon the ailment in question:

A: “Only with giardia would I go straight to a doctor. The rest of it I would leave it to see if my body could heal itself.”
I: What does it take for you to go see a doctor or the hospital about your chest pains?
A: “If I feel incapacitated to the extent which I could not move. Um, the pain level was very intense.”
I: So you will still take a lot of chest pain before you go see the doctor?
A: “Yep.”
I: Do you think that is a good thing? Is that what the doctors are recommending?
A: “No, but it is just me.”

(Aboriginal Man, Adult: 26–45 years)

A further two (4.3%) stated that they leave going to the doctor for as long as possible for themselves, however, they go immediately for their other family members:

A: “I leave it as long as possible.”
I: What about your baby?
A: “No, I'd take her straight away - as soon as I see a sign that she is sick.”
I: So why do you take the baby so quickly, if you take ages to go yourself?
A: “I know I can say things about how I feel and that, but with her I’m not sure.”

(Aboriginal Woman, Young Adult: 16–25 years)
Forty individuals provided meaningful answers to the question: “If you have a toothache do you immediately seek help, or do you leave it as long as possible before seeking help?” The response to the question varied considerably (see Table 30). A large number of individuals (42.5%) stated that they sought help straight away:

A: “No with toothache as soon as possible to the dentist.”
I: Would you see a doctor for a medical problem, or a dentist for a dental problem first?
A: “No probably about the same, but then again I know that, um, dental, I’ve had problems, personal problems, where I had a pain near the eye, corner of me eye and I never realised it at the time. And I let it go for a while and I found out later that it was a problem with my tooth.”
(Aboriginal Man, Senior Adult: 46+ years)

A lesser number of individuals (32.5%) leave it as long as possible before seeing a doctor:

A: “Um, I’ve always kept a bottle of cloves in the bathroom cabinet… It is a tiny little bottle that you can dab a match stick in and it is like an antiseptic.”
I: When do you eventually go see the dentist?
A: “I leave it as long as possible.”
(Aboriginal Man, Adult: 26-45 years)

A: “Until there is a great big whopping hole in it [laughs].”
I: So you’ll leave teeth problems longer than your medical problems?
A: “Yep. You know what the old phobia is. Scared of the dentist more that what you are the doctor.”
(Aboriginal Woman, Adult: 26-45 years)

Five (12.5%) individuals left it a day or two before seeking help:

“Just wait and see if it goes away. By the next day, I'd probably go.”
(Aboriginal Woman, Young Adult: 16-25 years)

“Leave it for a day or two. Leave it until it gets worse.”
(Aboriginal Woman, Adult: 26-45 years)

One individual (2.5%) does not ever seek help for dental problems and four (10%) individuals treat the toothache personally and then wait and see.
Table 30: Comparison between speed to seek a doctor versus speed to seek someone concerning a toothache

<table>
<thead>
<tr>
<th></th>
<th>Straight Away</th>
<th>Between 'straight away' and 'as long as possible'</th>
<th>Leave it as long as possible</th>
<th>Depends on ailment</th>
<th>For self 'as long as possible', but other family members 'straight away'</th>
<th>Don’t ever go</th>
<th>Treat it personally and then wait and see</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you see a doctor immediately, or do you leave it as long as possible before seeing a doctor? (n=46)</td>
<td>39.1% (18)</td>
<td>15.2% (7)</td>
<td>30.4 (14)</td>
<td>10.9 (5)</td>
<td>4.3% (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a toothache do you immediately seek help, or do you leave it as long as possible before seeking help? (n=40)</td>
<td>42.5 (17)</td>
<td>12.5 (5)</td>
<td>32.5 (13)</td>
<td></td>
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A major determinant of the speed with which the participants seek help, be it for a toothache or a medical problem, is (a) whether there is pain and (b) the degree of pain. The greater the pain, the more likely a participant was to seek help:

I:  *If you have a toothache do you immediately seek help, or do you leave it as long as possible before seeking help?*
A:  “I'd rather have a baby than a toothache.”
I:  *So if you have a toothache, what do you do?*
A:  “Come straight to the dentist.”
I:  *Immediately?*
A:  “Oh yeah, like I said, I'd rather have a baby than a toothache.”
* (Aboriginal Woman, Senior Adult: 46+ years)

I:  *If you have a toothache do you immediately seek help, or do you leave it as long as possible before seeking help?*
A:  “Oh yeah. No, no, no. Straight away.”
I:  *So for medical problems you leave it as long as possible, but your teeth?*
A:  “Straight away. I can't bare that pain.”
* (Aboriginal Man, Adult: 26-45 years)
I: If you have a toothache do you immediately seek help, or do you leave it as long as possible before seeking help?
A: “Probably straight away.”
I: So would you see a dentist earlier or later than you would go see a doctor about medical things?
A: “I’d see the dentist later, but if I was in extreme pain I’d go straight to the dentist.”
I: So would you delay going to the dentist?
A: “Yes.”
(Aboriginal Man, Young Adult: 16-25 years)

I: If you have a toothache do you immediately seek help, or do you leave it as long as possible before seeking help?
A: “Just leave it and see how it goes.”
I: And would you go seek help with a tooth ache quicker than you would go seek help for a medical problem, or would it be the other way around?
A: “I think it would be about the same. It all depends on the pain. How much pain there is.”
(Aboriginal Woman, Senior Adult: 46+ years)

I: If you have a toothache do you immediately seek help, or do you leave it as long as possible before seeking help?
A: “No, go straight away.”
I: So why will you wait for ages if you have got a medical problem, but with tooth problems you’ll go straight away? Why is that?
A: “Because the tooth hurts.”
(Aboriginal Man, Young Adult: 16-25 years)

This finding concerning pain is also noted in the following section (Section 3.5: Frequency comparisons about seeing a doctor). Two participants answers to this question were interesting:

I: If you have a toothache do you immediately seek help, or do you leave it as long as possible before seeking help?
A: “Take antibiotics, all the paracetamols or what ever to get rid of it. If it goes away, well then we don’t worry about it, till it comes again, until it gets too bad.”
(Aboriginal Woman, Adult: 26-45 years)

I: If you have a toothache do you immediately seek help, or do you leave it as long as possible before seeking help?
A: “I go and get that done straight away too, because it’s different to a sore to your body.”
I: Why is that?
A: “Well if you get a tooth infection, then that can go straight to your brain and kill you.”
(Aboriginal Man, Adult: 26-45 years)
3.5 Frequency comparisons about seeing a doctor

McInman (2000) noted that the majority of general practitioner receptionists believe Aboriginal patients see general practitioners less frequently. Considering the state of Aboriginal health, this is a concern if Aboriginal people are not going elsewhere for their health care. A substantial number of reasons were suggested by the receptionists as to why they felt that Aboriginal patients visit their medical practice less frequently compared with non-Aboriginal patients. The two most common reasons expressed were: a) that Aboriginal patients only visit a medical practice if they are seriously ill and b) that Aboriginal people have a more casual attitude about their health. Other reasons included: a) hereditary characteristics, b) not being aware of the facilities, c) preferring not to rely on doctors, d) feeling inferior, or having low self-esteem, e) not feeling comfortable in public, f) having difficulty conversing and interrelating with people due to low levels of education, and g) thinking it is too much hard work to visit a doctor.

Thus the Aboriginal participants in this study were asked: “How frequently do you think Aboriginal people compared with non-Aboriginal people see General Practitioners? In other words, if non-Aboriginal people see doctors x number of times per year, how many times per year do Aboriginal people see doctors per year? Is it more times, about the same times, or less times?” The answer to this question would provide useful feedback as to: (1) whether Aboriginal individuals felt that Aboriginal people as a whole see general practitioners frequently, and (2) if they did not believe they went as frequently, reasons for this could be determined, along with an examination as to who they do seek help from (if at all).

Of the 17 individuals who provided meaningful answers to the question, 11 (64.7%) felt that Aboriginal people go less frequently, 3 (17.6%) felt that Aboriginal people go more frequently, and 3 (17.6%) didn’t know. Some of the responses are quite illuminating in that they not only provide reasons for why they feel Aboriginal people do not turn up as frequently and indicate who they instead seek help from, but they also note barriers to accessing such services.

Individuals who believe that Aboriginal people visit GPs less frequently:

A: “In a way I reckon less.”
I: Why is that?
A: “Because a lot of them just don't like going to doctors and that. Sometimes it's just hard getting to the place.”
I: You mentioned, 'just don't like going', why not?
A: “Because a lot of them, if they can fix themselves up, well they'll think it's okay, you know.”

(Aboriginal Man, Adult: 26-45 years)
A: “Less.”
I: Why is that?
A: “Oh, because sometimes they, like most Aboriginals are actually scared to actually go and see a doctor in case there is something wrong with them and then they tell them that they’ve got to change their lifestyle. And a lot of Aboriginals aren’t use to changes.”
I: You say they are scared, but you’re not. Why are you not?
A: “Oh, just because, ever since I’ve been a kid, like my grandmother has always pushed health out at me. Plus when I was younger, I was in and out of hospital, because I had xxxx trouble, but that's all right now. So I’m use to going to doctors, because until I was about 14, I was always having to go to the doctor, to have my kidneys checked.”

(Aboriginal Woman, Adult: 26-45 years)

A: “I’d say non-Aboriginal people would turn up more.”
I: Why is that?
A: “I think they just like seeing the doctor all the time.”
I: Why do you think that Aboriginal people don’t go to the doctor as much?
A: “Well they don't find themselves sick. Really sick, sick. They have to be really sick to go. They are sick, but they have to be really sick to go.”
I: How long will you wait before you go see a doctor?
A: “Two days.”
I: And how painful will it be?
A: “Bad. See with the non-Aboriginal people they’ll probably go straight away as soon as they get an ache. ‘Oh, I’m sick doc, I’ve got a headache.’ Doctor give him antibiotics, or Panadol.”

(Aboriginal Woman, Adult: 26-45 years)

A: “I reckon non-Aboriginal people see them more.”
I: And why is that?
A: “Because with some Aboriginal people, they really just don't care about themselves. A lot of them are scared. And they just don't like doctors altogether.”
I: Why do you think they [Aboriginal people] are scared to go to doctors?
A: “I'm not really sure.”
I: But you did say it?
A: “Some just don't like them.”
I: Have you ever heard anybody say they don't like them?
A: “Yeah. Because I'll end up in hospital, or have needles, or anything.”
I: Why not end up in hospital?
A: “Because they’re lonely, or some people get too lonely.”
I: Any other reasons?
A: “No.”

(Aboriginal Woman, Young Adult: 16-25 years)

“I think less, because they're afraid of the doctors. Um, like if they’ve got some terminal disease, that each time they go back they tell them they are deteriorating more and more, and they don't want to know that.”

(Aboriginal Woman, Senior Adult: 46+ years)
A: “Across the board it’ll be probably be less times than the, you know, the average person. Aboriginal people tend to, one is a lot of old beliefs where you only go see the doctor, or the hospital, if you are going to die. You know, ‘You’re not going to come home afterwards.’ So there is that believe, especially with the older ones, um.”

I: Sorry to interrupt, but what age do you call old?
A: “Um, some of them, even into their early fifties, because one thing is, you know, that ah, because you're coming off a settlement, say your living out of town, you go into town to the hospital, or a doctor, and the next thing they know, you’re dead. You know, so, um, it's a major complication. Generally it's because they haven’t received first care. Where today they living within an urban setting where they can get that first care. You know, as soon as something goes wrong, they can get, um, seen to. It is not that long ago, say into the seventies and that, there was people still officially isolated from a doctor, still 24 hours away from a doctor. So that problem always, problem is that the believe is still there. And I think it's just an education program. One is with the Aboriginal community has to be re-educated about, yes if they get to the doctor, if most things are treated in the first instance, they’re not going to have a problem. You know, they're going to get over it and live a long full life. You know, if they don't, well, they’re not going to live very long.”

(Aboriginal Man, Senior Adult: 46+ years)

A: “Very much less.”
I: Why do you reckon that is the case?
A: “Because they will only seek the problem if it gets worse; not at first. They'll think about it, but they'll assume that it will soon go away. And they’ll put up with a little bit of pain. But until it really gets worse, or something, then they will go and see them.”

I: But why do you reckon that is so?
A: “Because I think a lot of times they don’t want to waste their time. They think they’re going to waste their time and the doctors time if it's not right, but if it gets worse they know they are right then, then they will go and see the doctor.

I: Is it because they are embarrassed?
A: “No. Well I don't know about embarrassment. Well I never come across that see. I've seen VD clinics and all that sort of stuff. You know, your old Willy is your old Willy.”

(Aboriginal Man, Adult: 26-45 years)

A: “I reckon less.”
I: Why is that?
A: “I don't know. Um, well I haven't been to the doctor all this year and my family hasn't, oh my mum went to the doctors last year. I don't know, I suppose it depends what the family is, you know. Well if you have got a family that is always crook, or I don't know. If you've got a big family, a little family.”

I: So why don't you think that Aboriginal people don't turn up so much?
A: “I don't know. Just probably don't really worry about if they are sick. Just sleep it off, or if they are really serious, well, um, ‘let's go see a doctor now’. I suppose it would be like me, just lay in bed for three days and realise ‘Shit, I am sick’... But many Aboriginal probably don't worry about going to the doctors...”

I: Why don't you worry about going to the doctors?
A: “Think you can just sleep it off, or, you know, unless it is something real bad. You know, if you've got something, you know that something bad has happened to you, well you just better go and see them. But if it's nothing serious, you don't worry about it.”

I: And where do you get that attitude from?
A: “Um, I don't know. I don't know where I get that from.”

(Aboriginal Man, Young Adult: 16-25 years)
Individuals who believe that Aboriginal people visit GPs more frequently:

A: “I'd say more times.”
I: Okay, why do you think that Aboriginal people see doctors more times per year than non-Aboriginal people?
A: “Generally I would say living conditions. Living and life conditions.”
I: Can you explain that?
A: “Conditions is the state of the accommodation. Um, life conditions, socio-economic status, um, a lot of drug and alcohol problems.”
I: Because these conditions are worse for Aboriginal people, you think they would end up going more frequently?
A: “Yep.”
(Aboriginal Man, Adult: 26-45 years)

A: “I'd say they [Aboriginal people] probably turn up more.”
I: Why is that you reckon?
A: “It’s mainly because, um, I don't know, the culture. You know, looking after the culture. Mainly looking after their health, so that they can look after the youngest. Like the young ones and that.”
(Aboriginal Man, Adult: 26-45 years)

A: “Non-Aboriginal people less time.”
I: Why do you think that is?
A: “Because our, like I said, our immune system is very low.”
(Aboriginal Woman, Senior Adult: 46+ years)

Individuals who didn’t know:

“I don't know. I can't give you that information, because I don't look at the attendance of white people. You know, um, they’re everywhere, these people, these whites. But I know that Aboriginal people don't muck around as much as in the old days with their health as it is today, especially when it comes to their kids.”
(Aboriginal Man, Senior Adult: 46+ years)

“Oh geh. I wouldn't have any idea. I’m in no position to know to say if they go more or less, or whatever, because to me when you are sick, or when you need a check-up, or if your baby needs to be immunised, or anything like that, that's when you just go. You don't really keep count. I mean, there are people who are serious about their health, that go once every six months, or get a check up once every three, get the needles done once every x number of years. Then there's people that just like do it when they need to.”
(Aboriginal Man, Young Adult: 16-25 years)
McInman (2000, p. 52) found that “the majority of receptionists believe that a sizeable proportion of non-Aboriginal elderly patients are attending medical practices for non-social reasons.” He also noted that “one receptionist suggested that some non-Aboriginal people visit doctors unnecessarily for trivial reasons that Aboriginal people would not visit a doctor for” (McInman, 2000, p. 52). If, in fact, this is the case, then maybe the finding that Aboriginal people visit a general practitioner less frequently than non-Aboriginal people should be viewed with less concern. Thus the Aboriginal participants in this study were asked: “Do you think non-Aboriginal people see General Practitioners too frequently?”

Of the 13 individuals who provided meaningful answers to the question, 6 (46.2%) felt that non-Aboriginal people see General Practitioners too frequently, 1 (7.7%) felt that non-Aboriginal people did not see General Practitioners too frequently, and 6 (46.2%) didn’t know. As with the earlier question, some of the responses are quite illuminating:

**Individuals who believe that non-Aboriginal people see GPs too frequently:**

I: *Do you think non-Aboriginal people see General Practitioners too frequently?*
A: “I think so, every little thing they have to rush [to the doctor]. If it wasn't one thing, it was another. Attention seeking thing.”
(Aboriginal Woman, Adult: 26-45 years)

I: *Do you think non-Aboriginal people see General Practitioners too frequently?*
A: “Oh yes. Yes they bloody do.”
I: *Why?*
A: “I'm not sure. Aboriginal people might go, but they go because it’s a necessity, but non-Aboriginal people go as it’s a visit away from home and they sit down and watch bloody telly. They've got nothing to do. No self-esteem. They just watch TV. It's like they're vegetating… [The] older ones [non-Aboriginal individuals] don't know what to do with themselves honestly.”
(Aboriginal Woman, Senior Adult: 46+ years)

I: *Do you think non-Aboriginal people see General Practitioners too frequently?*
A: “Yes, fuss over little things; the flu etc.”
(Aboriginal Woman, Senior Adult: 46+ years)

I: *Do you think non-Aboriginal people see General Practitioners too frequently?*
A: “Yes.”
I: *Why is that?*
A: “I think they are all hypochondriacs. But you see this on, you know, screens and TV and shows and that, of these people, same people, just keep going back to these GPs all the time.”
(Aboriginal Man, Adult: 26-45 years)
I: Do you think non-Aboriginal people see General Practitioners too frequently?
A: “I think so. When I was hospitalised, um, a lot of them would be in hospital so frequently and to me they looked, well I don't know what was actually wrong with them, but I thought God, you know, you're here all the time. And then, when I would go down the street and I would see non-Aboriginal people that I knew, they were going to the doctor and like they had just been last week. That's what I think. I think they go more. Because I think they might be more concerned about their health. I mean Aboriginal people are concerned about their health, but they don't like to go all the time.”

I: Why is that?
A: “Like I said, they are afraid to find out what's wrong with them, all their condition is getting worse. What you don't know, don't hurt you.”

I: These non-Aboriginal people who maybe turn up too much, what age range are they?
A: “About 60 plus.”

I: And why do they turn up so frequently?
A: “I think, especially the elderly ones, I think it's, they're lonely. They want, their kids have grown up, their own jobs, own families and everything, they haven't got much time to spend with them, so that's how they get their company.”

I: Why do lonely elderly Aboriginal people not go to the doctors for company?
A: “I don't know. It could be transport or money. Because if they were sick enough, they would find a way to get there... Well see most of the, um, Aboriginal people don't believe in putting the elderly in homes. The families will look after them. So maybe that's the reason why they don't go to the doctor so frequently because they've got the family at home looking after them.”

(Aboriginal Woman, Senior Adult: 46+ years)

Individuals who didn’t know:

I: Do you think non-Aboriginal people see General Practitioners too frequently?
A: “Well I really couldn't answer that question actually. They probably would say the same about us too you know, because 90% of the Aboriginal people are smoking marijuana, or shooting up heroin, and snorting.”

I: What I found in the last study I did when I asked the receptionists that last question, they said non-Aboriginal people turn up a lot more.
A: “No, it's the other way around.”

I: They also told me that a lot of non-Aboriginal, especially elderly, would turn up to see the doctor because they had nobody else to see. It was their social event of the week. Do you think that Aboriginal elderly people would do that?
A: “I don't think so.”

(Aboriginal Woman, Senior Adult: 46+ years)

I: Do you think non-Aboriginal people see General Practitioners too frequently?
A: “I don't know. I'm not going to put myself in their shoes when it comes to viewing us. I don't know and it would be dangerous of me to turn around and say well now is a good opportunity to say there is fucking whites in the doctors and everything. And how dare I, because of those maybe seriously ill. And how dare I assume that I have the right to diagnose why they are there, the same way that I question people looking at an Aboriginal person in a hospital.”

(Aboriginal Man, Senior Adult: 46+ years)

I: Do you think non-Aboriginal people see General Practitioners too frequently?
A: “I don't know, because I don't go much myself.”

(Aboriginal Woman, Adult: 26-45 years)
The participants varied substantially in terms of when they last sought medical treatment of any kind. A quarter of the individuals (26.9%) had sought medical treatment in the last week and the majority (59.6%) had attended a health professional within the last month. Females were more likely to have seen a health professional recently compared with males, especially in the young adult and adult age categories. Such visits were to see doctors (76%), dentists (12%), hospitals (6%), chemists (4%), and a specialist (2%). Reasons for the visits varied from simple to complex issues and involved both standard and non-traditional treatments. Not surprisingly, as most of the recent visits to a health professional were to a doctor, there was substantial variation in the participants’ answers in terms of when they last sought medical treatment with a general practitioner. A quarter of the individuals (27.1%) had seen a general practitioner in the last week and the majority (56.3%) had attended a general practitioner in the last month. The gender difference, noted above for seeing a health professional, was also in evidence for seeing a general practitioner. There were two major reasons why participants choose to go to the medical centres they attended: (1) the patient’s family or personal doctor happened to be based there, and (2) the medical practice was close to where they were at the time. A large number of participants did not mind which general practitioner they saw. In some cases they had no choice as the medical centre was a single doctor practice, or the doctor they saw might be the only one available on the day. Patients who did ask to see a specific doctor, provided a variety of reasons for doing so. The main reasons were: (1) the doctor knew the patient’s personal history, (2) personal characteristics of the doctor, and (3) the patients felt comfortable with the doctor. No other age or gender differences were noted.

The majority of individuals (73.5%) stated they would utilise the services of a doctor if they had a medical problem. Only one individual said they would not seek help. The majority of individuals (68%) stated they would utilise the services of a doctor if they were ‘not well’. Three individuals said they would seek alternative medical treatment and some individuals (14%) said that they would go to the hospital if they were not well. The majority of individuals (60%) stated they would utilise the services of a doctor if they had the flu, while 20% would go to a chemist. The majority of individuals (74.5%) stated they would utilise the services of a doctor if they had a rash, while 15.7% would go to a chemist. Responses to ‘mildly burning you’ were a lot more varied than for any other scenario. A possible reason for this may be due to perceptual differences as to what constitutes mildly burnt. Common answers were to seek a doctor (39.2%), to seek help at a hospital (21.6%), or to treat it themselves (15.7%). Young adults appear more likely to utilise the services of a hospital than adults or senior adults if they mildly burn themselves. The majority of individuals stated they would utilise the services of a dentist (80%) if they had tooth problems. An important finding was that 10% would go to a doctor and 2% to a chemist for pain relief only (not to cure the underlying cause). Disconcertingly, three adults took dentistry into their own hands by removing some of their own teeth. Although dentistry is expensive, only one person said they would not take some action. No other age or gender differences were noted.
A large number of individuals (39.5%) said they used bush medicine. More than a quarter (29.7%) of the individuals had been treated by their parents or guardians and one individual (2.7%) was treated by their relatives (not by their parents or guardians) with bush medicine. The majority of the individuals (59%) who provided a meaningful answer to the question “do you feel that it is a good thing to use bush medicine?” said that it was. There was also partial support for it by another 5 (12.8%) individuals who thought it was some times useful, while at other times they felt it was of no use. Only one person (2.6%) flatly believed that bush medicine was not a good therapy tool. No age or gender differences were noted.

Forty-six individuals responded to the question: “Do you see a doctor immediately, or do you leave it as long as possible before seeing a doctor?” The responses varied with a large number of individuals (39.1%) stating that they sought the assistance of a doctor straight away. A lesser, but large number of individuals (30.4%) leaves it as long as possible before seeing a doctor. Six (13%) individuals left it a day or two before seeing a doctor, and one individual (2.2%) left it between 3 days to 2 weeks before seeing a doctor. Five (10.9%) individuals said their response depended upon the ailment in question, while a further two (4.3%) stated that they leave going to the doctor for as long as possible for themselves, however, they will go immediately for their family members. Forty individuals provided meaningful answers to the question: “If you have a toothache do you immediately seek help, or do you leave it as long as possible before seeking help?” The responses varied with a large number of individuals (42.5%) stating that they sought help straight away. A lesser, but large number of individuals (32.5%) leaves it as long as possible before seeing a doctor. Five (12.5%) individuals left it a day or two before seeking help. One individual (2.5%) does not ever seek help for dental problems and four (10%) individuals treat the toothache personally and then wait and see. A major determinant of the speed with which participants seek help, be it for a toothache or a medical problem, was (a) whether there is pain and (b) the degree of pain. The greater the pain, the more likely a participant was to seek help. No age or gender differences were noted.

The majority of individuals (64.7%) who provided meaningful answers to the question, “How frequently do you think Aboriginal people compared with non-Aboriginal people see General Practitioners? In other words, if non-Aboriginal people see doctors x number of times per year, how many times per year do Aboriginal people see doctors per year? Is it more times, about the same times, or less times?”, felt that Aboriginal people go less frequently than non-Aboriginal people. The remaining individuals felt that Aboriginal people go more frequently (17.6%), or didn’t know (17.6%). Equal numbers of participants felt that non-Aboriginal people see General Practitioners too frequently (46.2%), as did individuals who did not know (46.2%). One individual felt that non-Aboriginal people did not see General Practitioners too frequently. The number of participants who answered both questions was to small to examine sex and age differences. Considering virtually half of the individuals who did answer the second question said they ‘didn’t know’, such an analysis with a larger number of people answering the second question would be largely pointless.
Section C: Access to Health Facilities

This section consists of three sub-sections. The first sub-section (Section 4: Medical Practices and Staff) focuses on access difficulties related to medical practices. These include personal feelings about being in a medical practice, personal experiences with receptionists and doctors, and the kind of doctor Aboriginal people prefer to see. An important part of this sub-section is the focus on receptionists due to a previous study by this author (McInman, 2000). The second sub-section (Section 5: Access Problems) focuses on access difficulties participants in this study had. These include topics such as financial difficulties, time of appointment difficulties, and difficulties using bush medicine. An extremely important part of this sub-section is the focus on shame. The third sub-section (Section 6: Making Health Access Easier) focuses on four topics that have directly, or indirectly, an impact on access to health care facilities. These include a discussion on whether receptionists should suggest friends or family members also attend a medical appointment, whether health pamphlets and posters should be designed with an Aboriginal flavour, an idea for slightly redesigning Medicare cards, and a discussion about what the effect would be if Aboriginal medical centres were closed.

4. Medical Practices and Staff

This sub-section addresses five health access topics (personal feelings about being in a medical practice, personal experiences with receptionists, personal experiences with doctors, personal feelings about seeing a doctor, kind of doctor Aboriginal people prefer to see). An important part of this sub-section is the focus on receptionists due to a previous study by this author. This sub-section concludes with an examination of age and gender differences. This final topic (age and gender differences) also serves as a summary of Section 4.

4.1 Personal feelings about being in a medical practice

Maher (1999) notes that there are many things in traditional Aboriginal society which differ philosophically from Western society and these have an impact on the delivery of Western healthcare to Aboriginal people. For instance, bush medicine, traditional healers, and gender divisions in Aboriginal society are just a few examples that differ from Western society and have implications with regard to the Western medical system. Similarly, Maher notes that the traditional Aboriginal model of illness causation emphasises social and spiritual dysfunction as a cause of illness. Traditional Aboriginal society sees the main cause of serious illness as tied up with supernatural intervention. Thus Maher (1999, p. 229) notes how:

What Aboriginal people think about their access to health care.
“Western health professionals often experience difficulties in service delivery to Aboriginal people because of the disparity between Aboriginal and Western health belief systems.”

Such differences in the ways of viewing health, have implications on Aboriginal people accessing western health services. Radford et al. (1999, p. 77) notes the reluctance on the part of Aboriginal people “to access health services, especially in times of crisis, relates in part to perceptions of care services.” Thus an examination of the participants’ personal feelings about being in medical practices was conducted. Such an examination is doubly important because Tharawal Aboriginal Corporation have received complaints from Aboriginal people about doctors practicing in the area. They have also been told that some medical practices are boycotted.

Forty-six individuals provided meaningful answers to the question: “How do you feel when you are waiting in the medical centre?” The most common response (32.6%) was one of wanting to get it over and done with27. This impatient nature was articulated extremely clearly:

“When they take their time I get really frustrated. I just want to get up and walk out. And they take so long, just like the hospital actually.”
(Aboriginal Woman, Senior Adult: 46+ years)

“If I'm really, really sick, then I get really, really angry, because I'm waiting too long.”
(Aboriginal Woman, Young Adult: 16-25 years)

“If I have to wait a long time, then I make another appointment and leave. I find it stressful to have to wait around. Thus I leave and come back another day.”
(Aboriginal Woman, Young Adult: 16-25 years)

A large number of individuals (21.7%) stated that they felt good while waiting in the medical centre:

“I don't mind it, because it's time out for me and I can just sit there and think about things, or I might go with a friend.”
(Aboriginal Woman, Adult: 26-45 years)

A: “Comfortable, relaxed.”
I: You don’t feel nervous at all?
A: “No.”
(Aboriginal Man, Adult: 26-45 years)

“Don't feel nervous or anything.”
(Aboriginal Man, Young Adult: 16-25 years)

27 Such views are not confined to Aboriginal people. Many authors have noted how their patients are increasingly dissatisfied with waiting times (Dansky & Miles, 1997; Roper & Manela, 2000).
However, virtually an equally large number of individuals (19.6%) stated that they felt stressed, nervous, or uncomfortable while waiting in the medical centre:

“Bored.”
Do you feel embarrassed?
“Yes, sometimes embarrassed.”
Why do you feel embarrassed?
“Different people around me. Don't know them, have a met them.”
(Aboriginal Man, Young Adult: 16-25 years)

“Frustrated, intimidated, I suppose because it's full and language is a problem.”
(Aboriginal Woman, Senior Adult: 46+ years)

“A bit apprehensive.”
(Aboriginal Woman, Senior Adult: 46+ years)

Four (8.7%) individuals mentioned reading books, magazines, pamphlets and watching television:

“At ease. I like reading magazines, watch television.”
(Aboriginal Man, Adult: 26-45 years)

“Well normally I just, the same as I walked in there – crook as a dog. Or I just sit and read the books, magazines, what they got available, or pamphlets if they got them on the coffee table.”
(Aboriginal Man, Adult: 26-45 years)

The remaining individuals mentioned: nothing unusual (4.3%), good except when there is a lot of people there (4.3%), really annoyed (4.3%), language is a problem (2.2%), and that how they feel depends on what is wrong with the individual at the time.

To understand the degree of comfort that participants felt in the waiting room, individuals' answers (n=28) were probed further by asking them: “How comfortable do you feel when you are waiting to see the doctor in a medical centre's waiting area?” This produced relatively the same result as with the previous line of questioning. Twelve (42.9%) individuals said they felt comfortable:

“Love it, love it. In most medical centres you'll find people more personal, compared with the impersonal way people feel in a hospital. A hospital seems to me, is business, you’re a number, you’re a piece of meat. Um, and I have been treated really, really good by some lovely nurses, but they are not the initial receptionists there, who turns around and asks in a nice, clear, loud voice, ‘What's wrong with you?’, or ‘What do you think is wrong with you?’, or ‘Why do you want to see the doctor?’.”
(Aboriginal Man, Senior Adult: 46+ years)
“Very comfortable, because they have got big spacey chairs in there.”  
(Aboriginal Man, Adult: 26-45 years)

A: “Good.”  
I: You don’t feel nervous?  
A: “No I don’t. No I don’t. It’s the people that work in the medical centre, um, especially the ones that I go to they’re all friendly. They all know me as one of the patients. I go there everyday, um, for my sugar count and blood pressure. They’re good. They’re nice people.”  
(Aboriginal Man, Senior Adult: 46+ years)

“I feel comfortable. I feel comfortable because I look around, I see them other people and I look at them as they’re just as sick as what I am, alright. That’s how I look at them, but I don’t know the way they look at me. You know, I don’t know if they look at me the way I look at them, as being sick themselves, or like me. I feel comfortable, because another part I feel comfortable about waiting, because I’ve got to wait for my turn, because I might be the second to last one in the queue to see the doctor, if there’s one doctor on.”  
(Aboriginal Man, Adult: 26-45 years)

A further seven (25%) individuals said they felt slightly uncomfortable:

“Oh, a little bit uncomfortable, but not much though.”  
(Aboriginal Woman, Senior Adult: 46+ years)

A: “Not too comfortable.”  
I: Why do you reckon that is?  
A: “Because I’m not patient or anything.”  
(Aboriginal Man, Young Adult: 16-25 years)

A: “Not too comfortable. Like sometimes I’ll sit there for a little while and then I’ll go outside and have a smoke, or stand outside for a little while, and I’ll walk back in and sit down and that.”  
I: Why do you do that?  
A: “I don’t know. With dentists and doctors I get nervous. I get sweaty in the hands and that.”  
(Aboriginal Man, Adult: 26-45 years)

Six (21.4%) individuals said they felt uncomfortable:

“Not very comfortable because I think a hospital doctor can give more information than a GP.”  
(Aboriginal Man, Young Adult: 16-25 years)

“Not that good. Too many people around.”  
(Aboriginal Man, Young Adult: 16-25 years)
“I feel stressed when there is a lot of people there.”
(Aboriginal Woman, Young Adult: 16-25 years)

Two individuals mentioned that they felt comfortable in general practitioner waiting rooms, but not in hospital waiting rooms and one individual said his level of comfort depended upon the number of people in the waiting room.

Thirty-seven individuals were asked: “Do you feel intimidated in the medical surgery?” The over-whelming majority (75.7%) did not feel intimidated:

A: “Oh no, no.”
I: Why not?
A: “Well if I did, I would say something. I would say something. So you know, it doesn't, um, I don't feel that at all.”
(Aboriginal Woman, Senior Adult: 46+ years)

“No, not the one I go to. No because I walk in there and they… know my name this one I normally go to and they just put it up on the computer and they just ask me ‘would you like to see a certain doctor, or would you like to, you know, see the next available doctor?’. And I just said the next available one.”
(Aboriginal Man, Adult: 26-45 years)

A: “No, not really. No.”
I: Nothing fazes you much?
A: “No. Cool as a cucumber.”
(Aboriginal Man, Young Adult: 16-25 years)

One further individual noted that they use to feel intimidated, but not any longer. Four individuals (10.8%) said they did feel intimidated in medical centres:

“People steering. Are they undressing you, or are they being rude? I feel very intimidated, thus I go in all guns firing.”
(Aboriginal Woman, Senior Adult: 46+ years)

Two of the individuals who said that they were not intimidated in the medical centre, did note that they were intimidated by the doctor either as an adult, or in the past as a child:

A: “No. Probably by the doctor, because like, he knows what he’s doing and like I'm just too ignorant to listen.”
I: I’m meaning more before you’ve actually seen the doctor. Your sitting down and just waiting to see the doctor. Do you feel intimidated then - with people around you and that?
A: “No, it’s just people just getting on with their lives.”
(Aboriginal Man, Young Adult: 16-25 years)
“As a young bloke I suppose so, because when I was growing up it was sort of the GP was one of these 'God-like people'. Um, as I've got older, no. I reckon a GP now is just another person who has a skill that I don't have, that can possibly make me better.”

(Aboriginal Man, Senior Adult: 46+ years)

Another two individuals said that they were not intimidated at Tharawal Medical Centre, but they were at other medical centres:

“At some of them, but not at Tharawal. They look at you and are even rude, especially if an Aboriginal person comes in with a couple of kids.”

(Aboriginal Woman, Adult: 26-45 years)

A: “No, no. Not so much, not at Tharawal, no. I could say that I have been going [so much] over the last six years that I'm part of the furniture. But if I go to a different GP, I feel a little bit intimidated.”

I: Explain to me a little bit why?

A: “Um, I think it is on both sides, attitude on both sides. I mean, I'd go in, explain what my problems is, they ask you if you are Aboriginal and if you answer yes, then their tone of voice changes down an octave, gestures, facial expressions, change. When I walk into a different GP, they are all smiles. As soon as they ask you that question about Aboriginals the smiles just wipe off their face to a surly look, to a surly look. I can't so semi-surly, because what is semi-surly. It's just a sort of surly look, sort of what are you doing here?”

(Aboriginal Man, Senior Adult: 46+ years)

Similar results were obtained when 42 individuals were asked: “Do you feel out of place in a medical surgery because you might be the only Aboriginal person there?”

More people felt out of place compared with intimidated. Nevertheless, slightly more than half of the individuals (52.4%) did not feel out of place. A further three individuals stated that they did not feel out of place now, but in the past they had. Nine (21.4%) individuals stated they felt out of place, six felt out of place some of the time, and two individuals felt out of place most of the time, except in Aboriginal medical centres.

Without prompting, a number of individuals mentioned racism occurring while waiting in medical centres:

I: Do you feel out of place in a medical surgery because you might be the only Aboriginal person there?

A: “I don't. I used to when I was younger. I terribly did. I felt that and rightly so too, that me being an Aboriginal person with a dark skinned, was looked upon, was surveyed, was cut up into little pieces, was categorised, put in little shelves on different shelves on different jars, or whatever, I was whatever that the beholder saw me as and in their eyes I felt this. And I felt a physical feeling of it. You know it used to embarrass me so much, because my mum would never hear of me swearing, or staring at people, or snarling at people. I had to have, well it goes back to mum’s early days, um, she was brought up in a strict sense to that she had to have manners. So she just passed that on to us.”

(Aboriginal Man, Senior Adult: 46+ years)
A: “Only when the person behind the counter starts shuffling papers under your face and goes ‘fill this out and bring it back.’ Um, but only looking over their nose and you know, through their glasses of theirs, that’s it.”
I: Explain that to me?
A: “Well, it just seems to me, like, oh you know, here’s another one, you know, I'll give him the piece of paper and he’ll be out of my face. You know, for a while, and I know that he is going to come back, and they still have that same look on their face. It's not a smile. It's not, you know, an angry look. It's just blank look, and like, um, you can sense it, you know, with the feeling of, um, I wish this person, you know, wasn't in my face.”
(Aboriginal Man, Adult: 26-45 years)

“Axxxxx It all depends on how the reception is, you know. ...Just the sort of look they give you, or, um, the way they talk, you know. You know you're just standing behind someone, and they're talking real nice, and then when you come up behind them their voice sort of changes.”
(Aboriginal Man, Adult: 26-45 years)

Many of the participants mentioned being stared at:

“Yes, because they stare.”
(Aboriginal Woman, Young Adult: 16-25 years)

“I have experienced it. You're sitting there and everyone just looks at you. Eyes on you.”
(Aboriginal Man, Young Adult: 16-25 years)

While one individual did not receive such treatment:

“No, because I don't look Aboriginal. They won't know that I am Aboriginal.”
(Aboriginal Woman, Young Adult: 16-25 years)

Thus, it is not surprising that many individuals once again mentioned feeling more comfortable in Aboriginal medical centres than in western medical centres:

A: “No. But I mean, if it's in an Aboriginal medical centre, never, never do, because I, you know, I sort of feel a bit more comfortable in an Aboriginal one. But like a normal down town one, there’s just a little bit of a nervousness, well not nervousness, what did you say?”
I: Out of place.
A: “Yeah, out of place, yeah. A bit intimidated, because they don't really know me, or know what I'm like, or anything.”
(Aboriginal Man, Young Adult: 16-25 years)

A: “Well, when you go to the reception they ask you what nationality you are and in some surgeries they look upon you as, ‘oh you can go over there and wait’ and they treat you as if you are a second class citizen. And as I said is not in all surgeries, but it's in some.”
I: What are they like in Tharawal with regards to that?
A: “They’re excellent. It's just like going home. It's like being at home. You know, it's friendly and you can talk about anything and be in a relaxed atmosphere.”
(Aboriginal Woman, Senior Adult: 46+ years)
It was considered possible that traditional Aboriginal ways of communicating and respect for elders might affect some of the participants access to healthcare services. Thus, individuals were asked: “Are you affected by traditions of who you sit beside and face in the medical practice?” The following two people were not affected by such beliefs today. Nevertheless, some ways in which such beliefs might affect Aboriginal people are indicated in their answers:

I: Are you affected by traditions of who you sit beside and face in the medical practice?
A: “What do you mean by that?”
I: I’m told there’s [Aboriginal] traditions as to, um, who you can speak to in terms of age differences, how you can face them [interrupted by interviewee]?
A: “Yeah, with the elders, the younger ones are not allowed to look them in the eye. That’s why a lot of white Australians say that Aboriginal kids are very ignorant, but they don’t understand that the young kids are not allowed to look the older people in the eyes. When they are spoken to, they’ve got to hold their head down. And that’s why a lot of the kids, um, get accused of being ignorant and rude. But that’s the culture.”

I: Now, apart from their eyes looking down, is there anything else they are meant to do?
A: “I don’t know really about that. But most of the kids, you know, look down.”

(Aboutinian Woman, Senior Adult: 46+ years)

I: Does it [traditional Aboriginal traditions] affect you here in Sydney?
A: “When I was a little boy I wasn’t allowed to look at elders in the face. Not until they asked me to look at them. And like that still stands today. And, um, for people my own age, well I don’t care who I am sitting next to, but if they don’t want me sitting next to them, then I won’t sit next to them.”

(Aboutinian Man, Adult: 26-45 years)

Virtually all (91.7%) individuals asked (n=36) said they were not affected by traditional Aboriginal beliefs of who they could sit beside and face. A typical comment follows:

I: Are you affected by traditions of who you sit beside and face in the medical practice?
A: “No I don’t really care who I sit beside, or who I am facing.”

(Aboutinian Man, Adult: 26-45 years)

Not surprisingly, such beliefs did not affect these individuals when they attended medical centres:

I: Are you affected by traditions of who you sit beside and face in the medical practice?
A: “No, not really. If there is a seat over there I'll just sit there, you know. I'm not worried where I'm sitting as long as I can get in to see the doc.”

(Aboutinian Man, Adult: 26-45 years)
The same type of answers were obtained when individuals (n=25) were asked if they were affected by traditional Aboriginal beliefs with regard to who they could talk to; 96% of individuals asked felt that they were not affected.

Two individuals said that they were affected by such traditions. However, they said that such beliefs were not shared by urban Aboriginal people in the area this study was conducted:

I: Are you affected by traditions of who you sit beside and face in the medical practice?
A: “I am, but I've had to sort of the adjust, because, um, I sort of have a bit more knowledge and that than a lot of people down here in New South Wales. Out at the community, you know who to sit against, who you sit opposite, who you talk to, who you don't, what you say, what you do. Um, and I am not used to young people, younger people here questioning things that I say and do. Um, which in the north would be frowned upon by a lot of the elders.”
(Aboriginal Man, Adult: 26-45 years)

I: Are you affected by traditional Aboriginal beliefs of who you can talk to? Do these beliefs affect you when you are waiting to see a doctor in a medical practice?
A: “Depends on what situation you are in. When with the elders, yes. But when brought up in white society, it doesn't affect you.”
(Aboriginal Woman, Senior Adult: 46+ years)

Thus, if such beliefs had any impact on these individuals, it was totally situation-specific. In urban contexts such beliefs had no impact, but participants felt that “up north” such beliefs still played a role in Aboriginal culture. A good example is seen below of how a senior Aboriginal man, although he believes in such beliefs, has learnt to allow the western system to dominate his health treatment:

“I believe, in like, customs and traditional Aboriginal roles and the Aboriginal culture. Yeah, I believe totally in it, but I'm not talking, you know, in health and that. I'm not really talking about traditional roles, I'm talking about people's well-being. You know, so there is a certain amount of, um, as me saying as a senior Aboriginal person, I've got to take a step back for my own well-being when working with a doctor on my health, you know - take that side of it.”
(Aboriginal Man, Senior Adult: 46+ years)

Individuals were asked: “Is there anything that could be done to make you feel more comfortable in medical centre's waiting areas?” A large number of individuals did not feel that there was any thing else that could be done to make them feel more comfortable. However, approximately the same number of individuals felt that there were things that could be done. These suggestions can be seen in Appendix 6. The suggestions are discussed further in the last results sub-section (Section 6.5: Participants suggestions to make access better).
4.2 Personal experiences with receptionists

This sub-section of the results is very important for a number of reasons. Examining the experiences any patient, be they Aboriginal or non-Aboriginal, have with receptionists is important because, as Froelich and Welch (1996) highlighted in a study of walk-in patients to a medical clinic, satisfaction with care is associated with communication and emotional support more so than with the technical aspects of care. As they are the first contact most patients seeking medical treatment encounter, receptionists are an “integral part of the primary care service” (Carnegie et al., 1996, p. 504) as they are expected to provide these two services. Another reason why this sub-section is important is due to the findings of a previous study by this author (McInman, 2000). He found that the majority of receptionists professed to treat Aboriginal patients in exactly the same way as non-Aboriginal patients. Although some receptionists noted that in fact they treated patients differently and that this might extend to Aboriginal patients, there were very little indications of direct discrimination. Nevertheless, examples of self-reported negative and positive service to Aboriginal patients, while on the telephone and at the medical practices were noted. When questioned about this further, many receptionists realised that in order to treat individuals the same, they were actually treating some individuals in a negative manner as special groups have special needs. Thus, a substantial number of receptionists were found to be acting in an indirect discriminatorily manner, or what Blakemore and Boneham (1994) term institutional racism and as a consequence were unintentionally disadvantaging Aboriginal patients. Thus, McInman (2000, p. 4) concluded by suggesting that “future research should include, amongst other things, “interviewing Aboriginal individuals in the community to determine why they do, or do not, access medical services and to learn what problems they have in accessing medical services.”

Thirty-eight individuals provided meaningful answers to the question: “What are the medical receptionists like?” The responses were relatively evenly distributed from very good to poor (see Table 31). Four individuals (10.5%) suggested that receptionists were very good. These individuals noted how receptionists were welcoming and comforting:

A: “Very good.”
I: Why is that?
A: “Pleasant. Always serve you with a smile.”
I: Anything else?
A: “No. Oh, they make you feel comfortable. They offer you coffee, tea, water.”
(Aboriginal Woman, Senior Adult: 46+ years)

“Some are real welcoming. And some if they are real busy, they will tell you to just sit down and wait. They get use to you. Some are wonderful such as the receptionists in the rehabilitation ward at Liverpool hospital.”
(Aboriginal Woman, Senior Adult: 46+ years)
Table 31: Overall perceptions concerning medical receptionists, separated by gender and age category (n=38)

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<thead>
<tr>
<th>Age categories</th>
<th>What are the medical receptionists like?</th>
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<tbody>
<tr>
<td></td>
<td>Very good</td>
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<tr>
<td>Young adults (16-25)</td>
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<tr>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
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<tr>
<td>Adults (26-45)</td>
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The largest group of individuals (36.8%) could be categorised as believing the receptionists were good. These individuals noted how above everything else receptionists were helpful:

A: “Yeah they been good. They should make you feel welcome.”
I: Do they make you feel welcome?
A: “Yeah. I think it’s both ways. How you respond to them too.”
(Aboriginal Woman, Adult: 26-45 years)

“Good, talk to you, help with baby.”
(Aboriginal Woman, Young Adult: 16-25 years)

“The only ones I have had any thing to do with I find that they have had a, some of them, let's say like older nursing-staff that are not working as a nurse any more, and they're sort of, just too, um, they're working as a part-time, or they happen to be the doctor's wife, or whatever, and they're working as a receptionist. So I have no problem with them, you know. They seem quite, um, um, what do you say open and, um, willing to help you.”
(Aboriginal Man, Senior Adult: 46+ years)

Eight individuals (21%) suggested that receptionists were pretty good. These individuals noted how receptionists were relatively friendly, but more than anything, these individuals stressed how receptionists were proficient:

“Well most of them that I have seen have been pretty good. You know they’re good, they’re helpful. At the moment I can't think of anyone, you know, that's been rude to me.”
(Aboriginal Man, Senior Adult: 46+ years)

“They’re pretty good. They’re pretty professional at the medical centre which I normally go to.”
(Aboriginal Man, Adult: 26–45 years)
Four individuals (10.5%) felt that receptionists were poor. However, none of these individuals felt that they received such poor service because they were Aboriginal. Instead, they mentioned the receptionists not being friendly and needing to pay more attention to the customers:

A: “Some are snobby. Like, you go there and sort of, you are standing there, and they know you are standing there, but they just sort of don't answer you, or like they will say to you ‘are you alright?’. But, no I just and go xxxxx and play the game with them.”
I: And what's the game?
A: “Like, um, sit there and let them bore the shit out of themselves, I'll just stand there and I just look them dead in the eye and just wait for them to look at me. But I don't show anger and that... It doesn't faze me. When I went down to get my x-ray, actually with my tooth, it had to get x-rayed. I went up and I gave them me slip, or something, what I'm here for and all of that. I have sort of put on a coat and I am there and they started waving it in me face. Like breathing the cool air on me - just to be a smart arse. And I just, alright, oh sorry, um, I just gave it to them and stomped out. That is the only drastic thing I have come in with the reception.”
I: Why do you think they treated you like that?
A: “I suppose, she was probably busy, or something. Talking and yacking and that. Talking and that... They [receptionists at the x-rayed place] did the same with this other woman. She was a bit older than me. She's come in there and she is like ‘Excuse me!’ [tone was stressed]. Okay, like you can see me standing here, you know, take this. This old woman was real jumpy on her. Excuse me. I was sitting down there going, yeah give it to the woman.”

(Aboriginal Man, Young Adult: 16-25 years)

A: “Um, sometimes they’re slow. I’ve gone to the xxxxx and stood there for a couple of minutes before they've actually realised that I was there. Um, and there have been a couple of times that I've been there before a couple of other people and they’ve actually seen them first.”
I: Why is that?
A: “Mainly because I am one of those people who don't like to make waves.”
I: Why do you think that they did that though?
A: “Because most likely they didn't see me.”
I: Are you sure?
A: “Yes.”
I: You’re sure it's not because you are Aboriginal?
A: “No, no.”

(Aboriginal Woman, Adult: 26-45 years)

Eight individuals noted that receptionists varied considerably and thus the treatment they received was mixed:

A: “Some are good. Some are not. You know.”
I: So what are the good ones like?
A: “Well, they talk polite, you know. They make you feel, sort of comfortable, you know. Whereas some of them, ‘Yeah alright then, sit down here, you know. Talk real fast xxxx ‘sit over there and wait, you know, for the doctor’.”

(Aboriginal Man, Adult: 26-45 years)

“Some are bitches, but some are really nice. You’ll be standing at the counter and some will come up straight up to you, but others take forever.”

(Aboriginal Woman, Senior Adult: 46+ years)
A: “Some can be nice and some can be nasty.”
I: Tell me about the ones that are nice. What are they like?
A: “The ones that are nice, you know, they talked you with respect, um, they sort of like to gossip, when you, like your private life, and stuff like that.”
I: And the ones that are nasty?
A: “The ones that are nasty, well they don't want to talk to you. They'll just take your card and tell you to take a seat and they'll call you up next and if they don't want to know you, they don't.”
I: When you say they are nasty, why are they nasty?
A: “Why, maybe because they are in a bad mood, or, um, I don't know, something's wrong with them.”
I: Has it got anything to do with you?
A: “No, no.”
I: So it’s got nothing to do with you being an Aboriginal person?
A: “Could have, could have. Then again, it couldn't, you know what I mean? Like, it's hard to say with these ones. You know.”
(Aboriginal Man, Adult: 26-45 years)

Overall, most participants indicated that they were relatively happy with the service they received from receptionists. Participants were next asked: “In what ways do you think receptionists make you feel welcome when you arrive at a medical centre?” Most participants mentioned that they were greeted and the receptionist gave them a smile. Less common things mentioned were the tone and way of being spoken to, the receptionist being friendly and pleasant, the receptionist participating in ‘small talk’, speaking on the same level, offering assistance, providing comfort and saying goodbye.

The importance of the smile alluded to above was unmistakably articulated by an Aboriginal man:

“That smile kills me each time. Doesn't have to be any words just that look. The sparkle in their eye makes the smile, and you know that the smile is genuine when there’s that sparkle in the eye. Anyone can smile, but people who genuinely smile at a person shows it in their smile. It’s the smile that you see in the lower vision of your eyes… you see that sparkle, you see that twinkle, you see their wrinkles around the eyes, then you notice the corners of their mouth, and you know no matter whether the corners are down, or up, or cross, or whatever, that that is a genuine smile. And it can be just a fraction of a second. It doesn't have to be a big smile, but it can be just that recognition of here comes a fellow human being. That's all, that's all, we as clients, want is that recognition, when you first walk in, because we are coming there 10 out of 10, if you are not a hypochondriac, with a genuine concern, because otherwise they wouldn't waste their time being there. You know, so they are ill in a sense that they are worried. And they need all the support they can. If they know that they have got a good secretary there who gives them a smile, they can say, ‘Wow, I can talk about anything now, because I have got a back stop in this place.’ No matter what the doctor says, that receptionist is going to understand, because she's your friend, or he’s our friend.”
(Aboriginal Man, Senior Adult: 46+ years)

The tone of the responses were very positive, as the following two excerpts portray:
“Well most of them are, are quite friendly. It's very rare that you find the old snappy, snarling, you know, person. I've only ever seen one male receptionist.”

(Aboriginal Man, Senior Adult: 46+ years)

They are better than the doctor, because he sees you and he might saw there is nothing wrong with you, but the receptionists more comforting.

(Aboriginal Man, Young Adult: 16-25 years)

Participants were then asked three procedural questions to note whether they were treated negatively. If they did note being treated negatively, then the intention was to probe further to ascertain whether they were treated differently from non-Aboriginal people in such circumstances. The first of the three questions was: “To what extent are you kept informed if the doctor is running late?” The majority (63.6%) said they were informed. A further 9.1% were partly informed, 4.5% were not informed but did not see this as a problem, and one individual (4.5%) would simply ask if the doctor was running late. Thus, only four individuals (18.2%) might have a problem in that they were not informed. However, the responses indicated that, on the whole, participants accepted the fact that doctors could not always be punctual due to unforeseen circumstances. Such a belief is depicted clearly by an Aboriginal man:

“Um, I wouldn't really expect, I mean, if the doctor is running late, then like that’s, that’s the doctor. I mean, it’s got nothing to do with the receptionist, or the workers, or anything. I mean, the doctor knows when he’s got to go and when he’s got to come back. And um, same is, if like, if you have got trouble speaking English, I mean, it's not a workers’ thing, it’s a doctors’ thing. You just have to get on with it. Get over it, because there is nothing that you can do.”

(Aboriginal Man, Young Adult: 16-25 years)

The second procedural question was: “How are you treated if you arrive late for an appointment?” Largely this situation was not seen to be a problem either. Six (28.6%) individuals indicated that they were never late, while five (23.8%) individuals said that if they were running late, they would always ring and say that they would be late. Of those who did actually turn up to the medical centre late and who did not ring to say that they would be late, the majority (28.6%) stated that they were not treated differently than if they had turned up on time. Two (9.5%) individuals said that their card would be shuffled to the bottom of the queue. Another two (9.5%) individuals indicated that the first time they turned up late the receptionists would be pleasant. However, they mentioned that if they turned up a second time late, then the receptionist would get angry.

The participants who did not ring to say they were going to be late mentioned that the receptionists were not altogether happy with this:
A: “Oh, they give you a dirty look and you explain to them why you are late and you just say ‘can I reschedule and make another appointment?’ And they, sure enough, they’ll do it for you, or you know, they could treat you like an idiot and say ‘no sorry you have missed your appointment, you can't do it no more’.”

I: Do you think they treat you more like an idiot because you are Aboriginal that Aboriginal?
A: “No they have been treating me the same as practically everyone else while I have been there.”

(Aboriginal Man, Adult: 26-45 years)

I: Have you ever been late for an appointment?
A: “Oh, yeah. Heaps of times.”
I: And how do they treat you when you turn up late?
A: “You know they're not impressed, but underneath their breathe you know they want to curse you and that, but, you know.”
I: But you’ve never been treated badly because you have turned up late?
A: “No.”

(Aboriginal Man, Adult: 26-45 years)

Nevertheless, the participants accepted that if they turned up late, then they could not expect to be able to see the doctor immediately, even if they really would like to:

A: “Um, well there is nobody else to blame but myself isn't it as I'm the one who is running late. Not the doctors, not the receptionists.”
I: Do they treat you well when you arrive late?
A: “Yeah, yeah. I just say sorry I am late because I had something else to do before this appointment.”

(Aboriginal Woman, Senior Adult: 46+ years)

“Um, sometimes I feel a little bit put out when they say, um, right well, um, shuffle to the bottom of the queue. But, I'm, you know, I can understand that the doctor has only got a certain amount of time to see whatever patients and if I don't arrive on exactly that time, well I'm putting everyone else out, so I've got to wear it, and you know I'm not always happy about it, but that's my problem, I've got to get there on time.”

(Aboriginal Man, Senior Adult: 46+ years)

The third procedural question was: “Do you ask the receptionist any questions, or need any further assistance, after you have seen the doctor?” The majority of the (77.3%) individuals who answered this question (n=22) indicated that they did not ask receptionists any questions after seeing a doctor. The typical response to this question was:

“No, sign the paper, or get it over and done with and get out.”

(Aboriginal Man, Young Adult: 16-25 years)

Two (9.1%) individuals indicated that they asked the receptionists questions and a further three individuals (13.6%) said that they sometimes asked questions. Such questions were largely about signing Medicare forms or making another appointment.
Having asked the participants a series of questions that indirectly assessed whether receptionists working for general practitioners serviced Aboriginal people in a less than desirable manner, the participants were then asked directly: “Do you feel medical receptionists treat you the same way as a non-Aboriginal person, or do they treat you differently?” The majority (65.8%) felt that they were treated in the same manner:

“Personally I have never had any problems, you know, as in being treated differently than anyone else’.
(Aboriginal Man, Senior Adult: 46+ years)

I: When you go to other medical centres, apart from Tharawal, do you think the receptionist treat you the same way as they treat non-Aboriginal patients?
A: “Well the one in Campbelltown, she was pretty nice to everyone.”
I: Did she smile at you?
A: “Yeah.”
I: And did she talk to you?
A: “Yeah.”
(Aboriginal Woman, Young Adult: 16-25 years)

I: Do you feel the receptionists treat you the same way as a non-Aboriginal person, or do they treat you differently?
A: “Everybody is the same aren't they.”
I: Yeah, but do they treat you the same?
A: “Yep.”
I: Have you ever been to a medical practice where the receptionist has not treated you the same?
A: “No.”
(Aboriginal Woman, Senior Adult: 46+ years)

“Yeah. I reckon it's all the same. Depends how you look. If you are well presented, like not dirty, and that, and walking in with, um, you know, real woolly looking, you know. Like you haven't had a shower in a month, or something, I suppose they would say something about it, you know. Being unclean and that. But if you go in there looking well respected and that. You know, look after yourself, you go in there and they think, ‘Look at this fella. He seems alright’... If you go in there with grog on your breath and say ‘I want to see the doctor’ [tone used was harsh and slurred as if drunk], surely they are going to say something about you, you know.”
(Aboriginal Man, Young Adult: 16-25 years)

Three individuals (7.9%) felt that they were treated differently and a further 10 (26.3%) individuals felt that some times they were treated differently:

“Definitely. Can see the prejudice. Leave the black fella to last.”
(Aboriginal Woman, Adult: 26-45 years)

“Um, in some cases, you know like, some of them talk to non-Aboriginals real cordially and you’re standing behind them are they don't speak to Aboriginals in the same time of voice.”
(Aboriginal Man, Adult: 26-45 years)
I: Do the receptionist treat you the same way as a non-Aboriginal?
A: “Yeah, some do and some don’t.”
I: And the one’s that don’t, how do they treat you differently?
A: “Like, their noses up in the air. Like they don't want to really speak to you and
say hello to you. ‘How are you going?’, or anything. They'll just take your
name, sign this and that's it, take a seat.”
I: But they will treat non-Aboriginals, they’ll do different things, will they?
A: “Yeah, yeah.”

(Aboriginal Man, Adult: 26–45 years)

I: I would say definitely sometimes.”
I: Tell me a little bit about that?
A: “Why they just, there’s no chit-chat. It’s just straight out office work and
information onto those cards, or medical cards, then it's just waiting time.
Whereas, you see the other people come in and they have got a bit more time for
them, ‘How’s Joe and all that?’ They just seem to be sticking to the past.”
I: Why do you think they do that?
A: “I don't know really, because I think they think that they’re their doctor is their
father or their mother and that you’re coming there to use him for the least
amount of cash you can to get medical treatment. Whereas they see other people
and they think, ‘all there’s money, money, money.’ Nine out of 10 Aborigines
do not have money.”

(Aboriginal Man, Adult: 26–45 years)

I: In a nutshell, how do [receptionists] they treat you differently?
A: “Um, sort of, sort of, sort of inferior, you know. I grew up with that, I grew up
all my life, you know, like being Aboriginal, seeing all the racism, the shit that
goes on, you know. I mean, why should they carry on, they weren't even born
when I was going through the situation, you know. And maybe it's ignorance on
their behalf, or what they have been taught through the schools, I, I don't know.”

(Aboriginal Man, Senior Adult: 46+ years)

One reason Aboriginal individuals may be treated differently is that many turn up to
medical centres without a Medicare card. The service they receive may be perceived
by some Aboriginal individuals as racist. However, anyone attending some medical
centres without a Medicare card might also receive such treatment:

I: Do you feel the receptionists treat you the same way as a non-Aboriginal person,
or do they treat you differently?
A: “Not all the time, no. Some of them, xxxxx they will give a Koori a form, piece
of paper, a form, and just write down a name and that, so they waive it to us.
We've got to have a form. A piece of paper sort of thing. Some of them do,
yeah.”
I: And why would they give you that form?
A: “Because you haven’t got a Medicare card.”
I: If you had a Medicare card, would you have to fill out that form?
A: “No.”
I: Do you have your Medicare card on you?
A: “No.”
I: Why not?
A: “I don't know. Because I'm too fit.”

(Aboriginal Man, Adult: 26–45 years)
An individual who indicated that he did not feel he was treated differently from non-Aboriginal people, felt that receptionists were only a mirror of society at large:

“The problem that I see in everyday things, be it in clubs, hospitals, or whatever, the Aboriginal kids running wild in a hospital a more apt to attract the security’s eye, or the nurse’s eye, than other children doing exactly the same thing; being kids for Christ sake and you know making just as much noise.”
(Aboriginal Man, Senior Adult: 46+ years)

Thus it is not surprisingly that some individuals felt that they were more comfortable in Aboriginal medical centres:

“Feel welcome at Tharawal, but as I don’t know anyone at the other medical centres, I don’t feel welcome.”
(Aboriginal Woman, Young Adult: 16-25 years)

Another individual suggested that societal stereotypical viewpoints were such that she would not be affected because she did not look like a ‘typical’ Aboriginal person:

“I don’t think they think I’m Aboriginal until I fill out the form. Then I get, ‘Are you really Aboriginal?’.”
(Aboriginal Woman, Senior Adult: 46+ years)

During the course of the initial interviews, one participant explained how he found it difficult being served by a female due to his traditional Aboriginal beliefs:

“… using the traditional lifestyle approach, you wouldn't want to walk beside the doctor, go up to the receptionist, and the doctor say ‘oh look can you make an appointment for so and so.’ You wouldn't do that. You see it's sort of like, um, and this is something where Europeans, some of the blokes I have told think it is a great idea. But, um, Aboriginal men do not acknowledge their mother-in-law. So even if my mother-in-law was to come in here and she wanted me to give her a lift up to the shop, she would actually ask you [the interviewer], if you could ask me [the interviewee], to give her a lift up the shop. But she cannot look me in the eye. … if you are an Aboriginal male, it doesn't matter who, or what, your mother-in-law is, she cannot acknowledge you, you cannot acknowledge her, and she cannot look you in the face. So some of the young girls that work here, can talk to me on a certain level, but they should never try to speak to me on an equal level, but it is acceptable here, but it wouldn't be up there [Northern Territory].”
(Aboriginal Man, Adult: 26-45 years)

Thus a number of other participants were asked if they had this problem. Only two (9.5%) indicated in this manner and their answers did not indicate that this was a serious access issue.
Due to discussions prior to this study commencing, the following question was asked: “Do you refuse to go to a medical practice because of the way a medical receptionist has treated you?” The answers to this question were a little surprising when compared with the answers to the previous questions. Of the 41 individuals who answered this question, 8 (19.5%) said that they did refuse to go to at least one medical centre due to the way a medical receptionist had treated them. This figure is alarmingly high; one-fifth of these individuals have placed a self-imposed access barrier on their health care due to something negative about a medical receptionist.

An examination of the reasons why the participants said they were boycotting the medical centres, however, suggests that it was not as a result of the receptionists’ mannerisms or behaviours. For instance, one receptionist would not use the services of a medical centre because the receptionist working on the day did not give the person preferential treatment:

“Well I took some x-rays to him in she wanted to charge me for it and I said no. I said I'm not going to give you my card, because I’m only dropping off my x-rays. He was my father’s doctor and apparently she didn't know that he was treating our family and that and, um, he always gave us leniency and that. So I don't use him any longer, instead I use any practitioner.”

(Aboriginal Man, Adult: 26-45 years)

A young Aboriginal man arrived at a medical centre without a booking and expected to see a doctor when the practice was booked-out. The receptionist enquired what the visit was for. As the patient was unwilling to discuss this with the receptionist, he was told that he would have to come back the following day to see the doctor. The participant thus chose not to visit that doctor's surgery ever again.

Two participants indicated how they turned up to medical centres without Medicare cards and were told that they needed to present them:

“Yes, xxxxx [name of surgery]. They make you wait too long. I didn’t have my Medicare card and she wanted me to walk home and get it.”

(Aboriginal Woman, Young Adult: 16-25 years)

A: “Yeah, she turned me back. I had my Medicare number, but not my card and this bitch turned me back at xxxxx and I just said, ‘xxxxx’, because I was there gasping for air. I couldn't breathe and I had a hard weekend and me asthma, got the better of me asthma. I think them preservatives in all that Bourbon I was drinking. And I was really sick. Like I was having an asthma attack. And she declined me, ‘the xxxxx’.”

I: Have you ever been back to that medical centre?
A: “No.”

(Aboriginal Woman, Young Adult: 16-25 years)
One Aboriginal man indicated how in the past he did not have the level of self-esteem he now possesses and thus:

“I have on occasions turned around and walked away, for the simple reason, I wasn't strong enough to question the attitudes of these people. It was inbred into me that you don't ask questions, you don't question peoples’ behaviour… When I was young I wouldn't go back to various services because I was too shy to go past the receptionist. Now days, like I say, I have gained that strength to insist, because I am looking at not me, but my grandkids. The trouble they will have from this same person if I don't do something.”

(Aboriginal Man, Senior Adult: 46+ years)

To complete this line of enquiry, participants were asked: “Is there any medical centre you will not go to?” The results of this question were very similar to the answers to the previous question. Six (15%) of the 40 individuals who answered this question said there was a medical centre that they would not go to. An example from such an individual follows:

I:  Is there any medical centre you will not go to?
A:  “No.
I:  So you'll go to any medical centre?
A:  “If I am really sick.”
I:  Even the one at xxxxx?
A:  “Not the one down there, but.”
I:  So is there any other one, like that one, that you will not go to?
A:  “I went downtown to Campbelltown two weeks ago. They are pretty good down there too.”
I:  Is there any down in Campbelltown that you will not go to?
A:  “I only know of one down there.”

(Aboriginal Woman, Young Adult: 16-25 years)

One Aboriginal woman said that she would only go to Aboriginal medical centres:

“I won’t go outside the Aboriginal medical centres. Why look for trouble when you don’t need it?”

(Aboriginal Woman, Adult: 26-45 years)

The remaining 82.5% of individuals said there was no medical centre that they would not go to. Examples of these individuals include:

I:  Is there any medical centre you will not go to?
A:  “No, I don't thing I've seen one that I wouldn't go to.”
I:  And there isn't any medical centre you wouldn't go to because of rumours around the grapevine?
A:  “No I don't worry about peoples rumours. I take everything on me own face value. They [doctors] may not have done exactly what I wanted, but they have given me a, the, well at the end of the day, it's always turned out to be the best care that I've had.”

(Aboriginal Man, Senior Adult: 46+ years)
A: “No… Most of the time I come here. But I go to other doctors. To another doctor’s surgery.”

I: And what are they like?
A: “He’s pretty good. Yep.”

I: Do you feel just as comfortable there, or do you feel not as comfortable?
A: “Um, bit comfortable, but not as comfortable as here [Tharawal].”

I: So what’s the difference?
A: “Um, I don't know. You can't explain it, but there is a big difference…They’re more relaxed here.”

(Aboriginal Woman, Adult: 26-45 years)

A: “No, not really.”

I: So there is nowhere you have had such a bad experience that you will not go to?
A: “Never thought about it much. I don't care if they are racist, or anything, they get a mouthful from me anyway.”

I: You don't care if they are racist?
A: “No.”

I: Why not?
A: “Just don't. Um, I figure they have to do their job.”

(Aboriginal Man, Adult: 26-45 years)
4.3.1 Personal experiences with doctors

Having analysed the participants’ experiences with receptionists, their experiences with doctors are now examined. Of the 31 participants who provided meaningful answers to the following question, “What has been your overall personal experience when seeing a doctor at medical centres?”, the majority have been pleased with the treatment that they have received. For instance, 25 (80.6%) of the individuals responded in a positive manner; somewhere between okay and really good:

A: “Really good. I come away satisfied perfectly, or I'll never go back to that doctor again. I'll form an opinion as to whether I can trust that doctor.”

I: When I asked you earlier on you said there’s no medical centre that you would never go to again. You make me wonder though, is there a doctor you will never go to again?

A: “When I was young there were medical centres, there were shops, they were hotels, there were lots of places that I wouldn't go to. And a lot of them was, some of them were hospitals, and different sections in hospitals that I wouldn't go to. That was because I felt fear. I felt embarrassment. I felt ridicule. I felt whatever the feelings that, that you get from another person when they make you feel that way, or from the surroundings. Now that I’ve experienced those things, you know, got strong enough to be able to combat them, I'd deliberately go back to those, to see if those things that frightened me are still in place and if they are I’ll endeavour up to a ministerial complaint to have those things changed and be it a black organisation, or be it a white organisation, I don't care, they should be people friendly.”

(Aboriginal Man, Senior Adult: 46+ years)

A: “Most of them have been pleasant and been pretty good. I've, I've never had any bad experience with a doctor... I mean if they said something I didn't like, I'd tell them. But, I wouldn't swear. I'd go about it, dignified way.”

I: Would you tell me if you've had problems with doctors?

A: “Yeah honest, I have not had any bad experience with any doctors. And I've been to a lot of different doctors. I mean different nationalities.”

(Aboriginal Woman, Senior Adult: 46+ years)

A few individuals had mixed experiences:

A: “I found them all right. I've had no problems with the doctors. Not, not that I come across if anyone, any of the doctors have been, um, nasty, or, or, anything else like that.”

I: You haven't found doctors to be racist at all?

A: “Yes I did, sort of, come across, on some of the doctors, because, um, I can sort of pick that scent up. And once I know, once I know that, um, that not just doctors, but anyone, if a person is talking to me, um, or if I'm working for someone and I, I can sense that they're prejudiced. When I first, um, seen a doctor, I sort of, he sort of spoke nice ways, but it's just the way he said things and it's like a hint, like, you know, we don't really want you there, sort of thing.”

I: And you thought he was saying that because you're Aboriginal?

A: “Yeah, I thought, 'there must be something wrong with him, or he has had an argument with his Mrs or something, or I sort of trying to not bring prejudice in, if I can help it, but, um, xxxx. It all brings it down to that he was prejudiced of Aboriginal people, you know like.”

(Aboriginal Man, Adult: 26-45 years)
A: “Um, I usually just go see them when I'm sick and that's about it and just take whatever they say.”
I: Overall are they good, or bad, arrogant, pleasant?
A: “Well my usual doctor when I do go to see him he's very friendly. Um, he doesn't talk down to you. He talks on your level. And like he's a family man himself, and um so, overall he’s very good.”
I: Other doctors?
A: “There's been a few doctors that, um, I haven't, I've gone to see one doctor and he gave a wrong diagnosis. Then I went and saw another doctor, to get a second opinion, because I didn't trust his opinion, because I thought he was very abrupt. Um, he was just there to get the Medicare money. Um, like, in and out. Like he wouldn't listen to what you were saying to him.”

(Aboriginal Woman, Adult: 26-45 years)

Only one individual had largely only negative experiences with doctors:

“Hasn't been really good really, because a lot of doctors give you the impression you should shut up and not ask questions. It’s when you begin to ask questions that they become aggressive.”

(Aboriginal Woman, Senior Adult: 46+ years)

Even individuals who had experienced some less than desirable service, mentioned that overall doctors were at worse ‘okay’:

A: “Across the board, it’s been good. I've only had one bad experience and that was just a doctor who might have had a bad hair day, or something. You know, and um, and that was just a one off experience, you know. You know, it may have been the person who was in before me upset him’.”
I: Tell me a little bit about that?
A: “Well, it's just that, um, the usual question, um, what's the matter, or what are you here for and I sort of, started to, not so go into detail, but just explain that I felt that I was coming down with the flu, cold possibly, the flu, because, um, I felt warm, I had a runny nose and that. And the doctor sort of snapped at me. That he was the doctor and, um, he would diagnose, not me. He just wanted to know what my, what my feelings were as far as symptoms and he was going to diagnose. I wasn't to tell him that I felt that I thought that I [laughs] had the flu, you know. As I said, before that, somebody has probably upset him before me, or you know he's just had a bad, got out of the wrong side of the bed, or something.”

(Aboriginal Man, Senior Adult: 46+ years)

As the majority of individuals noted largely favourable attitudes towards doctors, it is not surprising that the majority of them have also never had a bad experience with a doctor. Of the 43 individuals who provided a meaningful response to the question, “Have you ever had a bad experience with a doctor?”, 27 (62.8%) had never had a bad experience.

A: “No, no. No bad experiences.
I: Have you ever had a bad experience with any doctor anywhere?
A: “No, not that I know of.”
I: No?
A: “Just go in and straight out.”

(Aboriginal Man, Adult: 26-45 years)
A: “No.”
I: Never?
A: “No. No.”
I: How many doctors do you think you have seen over your lifetime?
A: “Dr. xxxxx, here, referred me to one of the gynaecologists. I had a really tough time with my woman busos, so Dr. xxxxx referred me to a gynaecologist and I had a hysterectomy.”
I: But the actual doctor was okay?
A: “Oh yeah, he was great.”
(Aboriginal Woman, Senior Adult: 46+ years)

Although not mentioned often, the experiences the participants had appeared to be better with doctors than with the receptionists:

“No, no, not one. Not one. Who I have had a bad experience with is with the receptionists.”
(Aboriginal Man, Senior Adult: 46+ years)

A large number of individuals (37.2%) did note that they had at least once had a problem with a doctor. Nevertheless, even with such individuals, problems with doctors were rare. Usually when patients saw doctors, they had good experiences:

A: “Right there. That’s a left knuckle. I broke that on one of me nephews and he was drunk and he reset it wrong. But I’m not the only one. He reset one of my cousins legs and he done that all botched up too. And he is still working in the same hospital today. I don't believe it.”
I: Did you put in a complaint?
A: “Yes I did. I did. And so did my cousin. Me cousin had to. He almost lost his leg out of it.”
I: What happened at the end of all of that?
A: “He’s still working there and he’s still drunk.”
(Aboriginal Man, Adult: 26-45 years)

A: “Um, there is only once when I knew I had heart problems, um, when I was 40, so just over three years ago, um, there was also something advertising on the TV about diabetes. I had family history, at that time I was a little overweight, um, there were three or four points that indicated that I might be at risk. I went in and said to this particular doctor, I’d like to have a diabetes test, told her I had family history etc, etc, um, told her I had a heart problem and she said, um, I look too healthy to have a heart problem and that I didn’t need to have a diabetes test. She felt it was unnecessary.”
I: So what happened?
A: “I presume, I can’t remember exactly when I went in to see her, but I went and saw another doctor.”
I: Why do you think that first doctor was unwilling to test you for diabetes and your chest problems?
A: “Well I know I do look fairly healthy, um, but, um, she just presumed, I don’t know maybe she thought I was a junkie or something and was just after some pills. I don’t know, but I could not see the logic. Um, not seeing whether a person is diabetic or not, because I would have thought that preventive medicine was a lot better, but she didn’t.”
(Aboriginal Man, Adult: 26-45 years)
A: “No not really.”
I: How many times do you think you have been to a doctor since you have been 16 years of age and older?
A: “About five, three to five times.”
I: Every single time it has been okay?
A: “Yeah, pretty good. Oh yeah, once there was. I was at a party one night and I elbowed this cupboard. Like I was going down the stairs and I sort of went like that and it went crack. It hit me fair in the elbow, on the corner of this closet and it was hurting me. Like every time I was stretching my arm out it would click. So I went to this fella and all he did was touch me arm and then send me a bill for 30 bucks.”
I: He was a doctor right?
A: “And he only touched my arm and he said where does it hurt and I wasn’t even in there for 5 minutes. He just touched it and he told me to go up here, but that was way up the other end of town, so I didn’t end up going, but he still sent me a bill for 30 something dollars.”
I: And where did he want you to go to?
A: “To go get it X-rayed. But it was only like a clink, but I don’t get it much. And he sent me a bill for 30 bucks. And I thought that was cheeky.”
I: Did they tell you that you were not going to be bulk-billed?
A: “Um, no, I just thought I would go in there and my Medicare would cover it.”
I: Apart from the bill part, was there anything else you didn’t like?
A: “No, everything else was pretty good.”
I: So you’ve never actually had a bad experience with a doctor?
A: “No.”
(Aboriginal Man, Young Adult: 16-25 years)

More worrying from a doctor’s point of view is the fact that most participants who had at least one bad experience with a doctor, never went back to them again:

I: Are you scared to go to a doctor?
A: “To be honest, yeah. I don’t like him probing around with me. I mean the first doctor that I ever went to, like a gynaecologist, he was very rude and said, ‘That doesn’t hurt. You’re can handle it.’ You know, that sort of attitude. So I’m very picky, fussy, and I’ll go to a person who I know treats me with the right attitude and with respect like I would with you.”
(Aboriginal Woman, Adult: 26-45 years)

However, considering some of the alleged reasons why these participants would not want to go back, it was probably in the best interests of the doctor that they didn’t. For instance, one Aboriginal man said he would not go to a particular doctor in Brisbane because he didn’t keep information confidential. An Aboriginal woman recalled how a government medical doctor touched her intimately while doing a medical exam and that she felt he was just a “dirty old man.”

Even though some participants boycotted certain doctors and the medical centres that they work in, some indicated that they still use the same medical centre, but just don’t see the doctor in question:

A: “And I’ve never gone back to him again.”
I: Have you gone back to the same medical centre?
A: “Yes, I’ve been back.”
(Aboriginal Woman, Adult: 26-45 years)
A: “And I don't want to see him again.”
I: Would you go to the same medical centre and see other doctors there?
A: “Yeah.”
(Aboriginal Woman, Adult: 26-45 years)

So as not to examine only negative experiences with doctors, participants were also asked: “Have you ever had an excellent experience with a doctor?” Slightly more than half (55.6%) said that they had never had an excellent experience with a doctor. Nevertheless, a sizable group of individuals had:

“They’ve all been great.”
(Aboriginal Man, Adult: 26-45 years)

“No, but satisfied with the treatment…”
(Aboriginal Woman, Senior Adult: 46+ years)

“Yeah, my gynaecologist. He was perfect. I had a miscarriage and he did everything not to let that happen again. He was perfect.”
(Aboriginal Woman, Adult: 26-45 years)
4.3.2 Personal feelings about seeing a doctor

Having learnt that 80.6% of the individuals responded in a positive manner (somewhere between okay and really good) about their experiences with doctors and that overall, most participants indicated that they were relatively happy with the service they received from receptionists, participants were then asked a series of questions focusing on their personal feelings about seeing a doctor. Due to the above findings it is not surprising that the majority (70.8%) of individual were not embarrassed to go to a doctor.

A: “No.”
I: Why not?
A: “Because I know it is a necessity to go to the doctor when you’re sick. And you shouldn't be embarrassed, because everybody’s body is the same on the inside. It might be different on the outside, but we are all the same on the inside.”
(Aboriginal Woman, Adult: 26-45 years)

A: “No, not really.”
I: Why is that?
A: “Well if you've got to go, then you've got to go see the doctor. If you've got a problem, no matter what it is, big or small, you should get the advise on it.”
(Aboriginal Man, Adult: 26-45 years)

A few individuals mentioned that they were not embarrassed now, but that they had been when they were younger. The reasons for this earlier embarrassment varied:

A: “Once.”
I: Tell me about that?
A: “I had some sort of a cut downstairs on me little man. And, um, it was sort of just, it wasn't a cut, it was like a rash. It stung whenever it touched water, or anything like that. But I didn't see a doctor and it went away.”
I: There was a problem. Did it really need to be seen by a doctor?
A: “Yeah, I think it did. It was stinging and just like left this, sort of stuff down there, in my undies and all that.”
I: How long did it take to heal?
A: “About four days.”
I: And how long was the pain for?
A: “Only four days.”
I: So you were walking around in pain for four days?
A: “I wasn't. Yeah. Yeah. I was.”
I: You weren’t, or you were?
A: “I was.”
I: And how many other people knew?
A: “No one.”
I: Why didn’t you go?
A: “Just embarrassment and just thought it would clear up and it did.”
(Aboriginal Man, Young Adult: 16-25 years)
A: “No.”
I: Have you ever been embarrassed to go see a doctor?
A: “Oh last year I was getting a Pap smear done and I was a bit shy.”
I: Was that the first time you ever had one done?
A: “Yeah.”
I: Was that a male or female doctor?
A: “Female.”
(Aboriginal Woman, Young Adult: 16-25 years)

A: “No.”
I: Did you use to be?
A: “When I first, first female doctor I seen, I don't think it was an embarrassment thing. I think it was more that I, I'm, you know, I'd never thought about a female being in medicine, you know. And then all of a sudden I was, well actually I was into my early 20s and all of a sudden there was first female saying, 'I'm going to check you for hernias', or whatever, and I'm thinking, 'that's strange, what's she up to.' But, um, it's not an embarrassment thing. It was just a shock to see a female doctor for my first time.”
I: And now?
A: “No, I don't have any problem at all, now.”
(Aboriginal Man, Senior Adult: 46+ years)

A: “Never.”
I: Why not?
A: “It's very important to me, that I accept that I am sick in any part of my body and that it's going to be fixed up. When I was a youngster I used to be terribly embarrassed when I was young. I dare say that would be exactly the same with kids my age then today. They would have the same fears. It's only because of knowledge. You know, I had no qualms about baring my body in front of a woman doctor, or a male nurse, or a female nurse. I have no qualms. It doesn't worry me, but it is only because of the process of me growing and learning that knowledge and accepting that knowledge, that has got me here today. Not because of anything else. It is just an acceptance of it. There are things like that I do today that the kids wouldn't accept. Like you know, because they couldn't, because they haven't faced that yet.”
(Aboriginal Man, Senior Adult: 46+ years)

The remaining individuals said that they were either always embarrassed, or that it depended upon the medical problem. The following three accounts gives a good account of the situations and/or feelings these people encountered:

“Yes, because first thing they say is, are you sure it's not because you are so fat.”
(Aboriginal Woman, Senior Adult: 46+ years)

“Yeah, sometimes, you know like, I'm frightened to talk at first and then. But if he makes me feel a bit at ease, I'm right, you know, or see him the second time with it, I feel a bit easier there, you know. Or sometimes I just sit there and say 'this is what's wrong with me', and he'll have a look and give me a piece of paper, and I'll go to the chemist...”
(Aboriginal Man, Adult: 26-45 years)
To understand the emotional state of participants upon attending the medical centre, they were also asked: “Are you frightened to go to a doctor?” The majority (59.6%) were not frightened to go to a doctor:

A: “No.”
I: “Yeah?”
A: “Yeah. Oh, not really, because I lay in bed for three days when I had pneumonia. I didn't know I had it. I thought, ‘no, I'm right, I'm right.’ Then I started to feel afraid about me self. Like I felt like I was dying. And that is when I went to the doctors and he said ‘yeah, you were dying.’ I was sleeping it away. And I got up the courage to go around the corner and go see him. He said ‘you are lucky that you came and see’ me … temperature was like 100 and something. I got, got the courage to get up and go around and see him.”
I: You were at home sleeping it off?
A: “Yes.”
I: Tell me about that?
A: “Well, I was laying in bed for about three days and I thought I am not getting any better. And, um, my bed was ringing wet, like I wet the bed, but it was just the sweat coming off me. And then I started drying off. Like I had heaps of water next to me and I was just drinking it and drinking it and it was just going straight through me. And, um, when I went to get up, I was cramping up. Like me stomach, it wasn't me stomach it was me lungs. And I would cramp up and I would stop and I would be in heaps of pain, like being stabbed in the belly. And then I would walk around and stop and it would cramp up again. Painful thing.”
I: Why did you leave it so long to go see a doctor?
A: “I didn't think it was that bad. I thought I just had a bad flu. Like a bad cold.”
I: ...So when you went off to go see the doctor on the third day, were you frightened to see the doctor?
A: “No. No, I’ve never been frightened really to go see a doctor.”
I: So it was not the doctor that you were frightened of, it was more what was happening to you?
A: “Yeah.”
(Aboriginal Man, Young Adult: 16-25 years)

Five (10.6%) individuals mentioned not being frightened to go to a doctor, but they were frightened to go to a dentist:

A: “No. No. The only place that I ever get nervous is the dentist.”
I: Why is that?
A: “Because of the pain that ain’t there, but it is just the thought that you have a toothache, you know, and no one is mucking around with it and it aches like hell and you go to the doctor and they are going to hit you with a needle, psychologically you know that something is going to go into your skin. I feel very offensive and offended if there is a foreign body going into my body without my permission and me totally accepting it. And it took me a long time to understand that that needle, that they are putting in, is not going to just deaden the pain. I’ve found out what the substance is that they're put into my, it has been explained to me, so, therefore I accept it. That for me to get rid of the pain I have to go step-by-step thing of knowing what's happening and I have to accept things, unless they put your under gas.”
(Aboriginal Man, Senior Adult: 46+ years)
A: “No, only the dentist.”
I: Have you ever been frightened to go to the doctor?
A: “There was one time there when I actually had, um, pneumonia, borderline pleurisy, and um, it got to the stage where I had to go, but I didn't really want to go.
I: And what happened?
A: “I ended up in hospital for three to four weeks.”
I: How old were you then?
A: “30-35 [Note: approximate age to keep anonymous].”
I: So how long did you put up with it before you went to see the doctor?
A: “I went and saw the doctor when it got to the stage of borderline pleurisy.”
I: So you put up with it for how long?
A: “I put up with it, like, the pneumonia for about two weeks. Them my body just said ‘No, I’ve had enough’.”
I: So why did you leave it so long?
A: “I don’t know. Just didn’t feel like. I was too busy. Working, looking after the family.”
I: Are you sure that’s the only reason?
A: “Yep. Well, mainly it was that I was too busy with work and the family, and um, at the time, everybody was going on holidays and that, and there was nobody here. At the time, the new boss had just started as well. And me health just started going down hill, because I wasn't looking after myself properly.”

(Aboriginal Woman, Adult: 26-45 years)

Another five (10.6%) individuals mentioned being frightened to go to a doctor for a variety of reasons such as mentioned by the two people below:

“Sometimes, um, I get a bit frightened, because I don't want to know what's wrong with me. That's the only time I’m frightened. I'm not actually frightened of the doctor himself.”

(Aboriginal Woman, Senior Adult: 46+ years)

“Yeah, I was because of the needle. I hated needles. I used to get a lot because of boils and that.”

(Aboriginal Man, Adult: 26-45 years)

The remaining individuals mentioned being frightened sometimes, being frightened in the past but not now, and only when the treatment involves getting needles.

When individuals were asked: “What is the worst thing about seeing a doctor?”, they provided extremely varied responses (see Table 32). In fact, few individuals mentioned the same thing, except to note that five people mentioned not liking needles. When individuals were asked: “What is the best thing about seeing a doctor?”, there was a lot more consensus. The majority (58.6%) stated being told what was wrong with them or receiving medical treatment. The next most common response (24.1%) mentioned was being able to put their mind at ease.
Table 32: The worst thing about seeing a doctor? (n=28)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor refused me a hysterectomy</td>
<td>1</td>
</tr>
<tr>
<td>Hassles of seeing the doctor</td>
<td>2</td>
</tr>
<tr>
<td>Something is wrong about your health</td>
<td>1</td>
</tr>
<tr>
<td>Nothing</td>
<td>5</td>
</tr>
<tr>
<td>Getting the results</td>
<td>2</td>
</tr>
<tr>
<td>Waiting period</td>
<td>3</td>
</tr>
<tr>
<td>Fear there is something wrong</td>
<td>1</td>
</tr>
<tr>
<td>Needles</td>
<td>5</td>
</tr>
<tr>
<td>Don't know</td>
<td>1</td>
</tr>
<tr>
<td>Doctor who talks too much</td>
<td>1</td>
</tr>
<tr>
<td>Having a doctor who doesn't worry about how you feel</td>
<td>1</td>
</tr>
<tr>
<td>Tells you that you have something that you were not expecting</td>
<td>2</td>
</tr>
<tr>
<td>Could be the last time that you see someone</td>
<td>1</td>
</tr>
<tr>
<td>Getting the wrong diagnosis</td>
<td>1</td>
</tr>
<tr>
<td>Being told that you will have to stay in hospital</td>
<td>1</td>
</tr>
</tbody>
</table>
4.3.3 Kind of doctor Aboriginal people prefer to see

To ascertain whether the type of doctors available was a barrier to accessing health care services, participants were asked four questions. The first was: “Do you usually ask for a specific doctor, or do you not care who you see?” There was a relatively equal number of individuals who didn’t care what general practitioner they saw (52.4%) and those who choose to see a specific doctor (47.6%). Examples of three participants who didn’t care who they saw follows:

“When I’m sick, I don’t care.”
(Aboriginal Woman, Adult: 26-45 years)

 Doesn’t matter, but if can go to my GP so much the better.
(Aboriginal Woman, Senior Adult: 46+ years)

A: “They tell you if you want a certain doctor, or if you don't you can say the first available.”
I: Okay, and what do you normally do?
A: “I just say the first available doctor.”
I: So as long as they have the records at that medical centre you don't care who you see?
A: “Yeah.”
(Aboriginal Man, Adult: 26-45 years)

Those who asked to see a specific doctor did so because it was their usual doctor, because they wanted someone of the same sex, or for specialist knowledge:

I: Do you usually ask for a specific doctor, or do you not care who you see?
A: “Specific doctor as he takes his time with me.”
(Aboriginal Woman, Senior Adult: 46+ years)

“Depends on the pain, or where I’ve got it, or what's wrong with me, that I will come to a health service, be it a non-Aboriginal health service, or surgery, or whatever, and ask the receptionist does their doctor have knowledge of this. And if I go in and see this doctor and I will ask this doctor that I might need a second opinion, is there another doctor with expertise in this particular xxxx problem that I have, or whatever, you know. I'll go to the trouble of asking, because I am interested in making sure that I’m okay, like you know. If I am going to go to a doctor for treatment, I want good treatment.”
(Aboriginal Man, Senior Adult: 46+ years)

Some individuals went to single practitioner clinics and thus had no choice in which doctor they saw. Nevertheless, such individuals usually admitted that they preferred to see this doctor. Thus going to a single practitioner clinic was not an access barrier:
“Well normally I just go to, um, a single practitioner, you know. It's, um, I don't, well I haven't really been into a medical centre as such, where there is multiple doctors there, where they just, um, allocate you to whoever is available, except at, um, at the hospital where I've had, on the night and that, where your out of normal hours care, well I've had to go to the hospital and that, well I've had no troubles with who they have allocated me with.”

(Aboriginal Man, Senior Adult: 46+ years)

Some researchers have found evidence to support the claim that the race of general practitioners can be an access barrier. For instance, Saha et al. (1999) found that black American adults were more satisfied (for many measures of satisfaction) with the care they received from black opposed to non-black general practitioners. They also noted that black Americans treated by black doctors reported receiving more preventative care and medical attention than black Americans treated by non-black doctors. They hypothesised that the results may be partly due to better understanding of the individual’s culture as the doctor is of the same culture:

“Why might racial concordance between patients and physicians’ affect patients’ assessments of their health care? Our analyses provide some insight. Among blacks, the strongest association between racial concordance and the several response variables measuring patient satisfaction was with respondents’ ratings of their physicians in treating them with respect. This finding suggests that black physicians may have more harmonious interpersonal relationships with their black patients than do physicians of other races. Better relations may be a product of cultural and experiential similarities that promote mutual understanding and trust.” (Saha, et al., 1999, p. 1000-1001)

However, they went on to suggest another hypothesis:

“Alternatively, since many black physicians see large numbers of black patients, it is possible that better relationships are due to cultural competence acquired through practice rather than to factors more directly attributable to racial concordance.” (Saha, et al., 1999, p. 1001-1002)

More recently, Saha, et al. (2000) have found that both black and Hispanic Americans seek medical care from general practitioners of their own race and that this is not just because of geographic accessibility. These authors also noted that black physicians made up only 4 percent of the physicians in the United States, but they cared for more than 20 percent of black patients. Therefore, they suggested that the shortage of black doctors was a barrier that black patients faced in accessing health care. They thus suggest that:

“medical schools and health plans might rationally argue that the consideration of race in these [affirmative action policies] realms is reasonable and indeed necessary, to create a physician supply that reflects consumers’ preferences.” (Saha, et al., 2000, p. 81)
Edwards, Maldonado, & Engelgau (2000) note how the A&M University Health Science Center College of Medicine have changed their policy of admission along such racial lines so as to address the imbalance of a few minority physicians serving a large number of minority individuals. Research, however, has not been conclusive in this politically sensitive area. For example, Kahn et al. (2000) conducted interviews with 18 community leaders and 38 community members in Louisiana due to a syphilis epidemic which occurred predominantly among disadvantaged African Americans. The majority of interviewees felt that race was not a factor in choosing healthcare providers.

Participants in this study were asked the following question to determine whether the race of doctors is an access barrier for Aboriginal people seeking health care: “Would you rather see an Aboriginal, Indian, Chinese, or European doctor, or does it not matter?"

Some (17%) participants said they would prefer to see an Aboriginal doctor. Major reasons for wishing to be treated by Aboriginal general practitioners included a feeling that such doctors would be able to communicate more effectively, would be more familiar with Aboriginal culture, and that the participant would feel more comfortable talking to another Aboriginal person. Examples of individuals who felt this way follow:

I: Would you rather see an Aboriginal, Indian, Chinese, or European doctor, or does it not matter?
A: “Aboriginal.”
I: And why is that?
A: “Because they know what, they know what, they um, they know what they're talking about, what your needs are and all that. They understand what your problems, instead of filling the out prescription, saying they will make you.”

I: Whereas the Aboriginal doctor would use?
A: Bush medicine sort of techniques.
(Aboriginal Man, Adult: 26-45 years)

“Well I would have to say on that part, I would have to say my own colour, the Aboriginal. Um, because he will, once he knows what the reason I am there for, he will understand, he knows that because we are not, were not sort of. Um, because, because he will know, he'll understand, like, with me shame that will, um, shamed of seeing other people, other white people. Um, because there is a lot of us, that’s sort of like, don't like to see any other nationality, um, because it's some of them it's hard to understand what you're talking about. Like sometimes you can't understand them and see they might give you the wrong medication, or something, and you can't understand what he’s talking about and they can't understand what we are talking about. Where, the reason I choose to see my own colour is because he understands where we are coming from, um, then we understand what he is talking about…if he is going to put us on any medication. Well that’s to me, that’s what it is.”
(Aboriginal Man, Adult: 26-45 years)

“I think I might feel with the Aboriginal. Like, I wouldn't have to ask him, um, the questions like to all the other fellas, where he would explain it to my level.”
(Aboriginal Man, Adult: 26-45 years)
A: “Um, the Aboriginal one, I would. But if, if he wasn’t like, if it wasn’t an Aboriginal, I’d go, I wouldn’t choose over anyone.”

I: But the Aboriginal doctor you would choose as your first preference. Why is that?

A: “Um, because, like he’d be able to, like, talk, talk the, um, wouldn't talk down to you. Like most doctors do. Plus, like, he’d be able to communicate with you better.”

I: What do you mean by ‘talk down to you’?

A: “Oh, sometimes, um, you get some doctors that, um, will ask you your symptoms and then they won't believe you and then they tell you what’s wrong with you, after you have told them what's wrong with you.”

I: And you think they do that because you are Aboriginal?

A: “No.”

I: But you don’t think that an Aboriginal doctor would do that?

A: “No. Because they are more in line with you, because of their growing up.”

I: Okay, an Aboriginal doctor won’t do that to you. Will an Aboriginal doctor looked down at non-Aboriginal patients?

A: “Um, it all depends, on what they're upbringing was and that.”

I: So you think that Aboriginal doctors will relate well with Aboriginal patients, but not necessarily well with non-Aboriginal patients?

A: “Yeah.”

(Aboriginal Woman, Adult: 26-45 years)

The majority (75.5%) of individuals, however, stated that it did not matter what race the general practitioner was:

I: Which would you prefer, an Indian, Chinese, Aboriginal, or European doctor, or does it not matter?

A: “It does not matter.”

I: So you would be just as happy to go to a Chinese doctor as an Aboriginal doctor?

A: “Yeah, yeah. Well, I went to a Chinese doctor to get my toe nails taken out. Even though we bag them a lot, I tell you what by God he was fantastic with a needle. Very steady hands.”

(Aboriginal Woman, Senior Adult: 46+ years)

A: “Doesn't really worry me as long as I'm getting seen, getting treated for whatever I went there for. Eh, and I'm in there as quick as possible and out of there, you know.”

I: It doesn't worry you in the slightest?

A: “No, it doesn't worry me. I'm happy, I'm happy if, you know, because I know if they have got the qualifications they should be professional enough to treat you and get you out of there as quick as possible.”

I: Does it worry you if the doctor has got their qualifications from overseas? Does that bother you?

A: “No not really.”

(Aboriginal Man, Adult: 26-45 years)

A: “It really wouldn’t matter.”

I: Why?

A: “I don’t know, doctors are doctors. They tell you if you’re sick, or whatever, and they give you a prescription and you go grab it. I just ask, um, like, people that I know, if they have been to that doctor and is he any good or she any good. And they say yeah or no.”

(Aboriginal Man, Young Adult: 16-25 years)
In fact, some participants indicated that the race of the doctor was so unimportant that even if an Aboriginal doctor was available, they would not necessarily ask to see this doctor:

A: “No, not really.”
I: Why not?
A: “I don’t know, I reckon they would be all the same mate. Depends if I know them, or something. I would say yeah I want that black fella, that Aboriginal fella, to do it for me. But it wouldn’t matter who was doing it for me.”
I: If you knew the Aboriginal doctor, you’d probably go for him, but if you didn’t know the Aboriginal doctor, then?
A: “It wouldn’t matter.”
I: What about if you knew the Chinese doctor, but you didn’t know anybody else, would you go for him?
A: “Yeah.”
(Aboriginal Man, Young Adult: 16-25 years)

Some people were uncertain about their beliefs on this matter. One Aboriginal man was not sure if he would prefer an Aboriginal doctor or whoever he was assigned. He, however, gave the researcher the impression that he would leave it up to the receptionist to decide:

A: “Well, oh well, it's pretty obvious what I would answer? If an Aboriginal doctor was qualified, 100 percent qualified, I'd go [to the Aboriginal doctor], but then again, not necessarily. I'd go to whoever was first up first in sort of thing.”
I: But say if all four didn’t have a patient and they were all ready and they're all just sitting there at their desks waiting for a patient?
A: “[Interrupted by the interviewee] Well, it would be up to the reception, you know. If she said that there was a doctor that was vacant now, and if it’s an Asian, then I am quite happy to walk to the clinic, and in the examination room if there is an Asian person there, then that will be my doctor for the duration, irrespective of whether I knew there was an Aboriginal doctor here later on, I would not change. I am one of those persons, the designated doctor is your doctor.”
I: And if the receptionist gives you the choice?
A: “I'd say because I'm an Aboriginal, yes I would ask, um, for the Aboriginal doctor.”
(Aboriginal Man, Senior Adult: 46+ years)

Four (7.5%) individuals said they would prefer Chinese doctors. The main explanation for this was a belief that Chinese doctors were the most knowledgeable:

A: “Chinese.”
I: Why is that?
A: “I have a lot of faith in Chinese doctors.”
I: Where do you think you got that faith from?
A: “From my mother. Um, well I was adopted. I was xxxxx [young age] and I had six weeks to live and it was a Chinese doctor who saved my life.”
(Aboriginal Woman, Senior Adult: 46+ years)
Chinese… Because they know what they are doing.”
(Aboriginal Woman, Young Adult: 16-25 years)

Not a single participant mentioned that their first choice would be a European doctor. In fact, one participant actually mentioned that Aboriginal people would prefer not to go to European doctors:

“I find that most of the Aboriginal people that go to, they would rather go to, um, Indian doctor, or Chinese doctor, other than the white society. Because they are more or less on our level… They [European doctors] put themselves above all the rest of the other cultures and they look down, instead of looking out their eyes.”
(Aboriginal Woman, Adult: 26-45 years)

Participants were also asked whether the age of general practitioners was an important factor in determining whom they chose to see. The majority (55.8%) of individuals, as with the question concerning race, did not mind how old the doctor was. Typical reactions follow:

I: Would you rather see an old, or a young doctor, or does it not matter?
A: “No. Age does not bother me, as long as they have the qualifications, well they have been trained to do them things.”
(Aboriginal Man, Adult: 26-45 years)

Anyone, you know. Because you get some good young ones and you get some good old ones. Like, when I was up, a couple of doctors I seen, a couple of old fellas they sort of made you feel at ease and that. But I also saw some young ones and they were’s alright too.”
(Aboriginal Man, Adult: 26-45 years)

“No not really. I reckon if they’re both doctors and they went to Med school and stuff, I reckon they have got the skills and that. As long as they don’t go pushing needles into you everywhere.”
(Aboriginal Man, Young Adult: 16-25 years)

A sizable number of individuals (32.7%) said that they would prefer older doctors. The explanation for such beliefs was that such doctors would be more knowledgeable:

A: “Old.”
I: And why is that?
A: “Because they are wiser. They know what they are talking about. The young doctors, well they might think, but he doesn't know, see.”
(Aboriginal Man, Adult: 26-45 years)

Similarly, no participant mentioned that they would prefer to see an Indian doctor.
“I suppose, you know, like, from my point yeah an older one, as the old type of GP I like, because they tend to sit and not just talk about my problem, but also they tend to ask questions about the family and they, um, I can see the benefit in that. I may be missing something. It may be something that is say hereditary, you know. Um, so those types of characters, yeah, I’ve, I suppose the doctor that I see at the moment, he's that kind of character. And I think that I’ve specifically sort them out.”

(Aboriginal Man, Senior Adult: 46+ years)

Two individuals said that they would prefer younger doctors. This was largely because they felt that younger doctors were more up-to-date. Another four individuals said they would prefer a doctor who was somewhere in between young and old.

Participants were also asked whether they would rather see a male, or a female doctor, or does it not matter? Overall there were largely only three types of responses to this question. The majority (51%) of individuals said that it did not matter what sex the doctor was. Examples of such individuals’ beliefs follow:

A: “That doesn't matter either.”
I: What about if you need to have your old fella [penis] checked out?
A: “That doesn't matter either. I’ve had nine cases of the Jack and five times I had to see a female doctor. So it doesn't matter.”

(Aboriginal Man, Adult: 26-45 years)

“Whatever doctors there. If you are crook, sick, whatever it is and you definitely need to see a doctor, it doesn’t matter how long it is going to take, you’ve got to stay there and see a doctor. Doesn’t matter if it’s a male or a female.”

(Aboriginal Man, Adult: 26-45 years)

A: “It does not matter. I’m comfortable with both. Like in any area. Any area at all. I am not the least embarrassed, so long as the doctor is good.”
I: So how about seeing a young female doctor?
A: “I have no qualms… You know, you are there for your problem. And, I always go by, I couldn’t give a hang what nationality they are. And I couldn’t give a hang what sex they are. So long as I am treated properly.”

(Aboriginal Man, Senior Adult: 46+ years)

A number (11.8%) of individuals said that the gender of the doctor did not matter, except when a full body examination was required or when a discussion would be required about sexual matters:

A: “Um, that would depend on what I was going to have a check up for.”
I: ...What sort of things?
A: “Um, if there are any male related problems, like if I had to have a medical done which sort of required me to do government work and I would have to strip off, then no not in front of a female doctor.”

(Aboriginal Man, Adult: 26-45 years)
The final common response (33.3%) was made by individuals who always wanted to see a doctor of the same sex. Examples of individuals who shared this belief follows:

A: “Male doctors.”
I: Because?
A: “Oh well, what about if you have something hanging down off your, off your, down underneath there, you can’t just go I have got a sore on here, or something, you know. Or this here is hurting. A bit shameful, you know.”
(Aboriginal Man, Young Adult: 16-25 years)

A: “Male.”
I: Why is that?
A: “No particular reason. No particular reason. Just that I have grown up with male doctors, you know. There's nothing against female doctors, it's just that I have grown up with male doctors.”
I: Do you feel more comfortable with male doctors?
A: “Not necessarily. I think it is male on male, you know.”
(Aboriginal Man, Senior Adult: 46+ years)
4.4  Age and gender differences

While waiting in medical centres, 32.6% of the individuals wanted to get it over and done with more than anything else, 21.7% felt good, 19.6% felt stressed, nervous, or uncomfortable, while the remaining individuals mentioned: reading books, magazines, pamphlets and watching television (8.7%), nothing unusual (4.3%), good except when there is a lot of people there (4.3%), really annoyed (4.3%), language is a problem (2.2%), and that how they feel depends on their ailment. More individuals (42.9%) said they felt comfortable waiting to see the doctor in a medical centre's waiting area, than uncomfortable (21.4%), or slightly uncomfortable (25%). Two individuals mentioned that they felt comfortable in general practitioner waiting rooms, but not in hospital waiting rooms, and one individual said his level of comfort depended upon the number of people in the waiting room. An age difference was noted whereby the older age groups had less individuals feeling uncomfortable. The majority (75.7%) of individuals did not feel intimidated in medical centres, while 10.8% said they did feel intimidated. One individual noted that they use to feel intimidated, but not any longer. Two of the individuals who said that they were not intimidated in the medical centre, did note that they were intimidated by the doctor either as an adult, or in the past as a child. Another two individuals said that they were not intimated at Tharawal Medical Centre, but they were at other medical centres. More than half of the individuals (52.4%) did not feel out of place in medical centres, whereas 21.4% did. Three individuals noted that they did not feel out of place now, but that they use to and two individuals felt out of place most of the time, except in Aboriginal medical centres. Without prompting, a number of individuals mentioned racism occurring while waiting in medical centres. Many of the participants mentioned being stared at. Thus, it is not surprising that many individuals mentioned feeling more comfortable in Aboriginal medical centres than in western medical centres. A large number of individuals did not feel that there was anything else that could be done to make them feel more comfortable in medical centre waiting areas. However, approximately the same number of individuals felt that there were things that could be done. No other age or gender differences were noted.

Virtually all (91.7%) individuals asked said they were not affected by traditional Aboriginal beliefs of whom they could sit beside and face. Thus, such beliefs did not affect these individuals when they attended medical centres. The same type of answers were obtained when individuals were asked if they were affected by traditional Aboriginal beliefs with regard to who they could talk to; 96% of individuals asked felt that they were not affected. Two individuals said that they were affected by such traditions. However, they said that urban Aboriginal people did not share such beliefs. Thus, if such beliefs had any impact on these individuals, it was totally situation-specific. In urban contexts such beliefs had no impact, but participants felt that “up north” such beliefs still played a role in Aboriginal culture. No age or gender differences were noted.

Participants views concerning the service they received from medical receptionists were relatively evenly distributed between very good and poor: 10.5% of individuals
suggested receptionists were very good, 36.8% felt receptionists were good, 21% suggested receptionists were pretty good, and 10.5% felt that receptionists were poor. No participant felt that they received poor service because they were Aboriginal. Instead, they mentioned the receptionists not being friendly and needing to pay more attention to the customers. A number of individuals noted that receptionists varied considerably and thus the treatment they received was mixed. Overall, most participants indicated that they were relatively happy with the service they received from receptionists. Most participants mentioned that they were welcomed by receptionists by being greeted, receiving a smile, their tone and manner of speech, by being friendly and pleasant, participating in ‘small talk’, speaking on the same level, offering assistance, providing comfort and saying goodbye. No age or gender differences were noted.

The majority (63.6%) of individuals said that they were informed if the doctor was running late. A further 9.1% were partly informed, 4.5% were not informed but did not see this as a problem, and one individual (4.5%) would simply ask if the doctor was running late. Thus, only 18.2% of individuals might have a problem in that they were not informed, however, the responses indicated that, on the whole, participants accepted the fact that doctors could not always be punctual due to unforeseen circumstances. Six (28.6%) individuals indicated that they were never late for appointments, while five (23.8%) individuals said that if they were running late, they would always ring and indicate this. Of those who did actually turn up to the medical centre late and who did not ring to say that they would be late, the majority stated that they were not treated differently than if they had turned up on time. The majority (77.3%) of individuals indicated that they did not ask receptionists any questions after seeing a doctor. Two (9.1%) individuals indicated that they asked the receptionists questions and a further three individuals (13.6%) individuals said that they sometimes asked questions. Such questions were largely about signing Medicare forms or making another appointment. No age or gender differences were noted.

The majority (65.8%) of individuals felt that receptionists treated them in the same manner as non-Aboriginal people. Three individuals (7.9%) felt that they were treated differently and a further 10 (26.3%) individuals felt that some times they were treated differently. Thus, it is not surprisingly that some individuals felt that they were more comfortable in Aboriginal medical centres. Eight (19.5%) individuals said that they refused to go to at least one medical centre due to the way a medical receptionist had treated them. This figure is alarmingly high; one-fifth of these individuals have placed a self-imposed access barrier on their health care due to something negative about a medical receptionist. An examination of the reasons why the participants said they were boycotting the medical centres, however, suggests that it was not as a result of the receptionists’ mannerisms or behaviours. Two participants indicated how they turned up to medical centres without Medicare cards and were told that they needed to present them. Six (15%) individuals said there was a medical centre that they would not go to. One Aboriginal woman said that she would only go to Aboriginal medical centres. The remaining 82.5% of individuals said there was no medical centre that they would not go to. No age or gender differences were noted.
The majority (80.6%) of individuals had received positive experiences when seeing a doctor at medical centres. A few individuals had mixed experiences. Only one individual had largely only negative experiences with doctors. Even individuals, who had experienced some less than desirable service, mentioned that overall doctors were at worst “okay.” The majority (62.8%) of individuals had never had a bad experience with a doctor. A large number of individuals (37.2%) did note that they had at least once had a problem with a doctor. Nevertheless, even with such individuals, problems with doctors were rare. Most participants who had at least one bad experience with a doctor never went back to them again. Even though some participants boycotted certain doctors and the medical centres that they work in, some indicated that they still use the same medical centre, but just don’t see the doctor in question. Slightly more than half (55.6%) said that they had never had an excellent experience with a doctor. Nevertheless, a sizable group of individuals had. No age or gender differences were noted, except that few males stated that they had had an excellent experience, whereas almost all females stated that they had an excellent experience.

The majority (70.8%) of individuals were not embarrassed to go to a doctor. A few individuals mentioned that they were not embarrassed now, but that they had been when they were younger. The reasons for this earlier embarrassment varied. The remaining individuals said that they were either always embarrassed, or that it depended upon the medical problem. The majority (59.6%) of individuals were not frightened to go to a doctor. Five (10.6%) individuals mentioned not being frightened to go to a doctor, but that they were frightened to go to a dentist. Another five (10.6%) individuals mentioned being frightened to go to a doctor for a variety of reasons such as mentioned by the two people below. The remaining individuals mentioned being frightened sometimes, being frightened in the past but not now, and only when the treatment involves getting needles. When individuals were asked what is the worst thing about seeing a doctor, they provided extremely varied responses. In fact, few individuals mentioned the same thing, except to note that five people mentioned not liking needles. When individuals were asked what is the best thing about seeing a doctor, there was a lot more consensus. The majority (58.6%) stated being told what was wrong with them, or receiving medical treatment. The next most common response (24.1%) mentioned was being able to put their mind at ease. No age or gender differences were noted.

There were a relatively equal number of individuals who didn’t care what general practitioner they saw (52.4%) and those who choose to see a specific doctor (47.6%). Those who asked to see a specific doctor did so because it was their usual doctor, because they wanted someone of the same sex, or for specialist knowledge. Some individuals went to single practitioner clinics and thus had no choice in which doctor they saw. Nevertheless, such individuals usually admitted that they preferred to see this doctor. Thus going to a single practitioner clinic was not an access barrier. Participants were asked “would you rather see an Aboriginal, Indian, Chinese, or European doctor, or does it not matter?” Some (17%) participants said they would prefer to see an Aboriginal doctor. Major reasons for wishing to be treated by Aboriginal general practitioners included a feeling that such doctors would be able to communicate more effectively, would be more familiar with Aboriginal culture, and
that the participant would feel more comfortable talking to another Aboriginal person. The majority (75.5%) of individuals, however, stated that it did not matter what race the general practitioner was. In fact, some participants indicated that the race of the doctor was so unimportant that even if an Aboriginal doctor were available, they would not necessarily ask to see this doctor. Four (7.5%) individuals said they would prefer Chinese doctors. The main explanation for this was a belief that Chinese doctors were the most knowledgeable. Not a single participant mentioned that their first choice would be a European (or Indian) doctor. In fact, one participant actually mentioned that Aboriginal people would prefer not to go to European doctors. The majority (55.8%) of individuals, as with the question concerning race, did not mind how old the doctor was. A sizable number of individuals (32.7%) said that they would prefer older doctors. The explanation for such views was that older doctors would be more knowledgeable. Two individuals said that they would prefer younger doctors. This was largely because they felt that younger doctors were more up-to-date. Another four individuals said they would prefer a doctor who was somewhere in between young and old. The majority (51%) of individuals said that it did not matter what sex the doctor was. A number (11.8%) of individuals said that the gender of the doctor did not matter, except when a full body examination was required or when a discussion would be required about sexual and/or reproductive matters. The final common response (33.3%) was made by individuals who always wanted to see a doctor of the same sex. An age difference was noted with young adults not minding what doctor they saw, whereas older age groups tended to prefer seeing a specific doctor. A similar trend was noted for age of doctor preferred for female participants. A lack of male senior individuals may have prevented concluding this. An age trend was also noted for the gender of doctor preferred. No other age or gender differences were noted.
5. Access Problems

This sub-section addresses seven health access topics (financial difficulties, transport difficulties, telephone booking difficulties, communication difficulties, time of appointment difficulties, difficulties using bush medicine, shame). An important part of this sub-section is the focus on shame. This sub-section concludes with an examination of age and gender differences. This final topic (age and gender differences) also serves as a summary of Section 5.

5.1 Financial difficulties

It was anticipated that many Aboriginal people in the area would have difficulties accessing health care facilities due to financial hardship. To assess the extent of this potential barrier, participants were asked 7 questions. Individuals were initially asked: “Do you usually have enough money to pay for transportation to a medical service?” Fourteen (46.7%) individuals asked said they did, however, 13 (43.3%) said they did not have sufficient money, and an additional 3 (10.0%) individuals said that they sometimes did not have sufficient money. An example from one Aboriginal man clearly explains how lack of finances can cause some individuals to take drastic measures in order to get to a health care facility:

I: Have you ever had a time when you have had a medical problem, but you didn't have enough money to actually get to a doctor?
A: “No. Um, yeah I have, yeah. Once, and um, I got the taxi driver to drop me off at the hospital. Yep.”
I: Did he [interrupted by the interviewee]?
A: “No he didn't, but I made him.”
I: So he did it for nothing?
A: “Yeah. Well I wasn't getting out of his car, until he done it. Like I was already halfway out the cab and, when I collapsed, so the other half of me just held onto the cab. So yeah, he had to take me to the hospital. That was a big rush. That was alcoholic poisoning again. Um, I put in two weeks into a drinking session and that's what came of it - alcoholic poisoning and DT’s and everything.”

(Aboriginal Man, Adult: 26-45 years)

As over half the individuals asked said that they did not usually have enough money to pay for transportation to attend a health care facility, it is understandable why, as was noted in Section 2.4 (Check-ups), only 36.2% of the 47 participants asked, reported going to a doctor when they were healthy. Obviously such financial/transport difficulties have serious policy implications and need to be addressed. This issue will be discussed further in the next sub-section (Section 5.2: Transport difficulties).
Just over half (51.2%) of the participants stated that they usually did not have a problem paying the medical service fee. A major reason for this was that many individuals stated that they only attended medical centres that bulk-billed. For instance, 73.2% of the 41 participants asked said they only go to a doctor who bulk-bills. Nevertheless, 14 (34.1%) of the 41 individuals said they usually don’t have enough money to pay for the medical service fee and a further 6 (14.6%) said that they sometimes don’t have enough money. One Aboriginal man’s difficulties sum up that of many of the participants:

*I:* Have you ever had a time when you haven't had enough money to be able to go to the doctor?

*A:* “Um, I’d have to say yes on that. Yeah, I have. Um, yeah, I have. Even though I wanted to go to the doctors I didn't have no money to go, um, because being unemployment, there's not a great lots of money for a person with family, so I didn’t. Then I had to borrow the money just to go and see a doctor. So I got the money to get whatever he’s going to give me, what tablets, medicine, whatever it is, so I can go see the doctor. I have got to go to a doctor where I’ve got to pay for it meself…, um, I’ve got to come up with $160, then I got told it was $60. When it was at $160 I couldn't afford that, even though I was working, as I’ve got bills to pay. I do find it a bit hard to see a doctor because the wage I’m on, um, you know like, I pay a fair bit of bills out. Um, I'd be lucky to have at least $50 to $60. I do and I’m not ashamed to admit that.”

*I:* Tell me, which is the part that is the problem. Is it the problem of paying the doctor, is it the problem of transportation, is it the problem of the money for drugs and prescriptions?

*A:* “The problem is having the money for the doctors as well as to get the scripts.”

(Aboriginal Man, Adult: 26-45 years)

Paying for service fees was even more problematic when participants had to see a specialist. In some cases this had severe negative consequences:

*I:* Has there ever been a time when you haven't had enough money to go to go to the doctor?

*A:* “Yep.”

*I:* Do you reckon most people I've interviewed, not necessarily here, but Aboriginal people would say yes to that?

*A:* “Yeah, especially if you have to go to a specialist. Specialists want money just to see them. Most specialists do require you to pay, you have to pay.”

*I:* They don't bulk bill you?

*A:* “No. They are pretty fair. I been to one a couple of weeks ago with me baby. And I said, No I haven't got enough’, and she said, ‘Don't worry. I'll fix it up.’ So that was pretty good. But I panicked. I said, ‘I haven't got it’. My little heartbeat went bump, bump, bump, bump.”

*I:* So what would you have done?

*A:* “Probably would have gone home without taking my little fella to the specialist.”

*I:* Who made the major decision that you wouldn't have to pay?

*A:* “The receptionist, because when I said ‘I didn't know’, she said ‘Don’t worry about it. I'll fix it up.’”

*I:* How much were they going to charge?

*A:* “Seventy-five dollars.”

(Aboriginal Woman, Adult: 26-45 years)
A: “When I was burnt I had to go to the specialist and he demanded to have a $100 fee up front, which I didn't have. So I couldn't go to see him. I asked him if I could pay it off and he refused to let me. So I had to not go.”

I: Where was the burn?
A: “All down the side of my body and on my face.”
I: So what did you do?
A: “I went home and cried. And I ended up ringing up the doctor [at Tharawal] and I said, I explained to them what happened. They got on to, um, my doctor that I had seen about my burns and you know they got a referral to one that, you know, would let me pay it off. But I mean that took a matter of four weeks before I could get in to see him. You know, so that was a long time for me to wait.”

( Aboriginal Woman, Senior Adult: 46+ years)

Thus, it is not surprising that there was a mixed reaction to the question: “Are you concerned about the billing arrangements when you ring up to make an appointment?” Seventeen (50.0%) individuals were not concerned about this. The major reasons mentioned were that participants largely only visited medical centres that bulk-billed, that they already knew the billing arrangements of the medical centre in question, and that they were employed and thus could afford the service fee. Two (5.9%) individuals said that they were sometimes concerned, while the remaining 44.1% of individuals said that they were concerned. One individual explained how this varied depending upon where he was living at the time:

I: Are you concerned about the billing arrangements when you ring up to make an appointment?
A: “Yeah, yeah, yeah. See some of the towns don't bulk bill. Like in the country they don't bulk bill. So the only ones they bulk bill are those on the pension. But if you are on New Start, or anything like that, it means money upfront first. And then you get half that back off Medicare.”

( Aboriginal Woman, Senior Adult: 46+ years)

An Aboriginal woman said that she has telephoned medical centres to make a booking on a couple of occasions, only to find out that she would have to pay. As a consequence, she has waited until the following day and then gone to the Aboriginal Medical Service. Similarly, an Aboriginal man mentioned that he was also embarrassed to ask if the medical centre bulk-billed:

A: “No, no, no.”
I: And what about if you ring up, not Tharawal, but another place?
A: “Well I, I, I do. I sort of get a little bit embarrassed about, you know, asking them how much it is going to cost me and that, even though I, um, even though I am on Medicare, I still get embarrassed just by asking, ‘how much the consultation is going to cost me’, you know. Like the point in fact, when I was going to get my knee x-rayed and get a specialist to look at my knee, just to look at it was $95. Just to take the bandage off my knee, wiggle my leg around.”

( Aboriginal Man, Senior Adult: 46+ years)

Surprisingly, more than three-quarters (75.8%) of the individuals asked said that they usually had enough money to buy medications. An analysis of the participants’
comments revealed that these participants simply acted resourcefully by planning for such situations, or asked friends, family members, or relatives to help out:

“Well when I’ve had to, I’ve always had it.”
(Aboriginal Man, Adult: 26-45 years)

“I always make sure I do. I get it on my pension day.”
(Aboriginal Woman, Senior Adult: 46+ years)

If these means of acquiring the medications were not available to the participant, then health professionals would help out. For instance, one Aboriginal woman explained how her chemist helped her out. Similarly, five participants mentioned that their general practitioner would provide them with free medication, such as free antibiotics:

I: Do you usually have enough money to buy medications?
A: “Sometimes. I've been going to the chemist for 26 years and when I don't have the money to pay he books it. He puts it down unto I get paid the next fortnight. I go straight down and pay it. You know, it helps me a real lot.”
(Aboriginal Woman, Senior Adult: 46+ years)

I: Do you usually have enough money to buy medications?
A: “Not really. I get the medication off the doctor.”
(Aboriginal Man, Adult: 26-45 years)

I: Do you usually have enough money to buy medications?
A: “Sometimes. Not always. In Brisbane I could ring up a Brisbane medical service for Aboriginal people and obtain medication if I ran out of money.”
(Aboriginal Man, Adult: 26-45 years)

To put in perspective exactly how much of a barrier finances were, participants were asked two questions focusing specifically on their ability to pay ‘today’. As can be seen in Table 33, slightly over half of the participants did not have enough money to pay either the transportation cost to a medical service and medical service fee, or the cost of medications at a chemist. The consequences of not having enough money for health care varies substantially from individual to individual. Some participants simply accepted this, others were more resourceful, while others committed criminal acts so as to receive medical care:
“It's a thing that, that all people don't have money all the time. Um, and that's the same with black and white. Like you know. Um, if you can't make an arrangement with the service that will accept your Medicare card and with no payment, or part payment later on, you know after you have seen the doctor, you'll just have to go without the treatment. What I'm saying is that is health services decide to put a levy on every customer that they have of five dollars, well when a person get sick and they don't have the five dollars, well they can't go and see the doctor. That's it, there's no good crying about it.”

(Aboriginal Man, Senior Adult: 46+ years)

“No, go to St. Vincents. They help pay for all the prescriptions.”

(Aboriginal Woman, Adult: 26-45 years)

“No. Have to jump the train all the time.”

(Aboriginal Woman, Adult: 26-45 years)

Table 33: Ability to pay for transportation to a medical centre, medical fees, and medication costs ‘today’

<table>
<thead>
<tr>
<th>Have enough money</th>
<th>Don’t have enough money</th>
</tr>
</thead>
<tbody>
<tr>
<td>“If you needed to, do you have enough money to be able to pay for transportation to a medical service and pay the medical service fee today?”</td>
<td>18 (45%)</td>
</tr>
<tr>
<td>“If you needed to, could you pay for the cost of medications at a chemist, today?”</td>
<td>18 (47.4%)</td>
</tr>
</tbody>
</table>

What Aboriginal people think about their access to health care.
5.2 Transport difficulties

Of 47 participants who answered the following question: “Do you have transportation difficulties getting to a doctor?”, the majority (28; 59.6%) responded that they had no problems. Most of these individuals either used their own car, or asked a friend or other family member to drive them. A reason for why so many people said that they did not have a problem can be found in the fact that 28 (63.6%) of the 44 participants asked, said that they, or a close family member, had a motor vehicle. Of the 28 individuals who said they had no transportation problems, however, two said they simply walked to the medical centre. Depending upon the medical ailment, this option would obviously not always be feasible. Furthermore, 8 of the 28 individuals said they had no problems because they used Tharawal’s free transportation service. The following five quotes give an indication as to whether these eight individuals would be affected if Tharawal stopped providing this service:

I: Do you have transportation difficulties getting to a doctor?
A: “Um, no. Um, personally no.”
I: So how do you get there?
A: “The local medical centre they’ve got a shuttle service, or, ah, drivers to pick you up, or to pick me up, go to the doctors and drive me back home. Um, which is a pretty good service.”

(Aboriginal Man, Senior Adult: 46+ years)

I: Say you had to go to the doctor today, how would you get there?
A: “Ring up Tharawal, ring up Tharawal.”
I: Do you have a car?
A: “No.”
I: Do you use public transport much?
A: “Only every fortnight when I go to put my form in.”

(Aboriginal Man, Adult: 26-45 years)

“No. Tharawal drive me. Actually they have been excellent.”

(Aboriginal Woman, Senior Adult: 46+ years)

A: “Not with Tharawal.”
I: And the reason for that is?
A: “Because when you have got your appointment booked, they usually ask you if you want a lift.”
I: And how many times would you use their services?
A: “I only use it if it is a really cold day, or rainy and that, but usually I walk.”
I: Just so I understand, how far do you come from?
A: “Just around the corner.”
I: If Tharawal was closed, would you have transportation difficulties then to get to the doctor?
A: “Um, not really, because we’ve got a car at home, but I don’t drive, but someone is always there.”

(Aboriginal Woman, Young Adult: 16-25 years)
“No. I usually ring Tharawal and they usually [come] and get me to xxxxx, but you’ve have got to ring them the day before. And to book it in the day before.”

(Aboriginal Woman, Senior Adult: 46+ years)

Sixteen (34.0%) individuals said they had transportation problems and a further three (6.4%) sometimes had problems. These individuals usually mentioned having to walk a long distance. Examples from two participants indicate the problems some individuals faced:

A: “Yes.”
I: So how do you get to the doctor?
A: “Sometimes, because I live over xxxxx (approximately 6 kilometres away) and I come here [Tharawal], because they have got me on the books and that, sometimes when I have no money I’ll walk here.

(Aboriginal Man, Young Adult: 16-25 years)

“If it wasn't to my local GP, yes because I have a disabled son.”

(Aboriginal Woman, Adult: 26-45 years)

Such problems would be compounded for those individuals where the public transport system did not go near either their home and/or the medical centre they usually go to. The following two participants note difficulties in the public transport system:

“Where the hospital is situated, where the bulk of the Aboriginal community is, is two buses away, two different buses, or a 5 km walk. The 5 kilometres is nothing if it was straight going, but it's not, it's very, very steep hills. You know, you have to walk down a kilometre and a half of a major artery, like you know; which is Campbelltown Road to that hospital… Transportation for everyone in this area getting to the hospital and back is a worry. It's a time-consuming thing.”

(Aboriginal Man, Senior Adult: 46+ years)

“Yes, but the length of time you have to wait between buses is a problem.”

(Aboriginal Woman, Senior Adult: 46+ years)

Nevertheless, it should be stressed that almost all (86.1%) the individuals that were asked, mentioned that the public transport system did go near both their home and the medical centre they usually go to. For instance, one Aboriginal woman explained how all she had to do was walk 100 metres from home to the bus stop and a further two minutes to the doctor’s surgery once getting off the bus.

Some readers might conclude that transportation is not a substantial access barrier for Aboriginal participants in this study because 59.6% of the individuals asked said that they had no transportation difficulties getting to a doctor, 63.6% of the individuals asked said that they or a close family member had a motor vehicle, and 86.1% of the
individuals asked said that the public transport system went near both their home and the medical centre they usually go to. Unfortunately, such a conclusion is too simplistic. As was noted in Section 5.1, over half the individuals asked said that they did not usually have enough money to pay for transportation to a health care facility. Furthermore, if the 2 individuals who state that they walk to the medical centre and the 8 individuals who use Tharawal’s transportation service are not counted, then slightly more (19) participants have transportation problems than don’t (18). Some readers might feel that removing the 8 individuals who use Tharawal’s transportation service from the analysis is unwarranted as: (1) the service is available, and (2) these participants mentioned that they had no transportation difficulties, however, a substantial number of participants mentioned that they either did not use the service because they found it less than reliable and desirable, or they used it and had to suffer the consequences. Using the service also places a barrier on what general practitioner the participants can visit, as the service will only take patients a certain distance. The following four individuals comments indicate the extent of feeling on this matter:

I: Do you use Tharawal’s transportation services often?
A: “No, they are slack on the transport.”
(Aboriginal Woman, Young Adult: 16-25 years)

I: Do you use Tharawal’s transportation services often?
A: “Sometimes, but their service is not crash hot… Not very often, because they’re not very good. They, um, sometimes they forget to come and pick you up. Other times, um, like when I need to get down and about… I’ve waited all day and I end up ringing and saying, ‘what the hell is going on?’ ‘Oh we forgot about you.’ And then other times they are so busy, because there's not enough transportation there to take everyone around to where they want to go, or where they need to go.”
(Aboriginal Woman, Senior Adult: 46+ years)

I: Do you use Tharawal’s transportation services often?
A: “No. They’re xxxxx [profanity]. Can’t keep appointments.”
(Aboriginal Woman, Young Adult: 16-25 years)

I: Do you use Tharawal’s transportation services often?
A: “No, never have. Never will, as they are too grumpy. Thus I just walk.”
(Aboriginal Man, Young Adult: 16-25 years)

Thus, transportation is a barrier that a significant number of Aboriginal individuals in the area have to overcome to receive adequate health care.
5.3 Telephone booking difficulties

Prior to beginning the interviews it was hypothesised that some Aboriginal participants would have difficulties making telephone bookings for medical appointments. Thus participants were asked: “Do you have difficulties making a phone booking for a medical appointment?” As a consequence of this line of questioning, a separate barrier to accessing health care was uncovered. Many of the participants mentioned that they either did not have a phone, or that they could only receive calls and not make calls out. To assess how extensive this barrier was, 15 participants were asked whether they had a telephone at home and whether they could make calls out, or whether they were restricted to only incoming calls. Four (26.7%) of these individuals did not have a telephone at home and five (33.3%) had a phone at home, but could only receive incoming calls. Thus, less than half (40%) had access to a telephone at home with which they could make telephone calls with.

Disregarding the fact that most participants probably did not have a telephone at home, 40.4% of individuals said they had (and 4.3% said they sometimes had) difficulties making telephone bookings for a medical appointment. The major difficulty expressed was one of feeling uncomfortable talking on telephones:

“Sometimes if I’ve got someone to do it, I’ll get them to do it, because I just don't like talking on the phone.”
(Aboriginal Man, Adult: 26-45 years)

A: “Um, no.”
I: What are you like on the phone? Are you nervous and jittery and all that?
A: “Yeah, yeah.”
I: So do you make the appointments yourself, or do you get other people to do it for you?
A: “Um, I get me, me sisters normally do it. But sometimes if I get brave enough, I'll do it, but other times my sister will do it.”
(Aboriginal Woman, Adult: 26-45 years)

“Sometimes. It depends upon what I’m ringing up for. I mean, they don’t know, but I know and I’m embarrassed and, you know, I get nervous and it takes me awhile to get to that phone and build up that courage to make it.”
(Aboriginal Woman, Young Adult: 16-25 years)

Thus, it is not surprising that a significant (28.3%) number of individuals prefer to simply turn up and wait for medical appointments, rather than make a telephone booking ahead of time. Although one of the reasons expressed for this action was unease while speaking on telephones, the majority of individuals who preferred to turn up said that this was because of convenience factors and that they just happened to be there. The researcher also got the impression that some participants did not like the restriction that an appointment time creates, however, no participant specifically stated this.
It is important to emphasise, however, that slightly more than half the individuals asked said that they would ring up to make an appointment. Since it can be assumed that the majority of individuals do not have a telephone at home, making telephone calls requires some individuals to use a neighbours or public telephone. Thus, if they are willing to go to such trouble, then obviously for at least half of the participants, making telephone calls is not a barrier to health care. This conclusion is further supported by the fact that the majority (56.7%) of individuals do not get other people to make phone bookings for them. Individuals who did mention that they sometimes asked other people to make medical bookings for them indicated that this was largely due to practical reasons such as being very unwell, lacking money, or medical receptionists making specialist and dental appointments. The few that said they always got someone else to ring up for them invariably mentioned that this was because they had difficulties at times understanding receptionists:

I:   When you ring up to make an appointment at a new place, that you have never been to before, will you ask them on the phone, how you have to pay?
A:  “Yeah, I do. Um, I get the Mrs to do all that for me. Um, I don't mind talking on the phones, or ringing people up, but it's, sometimes I can't understand what they mean by, you know. I can't understand what they are saying to me sometimes. So I get the Mrs to do all that.”
(Aboriginal Man, Adult: 26-45 years)

Unfortunately, there were a few (15%) individuals who, even if they had a telephone at home, would not use the telephone to make a booking to see a doctor, but would rather wait until someone came to their home to visit. Then they would ask the visitor to make the booking for them:

A:  “Yes.”
I:  Do you reckon a lot of Aboriginal people do that?
A:  “Yeah. There's a few around, yeah. I know a couple, a few times, they ask me, and I said, ‘I don't like doing it either. ‘You do it. I'm not going do it.’ I've been to frightened to do it too’.”
I:  Tell me, why is it you don't like doing it?
A:  “I don't know.”
I:  Is it because the people you will be speaking to will not be Aboriginal?
A:  “No. I get shame and talk upside down some time you know. Frightened. And then I'll get mucked up with the words and then I'll say the wrong thing.”
(Aboriginal Man, Adult: 26-45 years)

A:  “Yes.”
I:  Have you done that more than once?
A:  “Yes. Quite a few times actually.”
(Aboriginal Woman, Senior Adult: 46+ years)
5.4 Communication difficulties

It was hypothesised prior to conducting the interviews that some participants would have difficulties with various aspects of communicating. Thirty-one individuals were asked: “Do you have difficulties understanding the receptionist?” Of these individuals, 16.1% had difficulties and a further 16.1% had difficulties sometimes. Some of these difficulties surrounded understanding the information content:

A: “Yeah a bit.”
I: Tell me about that?
A: “Say they say a word that I don’t understand, or don’t know about either and I just wouldn’t know what they are talking about. Then I’ll just ask them, ‘what does that mean?’”
(Aboriginal Man, Young Adult: 16-25 years)

The largest difficulties, however, surrounded the receptionists’ speaking pattern and accents:

“Yes, depends upon their accent.”
(Aboriginal Woman, Senior Adult: 46+ years)

“Just depends on what country they are from, if they speak mumble and that.”
(Aboriginal Man, Young Adult: 16-25 years)

“Sometimes. If they are Chinese or something, you know, you have to get them to repeat their questions.”
(Aboriginal Man, Adult: 26-45 years)

The number of participants who had communication difficulties with doctors was relatively the same number as those who had language difficulties with receptionists. For instance, thirty individuals were asked: “Do you have difficulties understanding the doctor?” Of these individuals, 23.3% had difficulties and a further 20.0% sometimes had difficulties. The difficulties encountered were exactly the same as those posed by the receptionist: not understanding the information content, the doctors’ speaking pattern (e.g., mumbles, talks too softly, does not speak clearly) and accents.

Written communication skills were also assessed by asking 44 participants: “Can you read okay?” The vast majority (70.5%) of these individuals said that they could read. It is worth noting that of these 31 individuals who said that they could read, 12 (38.7%) mentioned having eyesight problems.\(^\text{29}\) Unfortunately, a sizable number

\(^{29}\) In fact, it is likely that the percentage of participants who had eye sight problems was actually higher than 38.7% as this ailment was not probed for.

What Aboriginal people think about their access to health care.
(22.7%) of individuals stated that they could not read ‘okay’ and a further 6.8% said that although they could read, they had some problems:

I: Can you read at all?
A: “No. Oh, I can read a bit to the, I can only read a bit to what I know of, you know.”

(Aboriginal Man, Adult: 26-45 years)

A: “Yeah, Yeah. I’m not the best at whatse, but yeah, I can read.”
I: So you can read basic things from the newspaper?
A: “Oh yeah, yeah, yeah, yeah. Only big words I get a bit stuck with.”

(Aboriginal Woman, Senior Adult: 46+ years)

I: What’s your reading like? Can you read okay?
A: “I get by.”
I: So if I was to turn this around and show you this, do you think, do you think you could read most of that?
A: “Some of it, yeah.”
I: Can you read a newspaper?
A: “Um, I pick up, when I, when I, when I feel like reading. I might read a bit and then if I can't read the rest, I’ll skip on to something else.”
I: ... We were talking about reading and you said that you sometimes do take people along?
A: “Yeah me husband. To every appointment.”
I: And you do that because?
A: “To fill out the forms. To read them.”
I: And you reckon a lot of Aboriginal people would be like that?
A: “Yeah.”

(Aboriginal Woman, Adult: 26-45 years)

The last Aboriginal woman quoted above actually felt that there were Aboriginal people who would not go to the doctors because they were embarrassed by not being able to write and that they would have to do fill out forms. The most disappointing aspect is that there appeared to be no improvements in the ability to read. There appeared to be an equal percentage of Aboriginal participants who could not read ‘okay’ in each of the three age categories. This trend is unlikely to be reversed quickly as the Australian Bureau of Statistics (1996b, p. 14) has noted that “most indigenous 15 to 24 year-olds (57%) had left school at Year 10 or earlier.”

To get a clearer picture of the practical ramifications of the participants’ abilities to read, 29 individuals were asked: “Do you have difficulties reading the yellow pages to find the doctor’s telephone number?” Six (20.7%) stated that they had difficulties and an additional participant mentioned that she found the print difficult to read because it was too small and thus she needed to use her glasses. Similarly, 29 participants were asked: “Do you have difficulties reading health pamphlets?” Five (17.2%) individuals stated that they had difficulties, two (6.9%) said they sometimes had difficulties and an additional participant mentioned that she found the print difficult to read because it was too small and thus she needed to use her glasses.

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What Aboriginal people think about their access to health care.
5.5 Time of appointment difficulties

McInman (2000) noted a potential health care access barrier. One of the twenty receptionists he interviewed believed that Aboriginal patients never attended her medical centre early in the morning. Thus participants were asked: “What time of the day do you normally visit a doctor?” Fifty participants provided meaningful responses to the question. Six (12%) individuals noted that this varied substantially, while another two (4%) individuals mentioned that it varied with the seasons:

“It depends if it is winter or summer. If it is winter then I leave it till the middle of the day. Summer I just go early in the morning.”

(Aboriginal Man, Adult: 26-45 years)

The most common time, mentioned by 20% of the participants, was between 10am and 11am. Apart from 3 (6%) individuals who mentioned that they would go any time necessary and 3 (6%) individuals who said that they would attend whenever the receptionist could ‘fit them in’, the remainder (52%) ranged from early morning to late afternoon.30

Of the 28 participants who provided meaningful answers to the question: “Do you ever have an appointment to see the doctor early in the morning, e.g., 9.00am?”, nearly one in every five (17.9%) said that they would not attend at this time. The major reasons cited for this were that the family came first, that they did not like to rush and they did not get out of bed early enough to go early in the morning:

A: “No, not really.”
I: Why not?
A: “Don’t know. Just so, I’ll get around there about 10 – 10 o’clock, ah, 11 o’clock, you know, before lunch, or something.”

(Aboriginal Man, Young Adult: 16-25 years)

“I: What time of the day do you normally visit a doctor?
A: “Early. Get it over and done with.”
I: What time is early?
A: “11.”
I: Do you ever get here at 8, 9 o’clock?
A: “No. I’d be just getting out of bed.”

(Aboriginal Woman, Adult: 26-45 years)

30 The range of times from early morning to late afternoon largely depicted a normal bell-shaped curve with 5 individuals saying they would attend in the early morning, increasing to 10 between 10am and 11am and then decreasing to 2 in the late afternoon.
Even individuals who said that they had actually been to a doctor early in the morning mentioned this last reason, not being able to get to the doctor early due to still being in bed:

“No, too early for me bro, unless it was serious. Depends really.”
(Aboriginal Man, Young Adult: 16-25 years)

Some readers may feel that if 82.1% of the participants were willing to go to a general practitioner at approximately 9.00am, and at least 10% of them choose it as their preferred time slot, then maybe appointment times are not in fact barriers for these participants in terms of accessing health care. Further probing of this issue, however, suggests that for many Aboriginal people arriving early in the morning for medical appointments is not an option. At no time did any participant mention that opening hours should be extended.\(^{31}\) Thus, the practical ramification of this finding is that health care professionals working with Aboriginal patients must appreciate that the bulk of their appointments will be in the middle of the day. This has obvious implications for the quality of service that can be provided if a high volume of people are attending only in a relatively short period. The following six quotes testify to the legitimacy that appointment times are an unfortunate barrier for some Aboriginal people receiving quality health care:

I: What time of the day do you normally visit a doctor?
A: “In the afternoon.”
I: What's the reason for that?
A: “There is too many seeing him in the daytime, between 8.30 and 12.30.”
I: Have you ever been to a doctor early in the morning, like 9 o'clock in the morning?
A: “No.”
(Aboriginal Woman, Senior Adult: 46+ years)

I: In the last study that I did, I found that the receptionists were saying we never see Aboriginal people turn up early in the morning. Any ideas why?
A: “Um, they're probably, despite how sick they may be, they probably have other things to do. Like getting kids to school, um, cooking or whatever, um, transportation, um.”
I: Would that not be the same for non-Aboriginal people?
A: “Um, no. I think, um, a lot of the time, that, um, non-Aboriginal people would put themselves first… I would also think, well I am not going to go at 8 o'clock in the morning, because of all the people going to work. The last thing I am going to feel like doing is being pushed and shoved around on buses, or trains, or whatever. So I would tend to wait until the rush is over.”
(Aboriginal Man, Adult: 26-45 years)

“I know that in my situation, if, if, if I’ve, if I’ve got to be there say half past nine, or 10 o'clock, or, my priority is not for me to get there at 9 or 10 o'clock. My priority is to get my kids to school, get my kids to school, um, go home and help with the housework, then if I've finished before five to nine, then I have got five minutes to go where I’ve got to go, to the doctors. Um, I’ve still got an hour to play with, you know.”
(Aboriginal Man, Senior Adult: 46+ years)

\(^{31}\) One individual did mention this later on in the interview (see Section 6.5 and Appendix 7).
I: What time of the day do you normally visit a doctor?
A: “Um, well it all depends. It all depends. Well if I can get out of bed; if I’m sick and I can get out of bed, I’ll go during the day. But if I can’t get out of bed to go see the doctor, I’ll wait until the night.
I: Would you ever go at 8.30, 9 o’clock in the morning?
A: “Yeah, I’ve done that. Only for, only for, only for my blood tests. That’s the only time.”
I: That last study I did with receptionists I told you about. One of the results I learnt was that they told me that they never see Aboriginal people turn up early in the morning, at 8.30 in the morning. Do you reckon that would be right?
A: “Well I don’t know, I don’t know. Well myself I don’t know why they don’t show up, why she said that in the first place anyway, because I don’t think any the Aboriginal people would want to go that time in the morning. Even if they have got an appointment, they sort of want to wait… It’s too early, they can’t be bothered getting out of bed, and getting themself to the doctors, you know, that’s them. But if it was me, I would have been out of bed, and I would have been there, you know. Um.”
I: So you think it’s quite likely that a lot of Aboriginal people don’t go early in the morning?
A: “Yeah, 9 out of 10 times most of them, yeah, I have to say that, because I’ve never seen, I’ve never seen any Aboriginal person go to a doctor that time in the morning.”
I: See it’s important because we are trying to find out what are the barriers that makes it harder for an Aboriginal person to go see a doctor. Now if Aboriginal people simply can’t get out of bed early and medical centres close at 5 o’clock, it means that there is less time in the day for an Aboriginal person to go see a doctor. So one of the findings we may come out with is that doctors centres actually need to stay open later so that Aboriginal people can get in there [interrupted by Interviewee]?
A: “It’s not that the doctors got to stay open later, it’s for the Aboriginal people to get off their butts and get in and see that doctor on like just normal, normal hours, you know.”
I: And how do you do that?
A: “They just got to do it mate.”
I: How do you get people to do that if a number of Aboriginal people don’t think a lot about their health [interrupted by the Interviewee]?
A: “Well if they are not concerned about their health and whatever else, what’s the point in going to the doctor? You know?… See a lot of Aboriginal people don’t like helping themselves. They don’t like getting out of bed. Right, because they’re nice and warm. This is what it is. It can be winter, it can be summer, um, but as I said they’re nice and warm in that bed. Even when they are sick and they know that they’re sick and they know what time the doctor and all that closes and opens, they’re not going to get out. At the earliest it’ll be 10, 11 o’clock. 11 o’clock will be the earliest for them to go see the doctor, because they're rugged up, had a shower, rugged up, nice and warm. You know. But like I said, they got to learn to, they got to learn to pull their weight as much as the doctors, you know. Well, like, um, the doctors close at this time, so you got to get there before that doctor goes home.”
I: Imagine if most of the people I interview believe like you that the answer is for Aboriginal people have to ‘get off their butts’ as you put it. We are trying to make this study practical and useful. So how do we help Aboriginal people ‘get off their butts’?
A: “Yes, that's a question, that's a question that everybody's got to answer, eh. You know, that's a hard question. Get the doctor there. Do house calls.”

(Aboriginal Man, Adult: 26-45 years)
I: *What time of the day do you normally visit a doctor?*
A: “Well, it all depends on when you’re sick. Um, like sometimes I have had to go see a doctor in the middle of the night because one of my girls was sick. So there’s not really a time.”

I: *Would you ever go at 8 or 9 o’clock in the morning?*
A: “Um, I’ve got a specialist appointment.”

I: *In the last study I did, receptionist told me that Aboriginal people do not turn up in the morning. Do you agree with that?*
A: “Oh yeah, sometimes.”

I: *Or do you think that’s rubbish?*
A: “It all depends on who they are, because I know for a fact that sometimes, a lot of people won’t turn up for their appointments early in the morning.”

I: *Why is that?*
A: “Because they have either forgotten about it, or, um, got on the grog the day before, or they are still on the grog.”

I: *Any other reasons?*
A: “Like, I know there’s been a lot of young parents that can't come early in the morning because of their commitments to their children. They had to get their children off to school.”

(*Aboriginal Woman, Adult: 26-45 years*)

I: *What time of the day do you normally visit a doctor?*
A: “In the morning, about 11, 10 or 11.”

I: *Do you reckon that you have ever been to the doctor at the 9 o’clock in the morning, or earlier?*
A: “No.”

I: *Why not?*
A: “Because I'm not fully, um, functional, I'm just, I'm still sort of, if I have to get up early, you know, I don't really want to listen to people, especially if it's a doctor, because I have to get up early for them.”

I: *I have recently completed a study with medical receptionists and found that they never see Aboriginal people early in the morning at their medical centres. Why do think that is?*
A: “Just lazy I guess, I wouldn't know. I'm mean my personal reason is because if I don’t get a good sleep and I get up and I have to go to the doctor, I don't really want to be there in the first place. Um, I don't really want to hear what they have to say, but I know I have to, you know, but I’m not concentrating.”

(*Aboriginal Man, Young Adult: 16-25 years*)
5.6 Difficulties using bush medicine

The majority (80.8%) of individuals asked (n=26) said that they had not used bush medicine at the same time as western medicine. Some individuals freely noted that they would not want to use both at the same time due to the possibility of unforeseen interactions between both drugs. However some individuals, when questioned directly about this, did not think such interactions were possible. For instance, one young woman said she used antidepressants at the same time as using lavender oil.

Most (65%) individuals have never told a doctor that they use bush medicine. Typical reactions were that they did not think it would be necessary to tell a doctor, and that bush medicine should be kept secret to only Aboriginal people:

I: If you went to a doctor, would you tell him that you use bush medicine, or would you not tell them?
A: “I’d keep it quiet.”
I: Why is that?
A: “Like, the gubos medicine, right, most of it is mainly drugs and codeine, but with bush medicine it is pure. It’s better than what the doctor is going to give you.”
I: But why wouldn’t you tell the doctor?
A: “Why wouldn’t I tell him. Like it's our secret.”
I: You might not tell him what you're used, but would you tell him that you’ve used something and just not tell him what it was? Or would you not tell him even that?
A: “I wouldn't even tell him that, no. Keep it secret.”
I: Why not?
A: “Ah, xxxxx, I don't know, I just wouldn't tell him.”
(Aboriginal Man, Adult: 26-45 years)

The majority of individuals who have told a doctor that they use bush medicine stated that the doctors’ reactions have been less than favourable:

A: “Yes.”
I: What was the reaction?
A: “Their reaction was ‘it’s very dumb.’ Another doctor said, he believes some of the bush medicine was very good.”
(Aboriginal Woman, Senior Adult: 46+ years)

I: Have you ever had a time when you told the GP that you have used bush medicine and had a bad experience by telling the doctor?
A: “…Oh, well, a couple of times I have [gone to the doctor] and they said what have you been doing about it? And I have told them [that I used bush medicine] and they have said ‘maybe you should’, not cut that out, but sort of ‘lessen that, but try this [Western medicine]. This will work.’ So I don't think that they believed it [bush medicine] would work.”
(Aboriginal Man, Adult: 26-45 years)
The reluctance of telling doctors about using bush medicine did not appear to be related to perceived likelihood of being punished. For instance, two-thirds (66.7%) of the individuals questioned (n=15) felt that they would not be punished by non-Aboriginal authority figures if they stated that they used bush medicine. Similarly, 64.7% of individuals asked (n=17) did not think that if a person was using bush medicine and they were also going to a doctor and the doctor found out, that the doctor would “give them a hard time.” Typical reactions were that it was none of their business, that they did not have the right to, and that doctors and non-Aboriginal authority figures would not understand. In fact, they really had difficulty understanding why they would be punished:

“I mean just the word punished. What is anybody going to do to me?”
(Aboriginal Man, Adult: 26-45 years)

Two other participants’ comments further show how most individuals did not see punishment as a likely scenario:

“No, because that has been around for thousands of years, hasn't it, the bush medicine. The real outback black fellas still use it nowadays.”
(Aboriginal Woman, Senior Adult: 46+ years)

“No as a matter of fact pharmacists are starting to introduce the substances from our bush medicines into their drug companies.”
(Aboriginal Man, Senior Adult: 46+ years)

A few people felt that they would be punished in such circumstances. One of these individuals suggested that they would get punished because:

“Some, some would because some of those items, Aboriginal bush medicine, are an illegal drug, so there could be legal repercussions from that.”
(Aboriginal Man, Senior Adult: 46+ years)

One barrier Aboriginal participants possibly face in telling doctors that they use bush medicine is a perception they have that western trained doctors do not understand bush medicine. For instance, of 25 participants asked: “Are there western trained doctors who understand bush medicine?”, only 4 (16%) felt they did, one (4%) felt Asian doctors might, one felt (4%) a very few might, and three (12%) said ‘maybe’. Some typical comments follow:

“No. They are all by the books and what the books say. I think insurance wise they got to do it that way to.”
(Aboriginal Man, Adult: 26-45 years)

“No. Maybe Asian ones would be as they’re into herbal things as well.”
(Aboriginal Woman, Adult: 26-45 years)
“Not really. Black South African doctors to.”
(Aboriginal Woman, Senior Adult: 46+ years)

“Don’t know. Never come across one. The two up north, yes, they understand the Aboriginal people, especially one of them.”
(Aboriginal Woman, Adult: 26-45 years)

A: “Out at the communities you don't tend to have doctors. You have nurses. Um, and, um, up north nurses and health care workers whose roles are a lot different to, sort of urban places, in that they do do a lot more. Now the nurses, um, what I found, those who have been out at the communities for a while, um, some of the women have let them in on, you know, a few different treatments and they are quite happy to go along with that, um, you know, in conjunction With European medicine.”

I: Could you see the day when bush medicine is a bit more accepted with Western-trained doctors?
A: “Um, I only see it is being supplementary to, um, I don't think society is ready to, sort of, um, take it on. There are some things like, um, the Asian, um, methods in healing practices. Even that is not fully accepted. Even though, you know some of the practices, acupuncture and that type of thing, um, is gaining more recognition. I don't think it is accepted by some people, or a lot of people.”
(Aboriginal Man, Adult: 26-45 years)

Thus, even if all these participants were considered to believe that western trained doctors are knowledgeable about bush medicine, they still only make up approximately one third of the individuals asked. Because, as noted in Section 3.3 (Bush medicine usage), 39.5% of individuals asked said they used bush medicine, it can be assumed that some of these people will not tell their general practitioner. Depending upon what bush medicine the individual is using and what medication the doctor prescribes, there is the possibility of a deleterious drug interaction. Thus a practical outcome of this study is that general practitioners in the area should take into consideration that some of their Aboriginal patients may be using bush medicine and if they are about to prescribe a medication, they should ask whether or not their patient in fact is using bush medicine. As almost four in every ten participants said they used bush medicine, another practical outcome of this study would be for general practitioners who work in the area to receive some education about bush medicine if they are not already familiar with the practice.32

General practitioners considering doing some education on bush medicine would be heartened to learn that of the 28 participants asked: “Would you ever go to a doctor specifically to discuss bush medicine?”, 7 (25.0%) individuals said they would and one (3.6%) individual suggested she might. Thus their education has the potential to be rewarded as one participant indicated:

32 Individuals interested in a simple, but contemporary, introduction to Aboriginal bush cooking are directed to Palmer (1998).
I: Would you ever go to a doctor specifically to discuss bush medicine?
A: “Yes.”
I: Why?
A: “Ask about how made, why it has been brought out now when it’s been around when I was little.”

(Aboriginal Woman, Young Adult: 16-25 years)

It should be pointed out that although complementary medicine is presently receiving favourable press (Drew, 2000; Easthope, et al., 1999; Eastwood, 2000; Pirotta, et al., 2000; Sharma, 1992), traditional Aboriginal bush medicine was perceived by the participants as less well received. Thus, many participants are very unlikely to visit a doctor solely about bush medicine:

I: Would you ever go to a doctor specifically to discuss bush medicine?
A: “He’d have to be Aboriginal.”
I: Would you ever do it?
A: “Just to see about it.”

(Aboriginal Woman, Adult: 26-45 years)

“No not really. I like to keep all that to myself. I mean that's how kooris are.”

(Aboriginal Man, Adult: 26-45 years)

“Probably not, as he would have to know about it.”

(Aboriginal Woman, Adult: 26-45 years)

“No. It’s past that. Times have changed and I don’t think you can go back, although some scientists are now looking at it.”

(Aboriginal Woman, Senior Adult: 46+ years)

This author suggests that Aboriginal people might be more willing to discuss their bush medicine usage with health professionals if such professionals were to follow some of the advice of Ernst (2000) concerning herbal medicine. Ernst (2000, p. 396) suggests that:

“As more and more herbal medicines are being used by more and more people, doctors should consider changing their often negative attitude towards them. Doctors, pharmacists, and other healthcare professionals need to be knowledgeable to advise their patients responsibly… Doctors also have to realise that detailed questions about the use of herbal drugs form an essential part of taking a medical history. Finally, doctors should monitor the perceived benefits and adverse effects of self prescribed herbal treatments consumed by their patients and bear in mind the possibility of herb-drug interactions. The minister for public health has emphasised the need for better protection and information for the public on herbal medicines, and doctors should take an active part in this process.”
5.7 Shame

I: Do you simply not make phone bookings to see the doctor, but rather wait until someone comes to your home to visit, and then ask them to make the booking for you?
A: "Yes."
I: Do you reckon a lot of Aboriginal people do that?
A: "Yeah. There's a few around, yeah. I know a couple, a few times, they ask me, and I said, 'I don't like doing it either. You do it. I'm not going do it. I've been too frightened to do it too.'"
I: Tell me, why is it you don't like doing it?
A: "I don't know."
I: Is it because the people you will be speaking to will not be Aboriginal?
A: "No. I get shame and talk upside down some time you know. Frightened. And then I'll get mucked up with the words and then I'll say the wrong thing."

(Aboriginal Man, Adult: 26-45 years)

A: "The reason why they say shame. Like, my own mother wouldn't even talk about what happened in the past and that, because it's a shame for a young girl to be raped at thirteen by a policeman and things like that. Things been done to them and they don't want to repeat it. Now that's a big shame. And they don't want nothing like that to happen to us. Do you understand?"
I: Do a number of Aboriginal people feel shame and therefore don't go to a doctor?
A: "Oh yes. A lot of them don't like going to doctors. The shame, because they just don't like, um, because of the experience that they had when they were younger, you know. And that's more or less scaring them. Even my own mother wouldn't go. They would rather die first, than go. Or near death. And that's family round. And I find that with a lot of them."

(Aboriginal Woman, Adult: 26-45 years)

Of all the potential or actual barriers to accessing medical facilities focused on in this study, the one that had the biggest impact was one not originally expected. During the course of the interviews, the researcher would often hear the word shame mentioned without probing for it (like in the first quote above). It became increasingly obvious that some participants would not access such services readily, if at all, even if all the other barriers were eliminated (as noted in the second quote above).

Due to the substantial impact shame has on preventing some Aboriginal people accessing health care facilities, it is important to understand exactly what it is. Potter-Efron (1989, p. 1-2) defines shame as “a painful state of awareness of one’s basic defectiveness as a human being.” Primary feelings of shame include identifying as inadequate, deficient, worthless, exposed, disgusting, and/or disgraced.33 Shame is so painful because it involves the individual’s total self image;

33 The make-up of shame is not uni-dimensional. Instead, cross-cultural research has shown that shame varies in its emotion-eliciting situations, causality attributions, reported physiological symptoms, and expressive reactions between cultures (Wallbott & Scherer, 1995). For instance, there are 5 distinct forms of shame in Chinese language and culture and Americans are capable of experiencing these, albeit artificially in research laboratory conditions (Frank, Harvey, & Verdun, 2000).
their central identity; their whole self. At the extreme, “a shamed individual questions the reason for his life, often finding no justification for his existence. He believes that he is less than fully human” (Potter-Efron, 1989, p. 5). A good example of how one of the participants, at an earlier stage in their life, felt that they were not fully human, is presented below. The participant also indicates how such a view had implications on their health:

“I have on occasions turned around and walked away [from medical centres], for the simple reason, I wasn't strong enough to question the attitudes of these people [receptionists]. It was inbred into me that you don't ask questions, you don't question peoples’ behaviour. You had to accept, because you had no authority to. You know up until 1970 something, we weren’t people, for Christ's sake, and for those people who did question, and if you made it,… you were called half-castes. You were questioned about your birth. And if the dirt wasn't there, they’d delve into your parents bloody past. Any thing to shut you up. And that was basically the aim.”

(Aboriginal Man, Senior Adult: 46+ years)

Such feelings can be triggered by unexpected, possibly trivial events (Kaufman, 1980). They usually are followed by both strong physiological (face blushes, eyes look down, stomach churns, knees weaken) and affective primary responses (“I am worthless”, “I am nobody”, “I am nothing”). What causes the shame experience to have such a strong impact is that the individual experiences a ‘double blow’. Not only do they view themselves as having negative qualities (the central characteristic being a sense of failure), but they also feel their inadequacies are completely exposed. Often times, such individuals will magnify their slightest flaws and/or feel as if anyone can see right through them. This leads to feelings of increased vulnerability and in some cases ‘paralysis by shame’.

Certain individuals are more prone to experience shame (Hoglund & Nicholas, 1995). Children who have been taught, both verbally and non-verbally, how, when, and where they can receive attention, will learn that they will not always be the centre of everyone’s attention, but that they do have a valuable place in the world. However, children who are brought up in an environment devoid of positive attention and who receive messages that they are no good, or not good enough, will tend to internalise their parents’ disapproval (Fossum & Mason, 1986) and are more likely to develop feelings of shame (Kaufman, 1980). Such viewpoints were echoed in some of the participants’ comments:

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34 An example of such a trivial event occurred during the data collection phase of this study. The researcher interviewed an Aboriginal man on the front steps of his house. At the completion of the interview, the researcher mentioned to the participant that he couldn’t help but notice that there was someone else at home and asked whether the participant would mind asking the other individual if they would like to participate in the study. After going inside to discuss this with his sister, the participant came back and informed the researcher “she has shame” and thus did not want to participate. The researcher then inquired whether what the participant really meant was that his sister felt ‘shy’, not ‘shame’. The participant was adamant that what his sister had said, and felt, was shame.
A: “Um, with my upbringing, like I’ve even, I’ve, um, I actually lived on the mission all my life, school year life and moved away from there. With my son’s father we move to the town there. But, like, I’ve always, thing with myself, like, I’ve never, ever thing with pride in me, because it’s never really been, it’s never really ever been taught. I believe. I think with all the, see from our parents, you probably go back to our parents. See its probably the way they have been treated, um, and they really never had any pride… and they were treated badly. Like I didn't know all the things that Aboriginals got treated until I was in my late 30s. You know, because my parents and my grandmother never ever spoke about it, because the things that were done to them, were as I said they probably would have um, what was done to them while they were growing up and parents from that way and whatever and it’s taught in with any of us, I think. I find… I haven’t got it in me, that I feel pride… about me or friends, unless another person say it to me, you know.”

I: How do you help Aboriginal people have more pride in themselves?
A: “Well I always believe it goes back to parents. How they bring you up, is how you turn out to be.”

(Aboriginal Woman, Senior Adult: 46+ years)

It is important to acknowledge that shame should not be seen solely as a bad thing. In fact it is a “necessary aspect of the human condition” (Potter-Efron, 1989, p. 17). One reason for this is that shame helps the individual distinguish between right and wrong (Madanes, 1997). The degree to which shame is necessary varies with the culture of the society (Berganio, et al., 1997; Lutwak, Razzino, & Ferrari, 1998). For instance, in Japan, shame-prone and self-effacing behaviour tends to be given positive functional value and is actively promoted by Japanese society, whereas in the United States the exhibition of shame and the showing of one’s vulnerability, tends to be prohibited (Okano, 1994). Thus, what is critical is the level of shame that an individual experiences. Potter-Efron (1989) suggests that there is a shame/pride continuum. At one end of the continuum is overwhelming shame, which is characterised by feelings of not being as good as others, being controlled by others, and perceiving pressure to fail. Loader (1998, p. 44) notes that “too much shame results in a sense of the self as fundamentally flawed, and can lead to lifelong problems in living.” Such individuals tend to withdraw from human companionship and in cases where they cannot withdraw, they will put on a ‘mask’ to prevent others from approaching them. An example of an individual who puts on a ‘mask’ is a person who drinks to hide their shame from others (Kurtz, 1981). The relationship between shame and alcohol usage was mentioned by a number of participants:

I: A lot of people talk, especially the older ones, talk the word shame... Can you explain to me what shame means to an Aboriginal person?
A: “Oh I think what she would have meant is that shame, like in shy, but because they don't know, I think they don't know what sort of questions, they think the questions that you are going to ask is, um, questions that might embarrass them.”
I: When I went up to the men’s camp... there was another guy who said, ‘I have shame’...?
A: “Well, like, even with my xxxxx [one of her relatives], like when I said to him, I said ‘you can have an interview’, he said, ‘go away xxxxx, shame.’ It’s, it’s, I think, it’s, it’s shame and shy, they sort of, they’re shy to talk and a bit worried about what questions are going to be asked. You know, they get shame, if like you said to me, ‘[do] I drink?’ I’d feel ashamed, if I said ‘yes I do.’ Or if I used drugs I’d be ashamed that you know.”
I: Do Aboriginal people feel ashamed to go to the doctor? And is that a barrier for Aboriginal people going to doctors, because they feel ashamed more so than the general public?

A: “Probably depending upon what, what they are going for, you know. Probably a lot of them would feel ashamed if they were going to a doctor because the problem that they got is through drinking or the problem they got is through use of drugs, depending upon what drugs they were using.”

I: Do you think they would feel more ashamed, or shame, than non-Aboriginal people for those same problems?

A: “I think so. Yes.”

I: And why would that be?

A: “I’m not really sure. Um, I think because that’s what white people think we’re all about. You know and we get shame because we are admitting what they already think we’re all about. Like, you know, they don’t, they don’t sort of, um, see me, and then look at another Aboriginal person, like if they see one person drinking around the park, or using drugs or whatever, they class us all as being the same.”

(Aboriginal Woman, Senior Adult: 46+ years)

At the other end of the shame-pride continuum is overwhelming pride, which is characterised by feelings of being better than others, controlling others, and perceiving pressure to succeed. It appears that the situation is more positive for the future generations of Aboriginal people in that none of the 20 young adults in this study stated that they felt shame. In fact, many stated that they had pride in themselves:

I: When I speak to Aboriginal people who are double to triple your age they often mention the word shame… Have you got any comments about that?

A: “Um, why would they be ashamed about their health. Like, say she, say fell over and hit her head and people were around, she just would not worry about it. Like, she wouldn't worry, she’d be too ashamed to go see a doctor. Like that’s stupid man.”

I: Do you think that Aboriginal people are more ashamed about their health than non-Aboriginal people?

A: “I don't know about that one.”

(Aboriginal Woman, Young Adult: 16-25 years)

A: “Well I think a lot of Aboriginal people carry pride, but it's just the point that they think ‘there’s something wrong with me. I’m too embarrassed to say something about it. I'm too scared… Like, I think it goes along with a lot of people. Like they are too scared to know what, like if they are sick and they don't want to go to the doctors it's because, ‘Hang on, I’m scared.’ A lot of them say, ‘Oh shame I don't want to go to the doctor in case, like, he, he’s, it's stupid or, like I’m embarrassed for him to know what's wrong with me.”

I: So is it that they are scared, or is it that they feel shame?

A: “I think it goes both ways. Like some of them might feel embarrassed about it, but I think a lot of people actually get scared about what's actually wrong with them too.”

I: Have you ever felt shame?

A: “No. If anything is wrong with me, then I go straight to the doctor. Otherwise it scares me if I’ve got a problem.”

(Aboriginal Woman, Young Adult: 16-25 years)
Individuals located in the middle of this continuum are seen as humble, autonomous, and competent. An assumption of Potter-Efron’s (1989) model is that a moderate level of shame is beneficial in that it alerts individuals to the fact that there is something wrong with the relationship between the individual and their world, or in the words of Kaufman (1980), there is something wrong with the ‘interpersonal bridge’ between the individual and others (and this needs to be repaired). Thus, moderate shame can be a stimulus for individuals to improve their lives and self-concepts. An example of a participant who could be described as having moderate shame is presented below:

I: Are you embarrassed to go to a doctor?
A: “Um, like I said, it doesn’t worry me, but it’s shame for the, the rest of the Aboriginal people. They sort of, themselves ashamed to see a doctor, a different doctor if they can’t see their own colour doctor. Um, that’s what I mean by shame.”

I: Do you feel that way?
A: “To me, sometimes, sometimes I look at it that way - I do feel shame. Then other times, it just comes in me head, don’t be shame, or shy, because you have something wrong with you and you’ve got to see the doctor…”

I: Do you see shyness as the same as shame, or are they different?
A: “Um, [long pause] yeah, it’s about the same. It’s, um, shame and shy, it’s, that’s another word for Aboriginal, the way we say things, you know, language, talk, sort of thing… But to me, um, yeah, I do and I don’t, because I’ve got to see, I do get shame, or shy, as you want to put it. Um, sometimes I do look at it that way and sometimes I don’t. I try to block it out if I can, because it’s I know that I’m sick and I’ve got to see a doctor, you know.”

One reason why some of the participants have heightened levels of shame is because they cannot read and/or write well. For instance, one Aboriginal woman always brings her husband with her whenever she visits a doctor, so that he can help her fill out the forms:

I: We were talking about reading and you said that you sometimes do take people along?
A: “Yeah me husband. To every appointment.”
I: And you do that because?
A: “To fill out the forms. To read them.”
I: And you reckon a lot of Aboriginal people would be like that?
A: “Yeah.”

(Aboriginal Woman, Adult: 26-45 years)

This woman felt that there were other Aboriginal individuals who would not go to medical centres because they would be required to fill out forms and that they would thus be embarrassed because of their inability to do so. Such inadequacies strike at the very heart of shame and have powerful consequences. For instance, not only has Baker, et al. (1996, p. 329) similarly found that “patients with low literacy harbor a deep sense of shame”, but such shame is “reinforced by hospital staff who become frustrated or angry when someone cannot complete a form or read instructions” (p. 329). These authors, summarising their findings, also noted:
“Seeking medical care is intimidating for patients with low literacy because they cannot understand signs and registration forms. Many patients recounted serious medication errors resulting from their inability to read labels. To cope with these problems, the patients with low literacy rely heavily on oral explanations, visual clues, and demonstrations of tasks to learn new material. Most also use a friend or family member as a surrogate reader… Because of their shame, patients with low literacy may be unwilling to disclose their problem to health care providers, and screening tests of reading ability may be necessary to identify those who need special assistance” (Baker, et al., 1996, p. 329)

On a positive note, the conclusions of Section 4.3.1, which analysed the participants’ personal experiences with doctors, appeared to be supported by this analysis of shame. If an Aboriginal person actually makes it beyond the reception area into the doctor’s office, then the possibility of increasing shame, although real, did not appear to materialise. It appeared that doctors were doing a good job in terms of not increasing the shame felt by their Aboriginal patients. An example from the following participant reinforces this conclusion:

I: A lot of people mention the word shame, especially older people, it seems to be one reason why some Aboriginal people don’t go to doctors, is because they feel shame. Any thoughts on that?
A: “No.”
I: If someone was to ask do you have pride or do you had shame, what would you tell them?
A: “I have pride.”
I: What about most of the Aboriginal people around here?
A: “They have shame.”
I: Why do you have pride?
A: “That’s just the way I am.”
I: And why do they have shame?
A: “xxxxx”.
I: Do you think that the Aboriginal people who have shame, if they were helped to have more pride, that would help their health?
A: “Yeah. Sometimes I’m ashamed. Sometimes, but not all the times. I just feel ashamed to ask for something.”
I: Do you think it’s your right to be able to ask for these things that you want?
A: “Oh yeah.”
I: So why do you feel shame?
A: “Shame that I ask in front of other people.”
I: So if you go inside the doctor’s room, how do you feel there?
A: “Good.”
I: So it’s when there are other people around is it?
A: “Yeah.”

(Aboriginal Man, Young Adult: 16-25 years)

One of the many reasons why general practitioners may not be increasing the shame felt by their Aboriginal patients is due to the continuous education they undergo. One area that has received substantial research interest has been the relationship between shame and abuse (Alessandri & Lewis, 1996; Andrews, et al., 2000; Feiring, Taska, & Lewis, 1998; Lewis, 1998; Talbot, 1996). There has also been a substantial amount published...
about the treatment of shame (Leeds, 1998; Lega, 1993; Namka, 1995; Zupancic, & Kreidler, 1999). Therefore, it is conceivable that most doctors have learnt to treat Aboriginal patients in a culturally appropriate manner or at least in a manner that is non-threatening. The need for general practitioners to ensure that they act in this manner is especially important for two reasons. The first is because of “the constant discrimination which Aborigines have experienced” (Lippmann, 1973, p. 27). The second is because individuals who experience more shaming experiences have poorer health. For instance, Rantakeisu, Starrin, and Hagquist (1999), researching 502 young (aged 16-25 yrs) Swedish unemployed people found that:

“Results support a link between the health and social effects of unemployment, on the one hand, and the degree of financial hardship and the number of shaming experiences on the other. Unemployed subjects who suffered a greater degree of financial hardship and who also experienced a greater number of shaming experiences exhibited the poorest health, reported deteriorated health to a greater degree, experienced negative changes in their lifestyle, did less in their free time, and had lower self-confidence than did other unemployed persons. The opposite applied for those who experienced less financial hardship and less pressure in terms of experiences of shaming.”

As a number of the participants in this study were unemployed, Rantakeisu, Starrin, and Hagquist’s (1999) findings are all the more important.
5.8 Age and gender differences

Slightly over half the individuals asked said that they usually did not, or sometimes did not, have enough money to pay for transportation to a medical service. Likewise, almost half of the individuals asked said that they usually don’t have enough money to pay for the medical service fee. A major reason suggested by those who could pay was that they only attended medical centres that bulk-billed. In fact, almost three-quarters of the participants asked said they only go to a doctor who bulk-bills. Paying for service fees became even more problematic when participants had to see a specialist. In some cases this had severe negative consequences. Exactly half the individuals asked were concerned about the billing arrangements when they rang up to make an appointment. The major reasons mentioned by those who were not concerned were that participants largely only visited medical centres that bulk-billed, that they already knew the billing arrangements of the medical centre in question, and that they were employed and thus could afford the service fee. Slightly over half of the participants did not have enough money to pay either the transportation cost to a medical service and medical service fee, or the cost of medications at a chemist. The consequences of not having enough money for health care varies substantially from individual to individual. Some participants simply accepted this; others were more resourceful and went to St. Vincents for help, while others committed criminal acts (catching trains without paying) so as to receive medical care. No age or gender differences were noted.

Surprisingly, three-quarters of the individuals asked said that they usually had enough money to buy medications. An analysis of the participants’ comments revealed that these participants simply acted resourcefully by planning for such situations, or asked friends, family members, or relatives to help out. If these means of acquiring the medications were not available to the participant, then health professionals would help out. For instance, one Aboriginal woman explained how her chemist helped her by allowing her to pay the pharmacy at a later date. Similarly, five participants mentioned that their general practitioner would provide them with free medication, such as free antibiotics. No age or gender differences were noted.

The majority of individuals responded that they had no transportation difficulties getting to a doctor. Most of these individuals either used their own car, or asked a friend or other family member to drive them. A reason for why so many people said that they did not have a problem can be found in the fact that most participants said that they, or a close family member, had a motor vehicle. Furthermore, virtually all individuals asked said that the public transport system went near both their home and the medical centre they usually go to. Of the individuals who said they had no transportation problems, however, two said they simply walked to the medical centre. Depending upon the medical ailment, this option would obviously not always be feasible. Furthermore, 8 of the 28 individuals said they had no problems because they used Tharawal’s free transportation service. Unfortunately, a substantial number of participants mentioned that they either did not use the service because they found it less than reliable and desirable, or they used it and had to suffer the
consequences. Thus, if the 2 individuals who state that they walk to the medical centre and the 8 individuals who use Tharawal’s transportation service are not counted, then slightly more participants have transportation problems than don’t. Thus, transportation is a barrier that a significant number of Aboriginal individuals in the area have to overcome to receive adequate health care. An age difference was noted whereby individuals in older age categories were more themselves, or a close family member, to own a motor vehicle. No other age or gender differences were noted.

Slightly more than a quarter of the individuals asked mentioned that they did not have a telephone at home and a third had a phone at home, but could only receive incoming calls. Therefore, less than half had access to a telephone at home with which they could make telephone calls to a health care facility. Slightly less than half of the individuals asked said they had, or sometimes had, difficulties making telephone bookings for a medical appointment. The major difficulty expressed was one of feeling uncomfortable talking on telephones. A significant number of individuals prefer to simply turn up and wait for medical appointments, rather than make a telephone booking ahead of time. The major reason suggested for doing this was because of convenience factors and that they just happened to be there. The researcher also got the impression that some participants did not like the restriction that an appointment time creates, however, no participant specifically stated this. Slightly more than half of the individuals do not get other people to make phone bookings for them. Individuals who did mention that they sometimes asked other people to make bookings for them indicated that this was largely due to practical reasons such as being very unwell, lacking money, or medical receptionists making specialist and dentist appointments. The few that said they always got someone else to ring up for them invariably mentioned that this was because they had difficulties understanding receptionists. Unfortunately, 15% of individuals said they would rather wait until someone came to their home to visit and then ask them to ring and make the booking, rather than ring themselves. No age or gender differences were noted.

One third of individuals asked either had difficulties, or sometimes had difficulties, understanding receptionists. The major difficulties were the receptionists’ speaking pattern and accents and to a lesser extent the information content. Similarly, 23.3% had difficulties and a further 20.0% sometimes had difficulties understanding doctors. The difficulties encountered were exactly the same as those posed by the receptionist: not understanding the information content, the doctors’ speaking pattern (e.g., mumbles, talks too softly, does not speak clearly) and accents. No age or gender differences were noted.

The vast majority (70.5%) of individuals asked said that they could read. Although 38.7% of these individuals, who said that they could read, mentioned that they have eyesight problems. Unfortunately, a sizable number (22.7%) of individuals stated that they could not read ‘okay’ and a further 6.8% said that although they could read, they had some problems. One Aboriginal woman believed that there were Aboriginal people who would not go to the doctors because they were embarrassed.
by not being able to write and that they would have to do fill out forms. The most disappointing finding is that there appeared to be an equal percentage of Aboriginal participants who could not read ‘okay’ in each of the three age categories, thereby suggesting that the problem was not being addressed adequately. One fifth of individuals asked said that they had difficulties reading the yellow pages to find telephone numbers of doctors. Similarly, 24.1% of individuals asked said that they had, or sometimes had, difficulties reading health pamphlets. No age or gender differences were noted.

The time participants said they normally visited a doctor varied from early morning to late afternoon in a typical bell-shaped distribution with the most frequently mentioned time period being between 10am and 11am. Nearly one in every five (17.9%) individuals asked said that they would not attend early in the morning (e.g., 9.00am). The major reasons cited for not attending this early were that the family came first, that they did not like to rush and they did not get out of bed early enough to go early in the morning. Even individuals who said that they had actually been to a doctor early in the morning mentioned that they couldn’t get to the doctor early due to still being in bed. No age or gender differences were noted.

The majority (80.8%) of individuals asked said that they had not used bush medicine at the same time as western medicine. Some individuals freely noted that they would not want to use both at the same time due to the possibility of unforeseen interactions between both drugs. However some individuals, when questioned directly on this, did not think such interactions were possible. Most (65%) individuals have never told a doctor that they use bush medicine. Typical reactions were that they did not think it would be necessary to tell a doctor, and that bush medicine should be kept secret to only Aboriginal people. The majority of individuals who have told a doctor that they use bush medicine stated that the doctor’s reactions have been less than favourable. The reluctance of telling doctors about using bush medicine did not appear to be related to perceived likelihood of being punished. For instance, two-thirds (66.7%) of the individuals questioned (n=15) felt that they would not be punished by non-Aboriginal authority figures if they stated that they used bush medicine. Similarly, 64.7% of individuals asked (n=17) did not think that if a person was using bush medicine and they were also going to a doctor and the doctor found out, that the doctor would “give them a hard time.” Typical reactions were that it was none of their business that they did not have the right to, and that doctors and non-Aboriginal authority figures would not understand. In fact, they really had difficulty understanding why they would be punished. One barrier Aboriginal participants possibly face in telling doctors that they use bush medicine is a perception they have that western trained doctors do not understand bush medicine. For instance, of 25 participants asked: “Are there western trained doctors who understand bush medicine?”, only 4 (16%) felt they did, one (4%) felt Asian doctors might, one felt (4%) a very few might, and three (12%) said ‘maybe’. Not surprisingly, 28.6% of individuals asked said that they would ever go to a doctor specifically to discuss bush medicine. No age or gender differences were noted.
Of all the potential or actual barriers assessed in this study, the most powerful was not originally expected. During the course of the interviews, the researcher discovered that shame was mentioned frequently, without probing for it. It became increasingly obvious that some participants would not access such services readily, if at all, even if all the other barriers were eliminated. It appears that the situation is more positive for the future generations of Aboriginal people in that none of the 20 young adults in this study stated that they felt shame. In fact, many stated that they had pride in themselves. No age or gender differences were noted.

One reason why some of the participants have heightened levels of shame is because they cannot read and/or write well. For instance, one Aboriginal woman always brings her husband with her whenever she visits a doctor, so that he can help her fill out the forms. This woman felt that there were other Aboriginal individuals who would not go to medical centres because they would be required to fill out forms and that they would thus be embarrassed because of their inability to do so. No age or gender differences were noted.

If an Aboriginal person actually makes it beyond the reception area into the doctor’s office, then the possibility of increasing shame, although real, did not appear to materialise. It appeared that doctors were doing a good job in terms of not increasing the shame felt by their Aboriginal patients. The need for general practitioners to ensure that they continue to act in this manner is important for two reasons. The first is because of the extensive discrimination Aboriginal people experience. The second is because individuals who experience more shaming experiences have poorer health. For instance, Rantakeisu, Starrin, and Hagquist (1999) have noted a link between (a) the degree of financial hardship and the number of shaming experiences, and (b) the social effects of unemployment and health. They also found that unemployed subjects who suffered a greater degree of financial hardship and who also experienced a greater number of shaming experiences, exhibited the poorest health, reported deteriorated health to a greater degree, experienced negative changes in their lifestyle, did less in their free time, and had lower self-confidence than did other unemployed persons. As a number of the participants in this study were unemployed, their findings are all the more important. No age or gender differences were noted.
6. Making health access easier

This sub-section focuses on four topics that have directly, or indirectly, an impact on access to health care facilities. These include a discussion on whether receptionists should suggest friends or family members also attend a medical appointment, whether health pamphlets and posters should be designed with an Aboriginal flavour, an idea for slightly redesigning Medicare cards, and a discussion about what the effect would be if Aboriginal medical centres were closed. The first two topics of enquiry (receptionists suggesting that friends or family members also attend, health pamphlets and posters designed with an Aboriginal flavour) were suggested prior to commencing the interviews. The next two topics (slightly redesigning Medicare cards, the effect of Aboriginal medical centres closing) were ideas that developed during the course of the interviews.

6.1 Should receptionists suggest others also attend?

During meetings to construct the initial “umbrella” questions, a suggestion was put forward that it would be a positive move for general practitioner receptionists to suggest to Aboriginal patients when they ring up to make a booking, that they can bring a friend or family member with them if they would like to. The idea behind this was that it was felt that Aboriginal people would find the visit more comforting, less traumatic and thus they would be more likely to visit in the future. To understand if this practice was already occurring, the following question was asked: “If you ring up to make a medical appointment are you asked whether you would like to have a friend, or family member accompany you?” Of the 36 individuals who provided meaningful responses to the question, the majority (77.8%) said that they had never been asked this:

A: “No, as there’s only enough room for patients in the bus.”
I: What about receptionists from over medical surgeries?
A: “No.”
(Aboriginal Woman, Young Adult: 16-25 years)

Of these individuals, most felt that it would be a good to be asked this. Largely they felt it would be good to be asked this to make the visit more comforting. However, other reasons suggested included help getting to the medical centre and understanding the doctor’s comments:

I: If you ring up to make a medical appointment are you asked whether you would like to have a friend, or family member accompany you?
A: “No.”
I: Would that be useful?
A: “Yes, for support, especially for some illnesses.”
(Aboriginal Woman, Senior Adult: 46+ years)
I: If you ring up to make a medical appointment are you asked whether you would like to have a friend, or family member accompany you?
A: “No.”
I: Do you see any advantage in taking anybody along with you?
A: “Yeah.”
I: What would that be?
A: “Like, um, sometimes you got a mate and he come there, he'll ask the doctor the question, you know. Explain it there for him. Or he'll make you feel at ease when you're sitting in the patient room. You've got someone to talk to.”

(Aboriginal Man, Adult: 26-45 years)

“The way I see it is, I like them to ask me, yeah, to bring a friend, or relative. Um, if I was, if I was fairly sick and that. I didn't feel the best. I was whoozy or dizzy or something like that. That would give me confidence, confidence to go there. I would know that I had support from the medical team and a friend and relative was there.”

(Aboriginal Man, Senior Adult: 46+ years)

I: If you ring up to make a medical appointment are you asked whether you would like to have a friend, or family member accompany you?
A: “No, but I think it's a positive thing.”
I: Would you be offended by it?
A: “No.”
I: Could you see it as being more advantageous for Aboriginal people than non-Aboriginal people?
A: “Yes.”
I: And why is that?
A: “Through lack of education, um, there is some cases and I know I have been asked to, sort of, go in with some people, um, where they didn’t feel that, um, they would understand, in case the doctor used some big words. To them, big words, but, um, yeah, or even the actual treatment itself, what if I get the wrong pills, or things like that.”
I: Do you think it’s a good idea to ask the question?
A: “Good idea.”
I: Can you see any time when it would be a bad idea?
A: “Um, only if there was personal, sort of, diagnosis that someone thought that maybe they would not want somebody else within the family to know - young girls going on the pill, which is the first thing that I can think of, um, STD’s.”
I: How do you solve that problem, because a lot of receptionists said ‘it sounds okay in theory, but you have the problem of patients not wanting other people to know’?
A: “Well, I mean, if they don’t want anyone else to know, then just asking them if they want to bring somebody else along, they can just say ‘no’.”

(Aboriginal Man, Adult: 26-45 years)

Two individuals, who had never had a receptionist suggest this, did not think that it would be a good idea. However they did not appear to comprehend why it might be a good idea, nor could they provide a reason as to why it would not be a good idea:

A: “No.”
I: Would that be a useful thing, or would that just be a waste of time asking?
A: “Oh, it would be a waste of time.”

(Aboriginal Woman, Adult: 26-45 years)
A: “No.”
I: Would that be useful?
A: “No.”
I: How would you feel if the receptionist did say you can bring somebody along with you, you don’t have to, but if you want to, you can bring a family member or friend with you? Would you like them to say that, or?
A: “No.”
I: Can you see a reason why they might say it?
A: “No.”
(Aboriginal Woman, Adult: 26-45 years)

There were eight individuals who indicated that they had been asked. Of these, two individuals said that this depended a great deal on what the medical situation was:

A: “Yes with big appointments, but not just day-to-day situations.”
I: Do you think that's a good idea?
A: “I think a lot of Koori people would feel better if a friend or family member came.”
(Aboriginal Woman, Adult: 26-45 years)

“... Oh no not really, only the gynaecologist before I went to the hospital.”
(Aboriginal Woman, Senior Adult: 46+ years)

Thus, it appears that most Aboriginal people view the suggestion to bring a friend or family member along with them to a medical centre positively, as long as receptionists couch it in voluntary terms. Practices such as making such suggestions may help decrease access barriers if they, as a by-product, cause Aboriginal patients to feel more comfortable in medical centres.
### 6.2 Information designed with an Aboriginal flavour

While constructing the initial “umbrella” questions, it was suggested that having information about Aboriginality and Aboriginal health on the walls of medical practices would help Aboriginal people feel more comfortable and thus they would be more likely to use such services again. Thus individuals were asked: “Does information about Aboriginality on the walls of medical practices help?”

Of the 39 individuals who provided meaningful responses to the question, the majority (59.0%) said that such information helped. There were four major reasons put forward as to how such Aboriginal posters helped: (a) that the posters were Aboriginal-specific and thus this provided Aboriginal people with a perception that the staff were culturally aware, caring and understood their situation; (b) that they made people feel comfortable and less fearful; (c) that they informed patients what is happening in the community; and (d) that the artwork was just something that ‘caught their eye’ and that the most important and useful part of the posters was the health-related information and that they could receive help with health matters. This last reason was the one most commonly mentioned. One example of each reason follows:

“Of course it does. People identify with it. To see something Aboriginal makes you think that they are culturally aware. I suppose it’s caring. They don’t have to do it, but if they do you know they care.”

*(Aboriginal Woman, Senior Adult: 46+ years)*

A: “Yeah, it's good to see that, when you go in. And it doesn't matter what medical centre, or what hospital, but it's always good to see that.”

I: *Why is that?*

A: “Um, because it shows, it shows us, that it's um, that the people there not only, it shows us, how can I put it, it shows us to, shows the Aboriginal people they're not to be afraid, not to be scared, well afraid and scared - that's the same thing as, um, and also not to be shame to come to this centre, you know, because their people have been in here, seen the doctor and think, ‘Ah’, it's you know. To see that, it's really good. I like, to me I like to go into a centre, into a doctor's surgery, or whatever it is, I like to see things like that. Even books, you know. Um, because then, then, then they're not afraid to go in see the doctor, because they know that they're right. Um, they know that they'd be right sitting there and waiting for their turn to go see the doctor. If they didn't have anything like that, then you can sort of say, ‘Oh well, like that place might be prejudice.’ Then again, it mightn't be. But that's the chance you've got to take… and with all the Aboriginal designs, that makes me feel comfortable.”

*(Aboriginal Man, Adult: 26-45 years)*

A: “Oh yeah, yeah.”

I: *Why is that?*

A: “Well say like if you are of the lost generation, or something like that, you know, like stolen generation. Or something like that, you don’t know nothing about the community itself, like the local community is all about.”

*(Aboriginal Man, Adult: 26-45 years)*
A: “Yes.”
I: How does it help?  
A: “It makes you more alert and you know what’s going on. Like there is health. It says health on it. Against AIDS and all that. Showing pictures like that. You can see it straight out. Straight there right in your face.”

(Aboriginal Man, Adult: 26-45 years)

One Aboriginal woman was not sure how the Aboriginal posters helped her, but she was sure that they did:

A: “Yes, helps by seeing the signs.”
I: But how does it help?  
A: “It helps by seeing them.”
I: But how?  
A: “Don’t know, but it helps by seeing them.”
I: Would you like to see more of them?  
A: “Yes.”

(Aboriginal Woman, Young Adult: 16-25 years)

Virtually everyone else said that the Aboriginal posters did not make a difference to them. However, some of these people did indicate that such posters might help other Aboriginal people:

A: “It doesn't really worry me necessarily, if they've got it, or if they haven’t got it.”
I: Does it help any Aboriginal people?  
A: “Well if they've got it, you've got it on there, you know, give them a bit more confidence to walk into that surgery. You know, they are saying, oh you are welcome in here.”
I: So would it be useful to have it on, um, say glass front doors, or the windows, would that help?  
A: “If they have got it on the window, you know, you go in there and see what is in there first of all. And if you do not know what a doctor's surgery looks like you’d walk in and have a look, because they have got the Koori posters on the wall or the door.”

(Aboriginal Man, Adult: 26-45 years)

Two other Aboriginal individuals who felt the Aboriginal posters made no difference to them had views that are worth mentioning. The first woman noted that the posters might present a false image of Aboriginal health, while the second woman found the posters offensive:

A: “Um, I’ve identified as an Aboriginal all my life, so, um, I know a lot about the Aboriginality and that. So the posters don't really help me.”
I: Do you like the posters there?  
A: “Yeah, sometimes they are colourful and that, but they, but they project an image that sometimes isn't real.”
I: What do you mean by that?  
A: “Um, well you go into, like, they’re healthy, whereas, um, in reality they’re not really healthy.”

(Aboriginal Woman, Adult: 26-45 years)
“No, a lot of Aboriginal pamphlets are insulting. I mean you don’t see a poster up there depicting a white person. You know?”

(Aboriginal Woman, Senior Adult: 46+ years)

Similarly, one Aboriginal woman was not sure if the Aboriginal posters helped her and another Aboriginal woman indicated that in fact it actually affects her negatively:

A: “There's too many. There's far too many Aboriginal this, Aboriginal that. Your Aboriginal. Just one poster to say that you are Aboriginal. Everywhere.”

I: Why don't you like that?

A: “It's degrading. Not degrading, people know that we are Aboriginal, um, people know that you are white, that others are flyby blacks and flyby whites... Mate, it is just like the reconciliation you know. It is a lot of crap to me. It is going to take a long time to hear them say sorry isn't it!”

(Aboriginal Woman, Senior Adult: 46+ years)
6.3 Redesign Medicare cards

One of the steering committee members originally suggested that a useful goal for the project that this study is a part of would be to ascertain what percentage of patients that visit general practitioners in the Macarthur area are Aboriginal. A variety of ideas were discussed, but all had major problems with them. During the course of the interviews, the author came up with a possible solution to the problem as a direct result of discussing this issue with two interviewees. These Aboriginal men disliked answering personal questions in medical reception areas, especially to anybody who was not a doctor:

“Um, and, you’d have the usual questions, like you know ‘Your Medicare card’, like you know, ‘And have you been here before?’, like you know, stupid questions. It seems to me, these are questions that you would want to tell your doctor. You’ve come to see the doctor, not to chat up the receptionist. Or the receptionists that get half your medical history down, before you go and see doc. And you don't like spreading it around in the GPs area. I'm not saying that this happens all the time, but initially when you come to a new one, that's what happens. The receptionist needs to get to know it. But I think it's too much all at once for me as a customer. I don't want to walk into a shop and be asked a million questions, that are not relevant to the conversation between her or him and me, plus whoever is sitting down their idly looking for something to do while they are waiting to see the doctor.”

(Aboriginal Man, Senior Adult: 46+ years)

A: “When I, I was speaking to a group of doctors the other day and I said to them do you actually get your receptionists to ask people, regardless of their colour, whether they identify as Aboriginal? And they said ‘No, why would we want to do that? It's easy enough to tell’. And I said, ‘Right well, if I brought a blond-haired, blue-eyed, fair-skinned person into your surgery, would you say that they were Aboriginal or white?’. They said, ‘Well just going by what you said, they would be white.’ And I said, ‘Oh well, that describes four of my boys.’ So, um, plus there are many others who, um, don't have any features that, um, you could identify as being Aboriginal, but they do identify as being Aboriginal, so that in some cases is only two generations from somebody who is full-blood. So having participated with the xxxxx Area Health Service, um, yeah, I found it quite interesting that a lot of the receptionists wouldn't, or didn't want to ask someone who was fair-skinned if they identified as being Aboriginal.”

I: Why don't you think they want to ask that?
A: “Well they felt that they might get abused by, um, as they put it, “red-necks.” Um, they felt embarrassed, um, but, um, with the pamphlets that were available, they said, ‘oh, it would be a lot easier for them after seeing these pamphlets and the information about why they should ask’."

I: What was the actual specific question that the receptionists had to ask?
A: “Do you identify as an Aboriginal or Torres Strait Islander?”

I: And which type of people were the ones that they found were the hardest to ask this question?
A: “The middle aged white male.”

I: Not female?
A: “No, not female... I'd prefer there to actually be, um, a thing at every doctors surgery, at the hospitals, um, when somebody first attends, that there be a questionnaire, um, two questions on every patient’s sheet. Are you of Aboriginal or Torres Strait Islander descent? Um, and do you identify as, because I have heard just recently where someone has said, ‘oh my grandmother was Aboriginal, but I’m not.’ So, although they obviously, that person, is of
Aboriginal or Torres Strait Islander descent, um, they don't identify as. That's fair enough. But those statistics, um, yeah.”

I: What is the point of asking those questions?
A: “Well I think there, um, they’re something that, um, should go into the National register. I mean it is the same thing as the census, you know, the questions asked there are, ‘are you of Aboriginal or Torres Strait Islander descent?’ Well, yeah, I think if, um, somebody wants to do something on medical research, they should be able to pull those numbers up and get correct stats regardless.”

I: You mentioned the embarrassment, or the potential embarrassment of these “red-necks”, what about Aboriginal people being asked that. Can you see Aboriginal people being embarrassed about being asked that?
A: “Some people I can. Some I could see being offended by it, but, um, the good thing about the pamphlet that was distributed out for a while, was that it gave a reason why it was so important to get the statistics, what this information would be used for, the fact that their names were not going to be used, but. It was quite informative. So I couldn't see anybody being offended by it.”

I: But if they hadn’t received the pamphlets, and you suggested that some Aboriginals may be offended, what type of Aboriginal people probably would more likely be offended?
A: “Um, I’d say more the elderly and those that weren’t, didn't have the stereotypical thing of skin colour, hair, looks, whatever.”

(Aboriginal Man, Adult: 26-45 years)

It is thus proposed that both Aboriginal and Torres Strait Islander people could have the right to choose whether they would like to have either the Aboriginal or Torres Strait Islander flag printed on the top left hand corner of their personal Medicare card. This flag, approximately one centimetre by one centimetre, would indicate that the individual was of such descent and could be used as an aid to collect vital statistical data on an important aspect of Aboriginal health. In an earlier study by the same author, McInman (2000) found that receptionists disliked, or would not ask, whether individuals were of Aboriginal or Torres Strait Islander descent. Using this method, those Aboriginal or Torres Strait Islanders wishing to be identified as such, could help provide information that appears otherwise difficult to obtain.

Unfortunately this possible solution was only conceived near the end of the interviews. Nevertheless, a few interviewees were able to provide their comments about the proposal. Thus some participants were asked: “What do you think of the idea of being able to decide if you wished to have an Aboriginal or Torres Straits Islanders flag on the top left hand corner of your Medicare card?” Virtually all people considered it was a good idea:

A: “That would be good.”
I: Would you be embarrassed by it?
A: “No.”

(Aboriginal Woman, Young Adult: 16-25 years)

35 A number of individuals will identify as both. For instance, the BEACH study of general practice (Britt, et al., 1999) noted in their study of indigenous participants attending medical facilities, that 87.0% stated that they were Aboriginal, 9.9% stated that they were Torres Strait Islanders, and 3.1% stated that they were both. Thus these individuals will also have to be considered in such a design.
A: “Yeah I reckon it would actually. It would be like, not plain, but interesting.”
I: Would you put it there?
A: “I would.”

(Aboriginal Woman, Young Adult: 16-25 years)

I: Have you got a Medicare card?
A: “Yeah.”
I: Would you be embarrassed if in the top left-hand corner [of the Medicare card] there was an Aboriginal flag on it which meant that you were either a Aboriginal or Torres Strait Islander?
A: “No.”
I: That would be alright?
A: “Yep.”
I: So obviously not every single person in Australia is going to have one of these, but if it was suggested that Aboriginal and Torres Strait Islander people could choose if they wanted to have the flag on their or not. The idea of that could be collected... do you think that would be a good idea?
A: “Yep.”
I: Do you think that there would be many Aboriginal people who would be embarrassed by having that?
A: “No.”
I: Why not?
A: “What's there to be ashamed of? They shouldn't be ashamed that their own flag is a fair on the Medicare card.”
I: What does the Aboriginal flag mean to you?
A: “It means a lot.”
I: Tell me about that?
A: “Well it means a lot to me because it's our flag.”
I: Does it mean more to you than the Australian flag?
A: “Yep.”

(Aboriginal Woman, Young Adult: 16-25 years)

One individual, initially not positively inclined towards having a flag on his Medicare card, changed his mind once he understood why it was being suggested:

I: If on the top left hand corner of the Medicare card, and it would be voluntary, you could either have it or not have it, it was up to you, have the Aboriginal flag here, or if you were a Torres Strait Islander have the Torres Strait Islander flag, do you reckon that would be a good idea?
A: “No.”
I: Just to explain why we are considering suggesting that, is that we do not have enough information about how many times Aboriginal people go to GPs and what sort of problems they have etc etc.
A: “Oh right.”
I: And receptionists are embarrassed to ask people if they are Aboriginal or not?
A: “My Mrs she is white... when we go to Aboriginal Medical services they sometimes ask are you Aboriginal? They question her and that. And she is, she's half Aboriginal.”
I: Now if she had this flag there, if she wanted to, she could pass them this [the Medicare card] and they wouldn't have to ask that question. Now that you know the reason for doing it, what's your view now?
A: “I reckon it's a good idea mate. I reckon if you really want to find out the surveys and that and know, I think it's all right.”
I: What does the Aboriginal flag mean to you?
A: “I just know that that's my flag.”

(Aboriginal Man, Young Adult: 16-25 years)
Two individuals were, however, strongly opposed to the idea. One viewed it as akin to the Star of David and could see many negative consequences. Similarly, an Aboriginal woman also felt that it was not a good idea:

A: “I don't think it would be a very good idea, because of the backlash. You know, a lot of people still, um, they think that the Aboriginals have got enough and they would say, ‘Why should they have that flag on there? Are they going to get more benefits?’”
I: *What does the Aboriginal flag mean to you?*
A: “Well it’s our heritage. It's part of us. It's to say that we are an individual people and, um, it's something that we are very proud of?”
I: *Does it mean more to you than the Australian flag?*
A: “Yep.”
(Aboriginal Woman, Senior Adult: 46+ years)

The author puts forward the proposal for debate; however, he is personally unsure whether it is a good idea. He notes both potential positive and negative aspects of the proposal, but stresses substantial canvassing and research is required. Nevertheless, such a system would solve the problem that the following participant’s father constantly faces:

I: *Can you see some point for the receptionist to ask patients are you of Aboriginal descent?*
A: “Yeah, yeah. Yes, I can, because my father went through it. He’s as white as anything and he’s Aboriginal. It's classed as, they called it, everyone's once in a while in a generation you’ll get a throw back. A throw back from the original community… you'll always get a throw back, but he’s 100% Aboriginal. When he goes to the doctors, one of the two questions is ‘are you Aboriginal or Caucasian?’ He says he’s Aboriginal, you know, nine times out of ten they don't believe him, but he’s got a letter of Aboriginality. Certificate of Aboriginality. He’s 70 odd and he still has to carry that around with him. And that's sort of, for him, a bit degrading for him. You know, he’s been through the whole lot, you know, the recession, the Stolen Generation and all that But for me personally, it doesn't matter to me if they ask if I am Aboriginal or not, because, I mean, just to see, to look at me, I mean a person must be blind not to see that I am Aboriginal.”
(Aboriginal Man, Senior Adult: 46+ years)
6.4 Effect of closing Aboriginal medical centres

As a result of listening to the participants comments on various issues, the researcher sometimes asked participants about what the effect would be if Aboriginal medical centres, usually with a reference to Tharawal, were closed down. Nine participants were asked directly what the effect would be on them. Equal numbers of individuals said that they would be affected negatively (n=4) opposed to not being affected at all (n=4). The first four individuals quoted below said they would be affected in a manner that appeared to be negative. For instance, one Aboriginal man stated outright that he would be affected negatively:

A: “It would affect us. Sometimes us black fellas shame when go to white fellas.”
I: Do you personally feel that way?
A: “Sometimes I do. Sometimes I don’t.”
I: Would you say only a few Aboriginal people feel that way, the majority feel that way, all Aboriginal people feel that way?
A: “Sometimes all of us feel that way.”
I: Would it be a bad move or a good move to close all the Aboriginal medical facilities?
A: “It would be bad.”
( Aboriginal Man, Young Adult: 16-25 years)

An Aboriginal woman said that she would be partly affected as she uses some of the services at Tharawal. However, as she boycotts using the doctors due to past experiences with a previous doctor, this would not be such a problem for her:

A: “It would be a very negative step to take.”
I: Why is that?
A: “Well we’ve got to have a place where we can, know that we can talk openly, and that we can trust the people we are talking to and that they will do the right thing by us. And, um, you know without that, you wouldn’t find half the Aboriginal community wouldn’t go into a medical health centre. They’d go back to the bush remedies.”
I: Now when you go to Tharawal, who do you see? What profession?
A: “I go and see the diabetic specialist up there. And then I go into the medical centre side and go see the sister and talk with her. Some doctors they’ve had up there have been really good, but some have been xxxxx and I refuse to see them now. So it’s very much you’re seeing the Aboriginal health workers up there, not so much say the doctor who is not Aboriginal.”
( Aboriginal Woman, Senior Adult: 46+ years)

Another Aboriginal woman said that she would not see a different medical centre, but instead would begin using home remedies:
I: What would you do if all Aboriginal medical centres were closed down?
A: “Just go to home remedies I suppose.”
I: And what sort of things would you use? Say you had a cold, what sort of home remedies would you use?
A: “Well I’ve got a book at home about home remedies. I use lemongrass, honey. It’s just like Lepsil. That’s just pure lemon juice, honey, with an Aspro in it. It’s the same thing. Why pay a lot of money when you can make a home remedy. And um, your temperature is taken down, all you need is vinegar and warm water, you know. It’s really easy with colds and that, just keep a dust-free, clean place…”
I: Do you think it would be a positive thing or a negative thing if all the Aboriginal medical centres were closed down?
A: “I think that would be a negative thing, because where else would our people go. I find that most of the Aboriginal people that go to, they would rather go to, um, Indian doctor, or Chinese doctor, other than the white society. Because they are more or less on our level… They [European doctors] put themselves above all the rest of the other cultures and they look down, instead of looking out their eyes.”

(Aboriginal Woman, Adult: 26–45 years)

And it appeared to the researcher that one Aboriginal man would be affected negatively because the participant felt that if Tharawal was closed down, then another Aboriginal medical centre would be quickly created, even if it was just a set of tents in a paddock, and thus the quality of the services offered would not be as high:

“I am quite proud of those people and I can assure you that the kids of today will soon make sure that there is another service if this one happens to [be closed].”

(Aboriginal Man, Senior Adult: 46+ years)

Of the four individuals who said that they would not be affected negatively, one Aboriginal woman said that she would simply go to another medical centre:

I: What would happen if this place [Tharawal] closed down overnight and therefore you would have to go to other places? Would you go, or would you not go to doctors?
A: “I suppose I’d have to go to other medical service that is close.”
I: So you wouldn’t be like some people, who simply wouldn’t go?
A: “No. I would have to go to another medical service.”

(Aboriginal Woman, Adult: 26–45 years)

Another three individuals said that they would not be affected personally. However, they stressed that other Aboriginal people would be affected negatively and thus they believed that such a move would not be considered a good idea:
A: “It doesn’t affect me, because I don't use it as a medical centre. Um, one is I
don't live in the immediate area. Um, and I go to my local GP, which is not far
from here.”

I: If Tharawal did close, do you think it would be a positive or negative step?
A: “I believe it would be negative in that, um, it's probably the only medical centre
in the area that it's located. And there’s possibilities of it, you know, of it
looking after the wider community, even though it's an Aboriginal medical
service. You know, which can add value to the rest of the community… If it
had to move from here, it would have to be moved to an area which is still
accessible to the broader Aboriginal community. As in having access to
transport and that… We're a little bit isolated here, but we still do have public
transport goes around here. You know, so during normal days operation times,
there is public transport going past and stopping just outside the gate here. So
people can access the place.”

(Aboriginal Man, Senior Adult: 46+ years)

I: How would it affect you personally, would it be a positive thing or a negative
thing, if all the Aboriginal medical centres were all closed?
A: “I think there’d be a lot of sick Aboriginals around… I know a lot of
[Aboriginal] people that won’t go to doctors, white doctors or white medical
centres, but they will come to Tharawal. And like there being an Aboriginal
medical centres around and like there's workers that live in the community, that
mix in with community people and like, you know, they'll say, oh you should go
around and see so-and-so, they weren't well, or I think they need to see a doctor,
but they won't go to a doctor. You know but like if you go around there, you
know, you go and visit the person and you say, ‘well look we have a medical
centre up here and there's all black workers up there. You know, I mean, you
can talk them into going there, whereas I think you have got a better chance of
talking them into going to a black one, than you would to a white.”

I: That's other people, but would it affect your health?
A: “Probably not, because I think, then again, because like I said, because I'm at
work where the doctors are, I go and see a doctor. I don't go out of my way, to
go downtown to see a doctor if I'm sick. Like if I get sick on the weekend, I
think oh well, when I go to work on Monday if it's not that bad, when I go to
work on Monday I'll go and see doc about it then, rather than get in the car and
drive downtown.”

(Aboriginal Woman, Senior Adult: 46+ years)

A: “I reckon that would be a stupid idea.”
I: Why is that?
A: “Because then they have got no, Aboriginal people will have no one to turn to if
they’re in trouble… Meaning, for example, say I got, say if I have problems
with, um, my electricity bill, or whatever, Tharawal people will help you out,
instead of most, like, instead of getting kicked out of home and stuff, so they
really do help. I think that would be really stupid.”

I: What about if they kept all the Aboriginal Medical centres, but they got rid of the
medical part of those centres?
A: “That would be even stupider.”
I: Why is that?
A: “Because, like, most Aboriginal people don't have enough, like, don't have
enough money, alcohol and stuff, to like go out and buy medicine, so if they shut
them all down, where are the Aboriginal people going to turn to? Because most
Aboriginal people like seeing Aboriginal doctors and stuff.”

I: Now you go to a non-Aboriginal medical centre, so would it affect you
personally?
A: “No, it doesn't affect me.”

(Aboriginal Woman, Young Adult: 16-25 years)
Finally, one individual was not sure what the impact of closing Tharawal would be on her. Nevertheless, she also indicated that such a step would be negative for other Aboriginal people:

I: *What would you do if Tharawal closed?*

A: “I'm not really sure.”

I: *Do you think it would be a positive thing, or a negative thing?*

A: “Negative.”

I: *And why is that?*

A: “Because I used to come in here for doctor and that.”

(*Aboriginal Woman, Young Adult: 16-25 years*)
6.5 Participants suggestions to make access better

So as to ensure that both: (a) an access issue was not missed, and (b) that the most important barriers to health care were provided a forum whereby they could be stressed at the expense of less trivial barriers, the participants were asked: “Is there any thing you would like to make it easier to see a doctor or other medical services?” Disregarding a substantial number of individuals who could not think of anything and two individuals who felt that there was nothing extra they needed as the present health care facilities and services suited them well, 27 individuals provided meaningful responses. The suggestions of these 27 Aboriginal people can be seen in Appendix 7. The suggestions put forward could be considered to belong to four overall categories: (a) operational procedures of medical centres, (b) relating to doctors, especially with regard to communication issues, (c) attitude, service and cultural awareness of receptionists, and (d) health education and health intervention strategies.

The suggestions categorised as relating to ‘operational procedures of medical centres’ included: reducing waiting periods in medical centres (n=4), opening medical centres for longer hours and as a by-product visits to hospitals would be decreased (n=1), doctors providing house-call service and/or free bus service to medical centres (n=4), ensuring that confidentiality is not breached at Tharawal’s medical centre (n=1), more money provided to Tharawal’s medical centre, but not necessarily administered by Aboriginal people (n=1), patients having their own medical database on disc so that they can go from medical centre to medical centre with all their medical records (n=1), and medical centres using identifiable colours on patients medical cards so that staff know that the patient is Aboriginal “and [an] underprivileged person, [thus] I’m going to try and help him” (n=1).

The suggestions categorised as relating to ‘doctors, especially with regard to communication issues’ included: more and better doctors in the area (n=2), improving communication skills of doctors (n=1), and providing interpreters if the doctor is a non-English speaking doctor (n=1).

The suggestions categorised as ‘attitude, service and cultural awareness of receptionists’ included: improving the attitude and service of some receptionists (n=2) and helping staff in medical centres become more culturally aware (n=2).

The suggestions categorised as ‘health education and health intervention strategies’ included: better health education and more pamphlets (n=3) and reducing smoking, alcohol and illegal drug usage in the community (n=3).

36 Interested readers are directed to Mount, et al. (2000) for a short review of some of the electronic healthcare databases presently being developed.
At the end of the interviews, each participant was given the opportunity to reflect on what they had said during the interview. The last question all participants were asked was: “If I was to remember only one thing from this interview, what would you like it to be?” Most participants found this question very difficult to answer and thus most did not provide a response. Four individuals, however, provided very forceful opinions. It is noteworthy that most of the views appear to mirror the conclusions and recommendations of the researcher.

“Um, if you want to get your word across to both races and that, just be down to earth and straightforward with them. Don't be shy to, um, race your voice, like, 'how are you going?' Come in here’, you know. Be straight out with them. And, um, same as, like, um, non-Aboriginal people, they might be a bit bit fussy and that, but, you see, you know, I don't know, just be straight up. I suppose some people you get out back bush and that too and that, yeah, they get real shy around that and they start mucking up. And that's why you've got to be, you jump right on them, you raise your voice and say something loud at them. You know. Don't make out, you know, your scared or that. Like up there, its like 'heh black fella' and all that.”

(Aboriginal Man, Young Adult: 16-25 years)

“I think better receptionist. Better, friendly receptionists, you know what I mean... Um, get a better reception, like, better understanding for the receptionists, you know. It's their attitude. Because if I was to, for argument sake, take my mother to the doctors, and she’s as black as your bag, right. That person is going to know that my mother is Aboriginal. And as you can see from the bag to myself, I’m a lot lighter than the bag. So if she can see my mother as an Aboriginal, why can't she see me as an Aboriginal?, see. Because, because I'm light-skinned, or what, but when I answer that question, 'are you Aboriginal?', there's a sort of defensive from the receptionist, you know, or a approach. They don't want to know about it and, um, that's the only thing I'd, if I could change their attitudes that's where I’d, me personally, that's where I would start. To sort of educate, that's where I would start, if I could educate them. If I was a public speaker with, um, and I, I had to speak in front of a class full of receptionists, that would be my first question, yeah.”

(Aboriginal Man, Senior Adult: 46+ years)

“So what should we do? Smarten our people up, keep them in schools, learn the vocations, and find work so they can fight back with their own words. Because that's what it's really all about when you're talking to a white man and a black fella and you see the difference. Because one will talk with big words and the Aboriginal, it's the same meaning, but just they are using the big words…”

(Aboriginal Woman, Adult: 26-45 years)
A: “Aboriginal health is not just visiting the doctor. Aboriginal health encompasses the whole family, in that, as I said earlier on about going to the old-style GP, where he talked about not only my complaint, but asked how the family was going. So normally, most things you find, or major illnesses that Aboriginal people are having, such as heart, diabetes and that, you usually find they’re running rampant right through the whole family. And everyone addresses them as an individual, instead of looking at them as a family concern. Also it is not that long ago that lot of Aboriginal families have only just moved out of settlements and that, where the style of housing and that. It's not that they’re, they’re not dirty people, it's just that they have never had to live in these styles of accommodation. Like, um, if your living in the middle of the bush, you don't have to mow the lawn. All of a sudden they are in this type of environment. They’ve got to keep the lawns and everything mowed etc and that, so all those types of things need to be looked at; not only their personal health, but the family and their extended family. Part of their extended family is the community they live in. Also their environmental health, which no one looking from medical practitioners point of view, they don't look at the environmental health, until, you know, the classic example which was during the week, with the house from hell, that was in the paper. You know, where all the garbage and everything was piled up inside the house. You know, no one has looked at that.”

I: Macarthur Division of General Practice are the ones that are going to go back to the GPs with the results of this study. What recommendations would you be giving them as to how to improve access for Aboriginal people?

A: “Well I think it really comes back to that, um, first impact when they walk through the door, which is really the receptionist, or the salesperson at the chemist, before they actually get to the doctor or pharmacist, how they treat the person. You know, if I’ve had a bad day, it doesn't mean that everyone that I am going to come in contact with has to have a bad day. You know, all right, if you are having a bad trot at the time, all right then, smile and bare it, or put yourself at the back and let someone else deal with the problem. You know, um, don't treat Aboriginal people different. Treat them as another person. You know, um, that's the main thing. Um, the other thing is, you know, a lot of Aboriginal people also have to come to reality, reality themselves, that because they are living in an urban atmosphere today, it's, they do not really know a lot of things about being an Aboriginal themselves. So why are they screaming about Aboriginals do this and that, you know. They’ve got to realise that the life they are living in a society, which is mainly non-Aboriginal, and that's the way they are living it. See if they want to be treated differently, well go back and live on the reserves, you know. I was brought up as an Aboriginal person..., but I am living in an urban setting, so I must react to that setting, and not react against it. And survive in it. Now I can do that as an Aboriginal person, but then to live back in my cultural side I react with the Aboriginal people around me in their culture. I can't expect you as a non-Aboriginal person to treat me culturally appropriately as an Aboriginal person as you're not an Aboriginal. Even if people trained you to be able to do it, you’re still a non-Aboriginal, so you can't do it.”

(Aboriginal Man, Senior Adult: 46+ years)
6.6 Age and gender differences

The majority (77.8%) of the participants had not been asked whether they would like to have a friend, or family member accompany them to a medical centre when they rang up to make an appointment. Nevertheless, most of them felt that it would be a good idea to be asked this as it might make the visit more comforting, they would have someone to help them get to the medical centre, and someone to help understand the doctor’s comments. Two individuals, who had not had a receptionist suggested this, did not think that it would be a good idea. However they did not appear to comprehend why it might be a good idea, nor could they provide a reason as to why it would not be a good idea. There were eight individuals who indicated that they had been asked this. Of these, two individuals said that this depended a great deal on what the medical situation was. Thus, it appears that most Aboriginal people view the suggestion to bring a friend or family member along with them to a medical centre positively, as long as receptionists couch it in voluntary terms. Thus receptionists who suggest this to Aboriginal patients may help decrease access barriers if they, as a by-product, cause Aboriginal patients to feel more comfortable in medical centres. No age or gender differences were noted.

The majority (59.0%) of participants said that having information about Aboriginality and Aboriginal health on the walls of medical centres helped. There were four major reasons put forward as to how such Aboriginal posters helped: (a) that the posters were Aboriginal-specific and thus this provided Aboriginal people with a perception that the staff were culturally aware, caring and understood their situation; (b) that they made people feel comfortable and less fearful; (c) that they informed patients what was happening in the community; and (d) that the artwork was just something that ‘caught their eye’ and that the most important and useful part of the posters was the health-related information and that they could receive help with health matters. This last reason was the one most commonly mentioned. One Aboriginal woman was not sure how the Aboriginal posters helped her, but she was sure that they did. Virtually everyone else said that the Aboriginal posters did not make a difference to them. However, some of these people did indicate that such posters might help other Aboriginal people. One Aboriginal woman noted that the posters might present a false image of Aboriginal health by showing Aboriginal people as being healthier than they really are. One Aboriginal woman found the posters offensive, while another Aboriginal woman indicated that in fact they actually affect her negatively. No age or gender differences were noted.

A possible solution to the lack of data on whether Aboriginal people actually visit general practitioners was developed. It is suggested that maybe each Aboriginal and Torres Strait Islander person could have the right to choose whether they would like to have either the Aboriginal or Torres Strait Islander flag printed on the top left hand corner of their personal Medicare card. This flag, approximately one centimetre by one centimetre, would indicate that the individual was of such descent and could be used as an aid to collect vital statistical data on an important aspect of Aboriginal health. Only a few participants were asked their opinion about the proposal as it was only developed near the completion of the interviews. Nevertheless, virtually
everyone asked considered it was a good idea. One individual, initially not positively inclined towards having a flag on his Medicare card, changed his mind once he understood why it was being suggested. However, two individuals were strongly opposed to the idea. One viewed it as akin to the Star of David during World War II and the other could see many negative consequences. Not enough participants were asked about this issue for age and gender differences to be noted.

Participants were relatively evenly distributed between those who would not be affected at all and those who would be affected negatively if Aboriginal medical centres, usually with a reference to Tharawal, were closed down. Of those who said that they would be affected one said that she would not see a different medical centre, but instead would begin using home remedies. Another participant felt that if Tharawal was closed down, then another Aboriginal medical centre would be quickly created, even if it was just a set of tents in a paddock, and thus the quality of the services offered would not be as high. Of the individuals who said that they would not be affected negatively, many stressed that other Aboriginal people would be affected negatively and thus they believed that such a move would not be a positive initiative. Not enough participants were asked about this issue for age and gender differences to be noted.

A substantial number of individuals who could not think of anything when asked: “Is there any thing you would like to make it easier to see a doctor or other medical services?” Two individuals felt that there was nothing extra they needed as the present health care facilities and services suited them well. Of the remaining 27 individuals who provided meaningful responses, their suggestions consisted of the following: reducing waiting periods in medical centres (n=4), opening medical centres for longer hours and as a by-product visits to hospitals would be decreased (n=1), doctors providing house-call service and/or free bus service to medical centres (n=4), ensuring that confidentiality is not breached at Tharawal’s medical centre (n=1), more money provided to Tharawal’s medical centre, but not necessarily administered by Aboriginal people (n=1), patients having their own medical database on disc so that they can go from medical centre to medical centre with all their medical records (n=1), medical centres using identifiable colours on patients medical cards so that staff know that the patient is Aboriginal “and [an] underprivileged person, [thus] I’m going to try and help him” (n=1), more and better doctors in the area (n=2), improving communication skills of doctors (n=1), providing interpreters if the doctor is a non-English speaking doctor (n=1), improving the attitude and service of some receptionists (n=2), helping staff in medical centres become more culturally aware (n=2), better health education and more pamphlets (n=3), and reducing smoking, alcohol and illegal drug usage in the community (n=3). No age or gender differences were noted.
DISCUSSION

The stereotypical view of Aboriginal people has been negative ever since Europeans came into contact with Australia. Captain Dirk Hartog, charting the Gulf of Carpentaria, a mere seven years after the Dutch claimed sovereignty of Australia, wrote: “the inhabitants... are the most wretched and poorest creatures that I have ever seen in my age or time” (Carstenz, 1623, cited in Day, 1996, p. 18). Dutch explorer Abel Tasman had similar views, suggesting Aboriginal people were “poor and bad-tempered people” (Day, 1996, p. 20). An English pirate, William Dampier, 100 years before the First Fleet arrived in Australia, described Aboriginal people as:

“the miserablest people in the world. The Hodmadods of Monomotapa, though a nasty people, yet for wealth are gentleman to these; who have no houses, and skin garments, sheep, poultry, and fruits of the earth... And setting aside their human shape, they differ but little from brutes... having no one graceful feature in their faces” (Dampier, 1697, reprinted in Gerald, 1994)

Even though Captain James Cook was living in a period when ideas of assumed superiority of European civilisation were being questioned, he seemed to abandon his temperate view upon his arrival in Australia in 1768. At the time, he described Aboriginal people as “some of the most wretched people upon the earth”37 (Cook, 1773, cited in Reynolds, 1989, p. 98).38

It was not long after the arrival of Cook, that Aboriginal people were captured and made prisoners. Webb and Ensticse (1998) give an account of possibly the first Aboriginal prisoner. Sailors from the marines had been ordered to seize and take away some ‘natives’. They were successful in securing one Aboriginal man, later named Manly. The way he was subsequently treated could be seen as exemplifying the way Aboriginal people have been treated ever since. He was offered food, shown pictures of people, birds and animals to note his recognition skills, had his hair cut, beard shaved, was bathed with soap, clothed in a shirt, jacket, and trousers, and had a handcuff attached to his left wrist. After the British established a penal colony in Botany Bay39 and incidents such as Manly’s capture, Aboriginal people have been oppressed and forced to integrate into European ways of living.

The nineteenth century saw Aboriginal people being killed in a variety of ways. They were forced from their land by the settlers, and although they fought back and

37 However, he did go on to say that, “in reality they are far more happier than we Europeans” (Cook, 1773, cited in Reynolds, 1989, p. 98).
38 Furthermore, he went on to say that, “All they seem’d to want, was for us to be gone.”
39 Initially relationships between Aboriginal people and the British were relatively civil. The first Governor-Designate of the penal colony in New South Wales, Captain Arthur Phillip, was under strict instructions, which he followed, not offend the Aboriginal people. His instructions were, “You are to endeavour by every possible means to open an intercourse with the natives, and to conciliate their affections, enjoining all our subjects to live in amity and kindness with them” (Lippmann, 1981, p. 15).
were successful at times, even the strongest Aboriginal warriors, such as Yagan, Dundalli, Jandamarra, Pemulwy and Nemarluk, were no match to the new breach-loading repeater rifles that replaced the unreliable flintlock rifles in the 1870s (O’Byrne, et al., 2000). They died in large numbers by the newly introduced diseases that the Europeans brought with them (smallpox, measles, venereal disease, influenza, whooping cough, pneumonia, tuberculosis). They also had to contend with the introduction of feral and domestic animals.40 These sheep and cattle destroyed waterholes and ruined the habitats that had sustained mammals, reptiles and vegetable foods. Thus to survive, starving Aboriginal people speared these sheep and cattle, but this only caused settlers to make reprisal killings. Aboriginal people also faced other difficulties. For example, in 1830 white settlers demanded that Aboriginal people be removed from Tasmania. Thus, they were captured and removed to Flinders Island in the hope of making them ‘civilised Christians’. In the process most died. Aboriginal people at the end of the nineteenth century were banished from towns, villages and farms and only issued passports if they could agree to ‘conduct themselves in a peaceful, inoffensive and honest manner’. Hence, “assimilation or annihilation was the order of the day” (Lippmann, 1981, p. 20).

Hasluck’s (1942) book was one of the first to tell the sorry tale of black-white relationships in Australia in the nineteenth century. He discussed such things as the first Mounted Police Corps, which supposedly was set up to protect Aboriginal people, but in reality it protected settlers against Aboriginal people. He noted the legal ‘pacification’ by police, which involved turning up to Aboriginal camps looking for criminal suspects, and bringing them back in chains, followed by floggings and jailing, and the not uncommon ‘arbitrary shootings’ to prevent escape, or save property. Shootings of Aboriginal people was not confined to the mounted police. Lippmann (1973) notes how:

“Dame Mary Gilmour recalled how, as a child, she was staying on her grandfather’s property and saw an Aboriginal man and his wife bathing in the river. A passing white settler, on his way home from an unsuccessful rabbiting expedition, raised his gun and shot the woman, for no reason other than for ‘sport’. When the husband, with a cry of anguish, went to his wife’s assistance, he also was shot and killed. In Tasmania, in the race wars which ended in Aboriginal extermination, black children were taken from their parents to become a source of cheap labour. In all parts of the country they were as common a target for bands of hunters as were kangaroos, and were regarded as a similar sort of pest, for their frequent raids on sheep and cattle to replace the wild game now beyond their reach, and their sporadic fighting to retain traditional lands. The settler reprisals which followed often wiped out the whole Aboriginal population of an area.” (p. 23)

The twentieth century saw armed resistance up until the 1920s. More severe was the establishment of legislation, which had the aim of segregating and ‘protecting’ Aboriginal people. Acts, such as the Queensland act of Parliament in 1897 and an

40 By 1860 there were 20 million sheep in Australia.
amendment to the act in 1901 were passed in all states. Such acts imposed restrictions on Aboriginal people’s rights to own property and seek employment. They also required reserves, under the guidance of Christian missions, to be set up to enforce such strict segregation. The Aboriginal Ordinance of 1918 also allowed the state to remove children from their Aboriginal mothers and place them in foster homes or childcare institutions. This practice continued up until the 1960s and caused bitter resentment with what has become known as the ‘Stolen Generation.’

After World War II, the plight of Aboriginal people worsened:

“All after the war ‘assimilation’ of Aboriginal people into white society became the stated aim of the government. To this end, the rights of Aboriginal people were subjugated even further - the government had control over everything, from where they could live to whom they could marry. Many people were forcibly moved from their homes to townships, the idea being that they would adapt to European culture, which would in turn aid their economic development. This policy was a dismal failure.” (O’Byrne, et al., 2000, p. 32)

In the 1950s, Aboriginal people were sometimes tied to trees and left overnight as punishment (without trial) for alleged misdemeanours, while the practice of bringing criminal suspects into Western Australian towns by neck-chains only ceased in 1958 (Lippmann, 1973). During the 1960s this assimilation policy came under attack as people became aware of the inequities it had caused. For instance, McQueen (1970, 1973) and Inson and Ward (1971) were one of the first to write about the serious inequity and racism in Australia. McQueen noted that racism was the ‘linchpin’ of Australian nationalism, and Rowley (1970, 1971a, 1971b) documented many instances of the inherent racism in almost all Aboriginal-white relations, including the unequal clashes over land and the indifference bordering on contempt with which Aboriginal people were treated.

The assimilation policy was officially replaced in 1972 by the new Labour government's policy of 'self-determination’. In 1967 Aborigines and Torres Strait Islanders were given the status of citizens of Australia. It was not, however, until 1991, when the report from the Royal Commission into Aboriginal Deaths in Custody (1991) was tabled to Parliament, that the government was moved to deal with the disadvantage of Aboriginal people on a scale necessary to make serious inroads into their problems. Because Aboriginal people have been socially disintegrated and made to feel “purposeless and bereft: their culture rendered meaningless and themselves passed by as permanent outsiders” (Lippmann, 1973, p. 13), it is not surprising that the 1996 Human Rights and Equal Opportunity Commission's Social Justice Statistics report presented a bleak picture of the realities of living in Australia as an Aboriginal person. The report indicates that compared with non-Aboriginal people, Aboriginal people die on average 20 years earlier, are approximately 20 times more likely to be homeless, are substantially worse off in economic terms with only 11 percent having an income of $25,000 or more, and are more likely to be unemployed (i.e., in 1994 Aboriginal and Torres Strait Islander unemployment equalled 38%, while the general Australian labour force was 10.5%).
It is important to provide readers with this brief overview of Australia's historical treatment of Aboriginal people, so they can better put into context the experiences, beliefs, and personal and family histories of the participants in this study. The author does not agree with Lippmann (1970, p. 23) who suggests that “the treatment of Aborigines by the early white settlers of Australia has by now been too well documented to require detailed repetition.” If anything, it is the author's opinion that the majority of non-Aboriginal Australians have at best a scant understanding of the “ceaseless disregard; deprivation of liberty; [and] massive institutionalisation (as a cheap way of avoiding race friction in the towns)” (Lippmann, 1973, p. 37) that has occurred. Instead, it is this author's opinion that the general public only see the aftermath; the “withdrawal on Aboriginal side, an opting out from the major society which has clearly spurned them” (Lippmann, 1973, p. 37).

The participants in this study tended to perceive their health as being average, with the remainder being more likely to view themselves as unhealthy rather than very healthy. There was a trend for older people, especially females, to perceive their health as being less than younger people. Slightly less than half had at least one medical problem, with the most common ailments being high blood pressure, eye problems and diabetes. A larger percentage of older people had a medical problem than younger people. However, there was no association between medical problems and self-perceptions of health. Participants varied considerably with regard to the extent that they thought about their health, although they were most likely to think about their health a lot, especially as a consequence of any one of a variety of things happening in their life. There were no obvious age or gender differences with regard to the extent to which participants thought about their health. They varied even more with regard to the extent to which they were concerned about their health. Young adults were most likely to have no or few concerns, whereas senior adults were more likely to be very concerned. They had varying views about the extent to which they were concerned about their health if they did not have a medical problem, but those who did have a medical problem were more likely to be concerned about their health. The majority of participants felt their health was important to them. There were no obvious age or gender differences with regard to importance of health. However, the degree to which they viewed their health as important was related to both concerns about health and the degree to which they think about their health.

Prevention of health is an important component of primary health care. Eight health issues (obtaining health information, health pamphlets, immunisation, check-ups, alcohol, smoking, exercise, nutrition) were researched with regard to the prevention of health problems. A substantial number of participants obtained their health information from a variety of sources. The three most common sources utilised were from the media and/or written sources, health professionals, and friends and family members. The majority of participants: (a) believed that they could get all the health information they required, (b) found it easy to do so, and (c) felt they did not have ‘problems’ obtaining the health information they required. Nevertheless, a sizeable proportion believed that at one time or another, they definitely couldn’t get all the health information they required. Some of the reason for this may be due to the fact that slightly more than one third of participants felt embarrassed asking about health issues at one time or another. Almost all of the participants read health pamphlets,
especially while waiting to be seen by a health professional. The majority of participants felt they were worth reading. Two-thirds of the participants felt that health pamphlets were enjoyable to read. Thus it is not surprising that the majority felt they were well written, although some individuals found some of the words were too difficult. To solve this problem, many participants suggested that the design of pamphlets should be in a cartoon format. Only a few individuals felt they would be embarrassed if health pamphlets were designed in such a manner. Unfortunately, a few of those individuals asked, did not realise that they could take health pamphlets from doctors’ surgeries home with them. Of the individuals who did know that they could take the pamphlets home, the majority had actually done so.

The majority of participants believed they understood what child immunisation was. However, the degree to which they actually understood varied considerably. Participants were definitely in favour of immunisation, even if they only had a rudimentary understanding of what immunisation was and how it worked. All the participants’ children had been immunised. The major reasons given for this were to protect from ill health, it was the thing to do, due to health promotion campaigns, personally been affected by not being immunised, due to the law, and felt that it was a good thing to do. Only one participant, a young male, did not want their children immunised. His wife, however, did want to have their children immunised and thus he relented. Approximately half of the individuals knew about the recent changes aimed at increasing immunisation rates, whereby parents are paid to have their children immunised. The majority of participants felt that some Aboriginal people would have their children immunised, only because of the money on offer. Many also felt that non-Aboriginal people were likely to do this.

Approximately one-third of participants reported going to a doctor when they were healthy. The major reasons stated for this behaviour were: (a) to have a check-up, (b) liking the doctors and thus it was something to do, (c) while being pregnant to have the baby checked, and (d) a spur of the moment decision. Those who had not been to a doctor when they were healthy tended to believe that such an action would be a waste of time. The majority of individuals felt that it was a good idea to see a doctor when they were healthy. The most common reason cited was for reassurance. Unfortunately, the percentage of participants who agreed that such action was a good idea was substantially larger than the percentage of participants who had actually been to a doctor when they were healthy. Similarly, many participants who thought that going to see a doctor when they were healthy was a waste of time really had a lot of difficulty seeing any point in doing so. The percentage of participants who had been tested for blood pressure, blood sugar, and cholesterol was 94.2%, 75.9%, and 54.5% respectively. There was an age difference for testing of blood glucose and cholesterol. The percentage of senior adults and adults who had been tested was higher than young adults. All senior woman asked, had received mammography testing, whereas only 25% of female adults and no young adults had participated in such testing. Only one of the women had not had their last mammogram within the last 3 years.
The majority of participants drank alcohol. There was a definite age difference for alcohol consumption. The percentage of senior adults who drank was lower than adults, who had a lower percentage of alcohol consumption than young adults. Slightly over a quarter of participants drank to excess. Participants in this study also clearly articulated that illegal drug usage was a major health problem in the area. There was an age difference with regard to excessive consumption. There were a greater percentage of young adults who drank to excess than adults or senior adults. The majority of participants smoked. There was an age/gender difference with regard to smoking in that the majority of young adults and adults smoked, whereas although the majority of male senior adults smoke, the majority of female senior adults do not smoke.

The majority of individuals were happy with the amount of exercise they completed. There was an age difference in that the majority of young adults, compared with adults and senior adults, were happy with the amount of exercise they completed. The level of perceived frequency of exercise participation was very high. Likewise, the majority of individuals had participated either on the day of the interview or the previous day. There was an age/sex difference for both the level of perceived frequency of exercise participation and last day exercise was performed. Specifically, there was no difference between male and female young adults and adults for these two variables. However female senior adults exercised far less frequently than male senior adults. Even with such high frequency of exercising, slightly more than one third of individuals felt that they exercised too little. Reasons for this finding include not knowing how much is the right amount of exercise to participate in and participants’ uncertainty as to whether walking was exercise. Encouragingly, virtually all individuals said they enjoyed exercising. Approximately a quarter of individuals asked were: (1) not happy with the type of food they ate, (2) not happy with the amount of food they ate, and (3) did not eat enough healthy food. Only 1 out of 32 individuals stated that they did not enjoy eating in a healthy manner. Lack of finances, individual’s organisation, attitudes and/or behaviours, were the major reasons cited why some individuals were eating cheap less-nutritious food, having smaller meals than required, or simply missing meals altogether. Slightly over half the individuals felt that they sometimes ate too much sugary food, sometimes drank too many sugary drinks, and sometimes ate too much fatty food. The difficulties of such a minority in the community must be acknowledged and addressed if substantial improvements in health are going to be made. Nevertheless, it is important not to loose sight of the fact that the majority of individuals were happy with the type of food they ate, happy with the amount of food they ate and ate enough healthy food. An age change was noted for eating too much fat, eating too many sugary foods, and drinking too many sugary drinks. Senior adults consumed less fat and sugar than adults, who consumed less fat and sugar than young adults.

Although the prevention of health problems is the most desirable action, this is not always possible. Sometimes health problems can not be avoided and thus they need to be addressed. Five health issues (last medical treatment, preferred medical facilities, bush medicine usage, speed to seek help, frequency comparisons about seeing a doctor) were researched with regard to the resolving of health problems. The participants varied substantially in terms of when they last sought medical...
treatment of any kind, however, the majority had seen a health professional within the last month (approximately a quarter had attended in the last week). The majority of visits were to see doctors, however, dentists, hospitals, chemists, and a specialist were also seen. Females were more likely to have seen a health professional recently compared with males, especially in the young adult and adult age categories. Reasons for the visits varied from simple to complex issues and involved both standard and non-traditional treatments. As most of the recent visits to a health professional were to a doctor, there was substantial variation in the participants’ answers in terms of when they last sought medical treatment with a general practitioner, the majority had attended a general practitioner in the last month, and the gender difference, noted above for seeing a health professional, was also in evidence for seeing a general practitioner. Participants choose the specific medical centres because the patient’s family or personal doctor happened to be based there and the medical practice was close to where they were at the time. A large number of participants did not mind which general practitioner they saw. In some cases they had no choice as the medical centre was a single doctor practice, or the doctor they saw might be the only one available on the day. Patients who did ask to see a specific doctor, provided a variety of reasons for doing so. The main reasons were: the doctor knew the patient’s personal history, personal characteristics of the doctor, and the patients felt comfortable with the doctor.

The majority of individuals stated they would utilise the services of a doctor if they had a medical problem. Only one individual said they would not seek help. The majority of individuals stated they would utilise the services of a doctor if they were ‘not well’. Three individuals said they would seek alternative medical treatment and some individuals said that they would go to the hospital if they were not well. The majority of individuals stated they would utilise the services of a doctor if they had the flu, while some would go to a chemist. The majority of individuals stated they would utilise the services of a doctor if they had a rash, while some would go to a chemist. Responses to ‘mildly burning yourself’ were a lot more varied than for any other scenario. A possible reason for this may be due to perceptual differences as to what constitutes mildly burnt. Common answers were to seek a doctor, to seek help at a hospital, or to treat it themselves. Young adults appear more likely to utilise the services of a hospital than adults or senior adults if they mildly burn themselves. The majority of individuals stated they would utilise the services of a dentist if they had tooth problems. An important finding was that some would go to a doctor or a chemist for pain relief only (not to cure the underlying cause). Three adults took dentistry into their own hands by removing some of their own teeth. Although dentistry is expensive, only one person said they would not take some action.

A large number of individuals said they used bush medicine. More than a quarter of the individuals had been treated by their parents or guardians and one individual was treated by their relatives (not by their parents or guardians) with bush medicine. The majority of the individuals felt that it is a good thing to use bush medicine. There was also partial support for it by another 5 individuals who thought it was some times useful. Only one person flatly believed that bush medicine was not a good therapy tool.
Responses varied with regard to the length of time it took participants to see a doctor. A large number of individuals stated that they sought the assistance of a doctor straight away. A lesser, but still large number of individuals left it as long as possible before seeing a doctor. Some left it a day or two before seeing a doctor, and one individual left it between 3 days to 2 weeks before seeing a doctor. Five individuals said their response depended upon the ailment in question, while a further two stated that they leave going to the doctor for as long as possible for themselves, however, they will go immediately for their family members. Responses varied with regard to the length of time it took participants to seek help for a toothache. A large number of individuals stated that they sought help straight away. A lesser, but large number of individuals left it as long as possible before seeing a doctor. Five individuals left it a day or two before seeking help. One individual does not ever seek help for dental problems and four individuals treat the toothache personally and then wait and see. A major determinant of the speed with which participants seek help, be it for a toothache or a medical problem, was (a) whether there is pain and (b) the degree of pain. The greater the pain, the more likely a participant was to seek help. The majority of individuals felt that Aboriginal people go less frequently than non-Aboriginal people. Equal numbers of participants felt that non-Aboriginal people see General Practitioners too frequently, as did individuals who did not know. One individual felt that non-Aboriginal people did not see General Practitioners too frequently.

While waiting in medical centres, a third of the individuals wanted to get it over and done with more than anything else, while the remaining individuals mentioned: feeling good, feeling stressed, nervous, or uncomfortable, reading books, magazines, pamphlets and watching television, nothing unusual, good except when there is a lot of people there, really annoyed, language is a problem, and that how they feel depends on their ailment. More individuals said they felt comfortable waiting to see the doctor in a medical centre's waiting area, than uncomfortable, or slightly uncomfortable. Two individuals mentioned that they felt comfortable in general practitioner waiting rooms, but not in hospital waiting rooms, and one individual said his level of comfort depended upon the number of people in the waiting room. An age difference was noted whereby the older age groups had less individuals feeling uncomfortable. The majority of individuals did not feel intimidated in medical centres. One individual noted that they use to feel intimidated, but not any longer. Similarly, two individuals who said that they were not intimidated in the medical centre, did note that they were intimidated by the doctor either as an adult, or in the past as a child. Another two individuals said that they were not intimated at Tharawal Medical Centre, but they were at other medical centres. More than half of the individuals did not feel out of place in medical centres. Three individuals noted that they did not feel out of place now, but that they use to and two individuals felt out of place most of the time, except in Aboriginal medical centres. Without prompting, a number of individuals mentioned racism occurring while waiting in medical centres. Many of the participants mentioned being stared at. Thus, it is not surprising that many individuals mentioned feeling more comfortable in Aboriginal medical centres than in western medical centres. A large number of individuals did not feel that there was any thing else that could be done to make them feel more comfortable in medical centre waiting areas. However, approximately the same number of individuals felt that there were things that could be done. Virtually all
individuals asked said they were not affected by traditional Aboriginal beliefs of whom they could sit beside and face. Thus, such beliefs did not affect these individuals when they attended medical centres. The same types of answers were obtained when individuals were asked if they were affected by traditional Aboriginal beliefs with regard to whom they could talk to. Two individuals said that they were affected by such traditions. However, they said that urban Aboriginal people did not share such beliefs. Thus, if such beliefs had any impact on these individuals, it was totally situation-specific. In urban contexts such beliefs had no impact, but participants felt that “up north” such beliefs still played a role in Aboriginal culture.

Participant’s views concerning the service they received from medical receptionists were relatively evenly distributed between very good and poor. Overall, most participants indicated that they were relatively happy with the service they received from receptionists. No participant felt that they received poor service because they were Aboriginal. Instead, they mentioned the receptionists not being friendly and needing to pay more attention to the customers. A number of individuals noted that receptionists varied considerably and thus the treatment they received was mixed. Most participants mentioned that they were welcomed by receptionists by being greeted, receiving a smile, their tone and manner of speech, by being friendly and pleasant, participating in ‘small talk’, speaking on the same level, offering assistance, providing comfort and saying goodbye. The majority of individuals said that they were informed if the doctor was running late. Furthermore, participants largely accepted the fact that doctors could not always be punctual due to unforseen circumstances. A quarter of individuals indicated that they were never late for appointments, while another quarter said that if they were running late, they would always ring and indicate this. Of those who did actually turn up to the medical centre late and who did not ring to say that they would be late, the majority stated that they were not treated differently than if they had turned up on time. The majority of individuals felt that receptionists treated them in the same manner as non-Aboriginal people. However, three individuals felt that they were treated differently and a further 10 felt that some times they were treated differently. Thus, it is not surprisingly that some individuals felt that they were more comfortable in Aboriginal medical centres. Approximately one in five individuals said that they refused to go to at least one medical centre due to the way a medical receptionist had treated them. An examination of the reasons why the participants said they were boycotting the medical centres, however, suggests that it was not as a result of the receptionists’ mannerisms or behaviours. Two participants indicated how they turned up to medical centres without Medicare cards and were told that they needed to present them.

The majority of individuals had received positive experiences when seeing a doctor at medical centres. A few individuals had mixed experiences and only one individual had largely negative experiences with doctors. Even individuals, who had experienced some less than desirable service, mentioned that overall doctors were at worse “okay.” The majority of individuals had never had a bad experience with a doctor. A third of individuals did note that they had at least once had a problem with
a doctor. Nevertheless, even with such individuals, problems with doctors were rare. Most participants who had at least once had a bad experience with a doctor never went back to them again. Even though some participants boycotted certain doctors and the medical centres that they work in, some indicated that they still use the same medical centre, but just don’t see the doctor in question. Slightly more than half said that they had never had an excellent experience with a doctor. Nevertheless, a sizable group of individuals had. Few males stated that they had ever had an excellent experience, whereas almost all females stated that they had an excellent experience. The majority of individuals were not embarrassed to go to a doctor. A few individuals mentioned that they were not embarrassed now, but that they had been when they were younger. The reasons for this earlier embarrassment varied. The remaining individuals said that they were either always embarrassed, or that it depended upon the medical problem. The majority of individuals were not frightened to go to a doctor. Five individuals mentioned not being frightened to go to a doctor, but that they were frightened to go to a dentist. When individuals were asked what was the worst thing about seeing a doctor, they provided extremely varied responses. In fact, few individuals mentioned the same thing, except to note that five people mentioned not liking needles. When individuals were asked what was the best thing about seeing a doctor, there was a lot more consensus. The majority stated being told what was wrong with them, or receiving medical treatment. The next most common response mentioned was being able to put their mind at ease.

There were a relatively equal number of individuals who didn’t care what general practitioner they saw and those who choose to see a specific doctor. Those who asked to see a specific doctor did so because it was their usual doctor, because they wanted someone of the same sex, or for specialist knowledge. Some individuals went to single practitioner clinics and thus had no choice in which doctor they saw. Nevertheless, such individuals usually admitted that they preferred to see this doctor. Thus going to a single practitioner clinic was not an access barrier. Participants were asked would you rather see an Aboriginal, Indian, Chinese, or European doctor, or does it not matter? Some participants said they would prefer to see an Aboriginal doctor, especially because they felt that such doctors would be able to communicate more effectively, would be more familiar with Aboriginal culture, and that the participant would feel more comfortable talking to another Aboriginal person. The majority of individuals, however, stated that it did not matter what race the general practitioner was. In fact, some participants indicated that the race of the doctor was so unimportant that even if an Aboriginal doctor were available, they would not necessarily ask to see this doctor. Four individuals said they would prefer Chinese doctors. The main explanation for this was a belief that Chinese doctors were the most knowledgeable. Not a single participant mentioned that their first choice would be a European or Indian doctor. In fact, one participant actually mentioned that Aboriginal people would prefer not to go to European doctors. The majority of individuals, as with the question concerning race, did not care how old the doctor was. A third of the individuals said that they would prefer older doctors. The explanation for such beliefs was that such doctors would be more knowledgeable. Two individuals said that they would prefer younger doctors. This was largely because they felt that younger doctors were more up-to-date. The majority of individuals said that it did not matter what sex the doctor was. Some individuals said that the gender of the doctor did not matter, except when a full body examination
was required or when a discussion would be required about sexual and/or reproductive matters. Individuals who always wanted to see a doctor of the same sex made the final common response. Young adults did not care what doctor they saw, whereas older age groups tended to prefer seeing a specific doctor. A similar trend was noted for age of doctor preferred for female participants. A lack of male senior individuals may have prevented concluding this. An age trend was also noted for the gender of doctor preferred.

Slightly over half the individuals asked said that they usually did not, or sometimes did not, have enough money to pay for transportation to a medical service. Likewise, almost half of the individuals asked said that they usually don’t have enough money to pay for the medical service fee. A major reason suggested by those who could pay was that they only attended medical centres that bulk-billed. In fact, almost three-quarters of the participants asked said they only go to a doctor who bulk-bills. Paying for service fees became even more problematic when participants had to see a specialist. In some cases this had severe negative consequences. Exactly half the individuals asked were concerned about the billing arrangements when they rang up to make an appointment. The major reasons mentioned by those who were not concerned were that participants largely only visited medical centres that bulk-billed, that they already knew the billing arrangements of the medical centre in question, and that they were employed and thus could afford the service fee. Slightly over half of the participants did not have enough money to pay either the transportation cost to a medical centre and medical service fee, or the cost of medications at a chemist. Some participants simply accepted this; others were more resourceful and went to St. Vincents for help, while others committed criminal acts (catching trains without paying) so as to receive medical care. Surprisingly, three-quarters of the individuals asked said that they usually had enough money to pay the transportation cost to a medical centre and medical service fee, or the cost of medications at a chemist. An analysis of the participants’ comments revealed that these participants simply acted resourcefully by planning for such situations, or asking friends, family members, or relatives to help out. If these means of acquiring the medications were not available to the participant, then health professionals usually helped out. For instance, one Aboriginal woman explained how her chemist helped her by allowing her to pay the pharmacy at a later date. Similarly, five participants mentioned that their general practitioner would provide them with free medication, such as free antibiotics.

The majority of individuals responded that they had no transportation difficulties getting to a doctor. Most of these individuals either used their own car, or asked a friend or other family member to drive them. A reason for why so many people said that they did not have a problem can be found in the fact that most participants said that they, or a close family member, had a motor vehicle. Furthermore, virtually all individuals asked said that the public transport system went near both their home and the medical centre they usually go to. Of the individuals who said they had no transportation problems, however, two said they simply walked to the medical centre. Depending upon the medical ailment, this option would obviously not always be feasible. Furthermore, 8 of the 28 individuals said they had no problems because they used Tharawal’s free transportation service. Unfortunately, a substantial number of participants mentioned that they either did not use the service because they found it less than reliable and desirable, or they used it and had to suffer the
consequences. Thus, if the 2 individuals who state that they walk to the medical centre and the 8 individuals who use Tharawal’s transportation service are not counted, then slightly more participants have transportation problems than don’t. Thus, transportation is a barrier that a significant number of Aboriginal individuals in the area have to overcome to receive adequate health care. An age difference was noted whereby individuals in older age categories were more likely to personally, or have a close family member who, owns a motor vehicle.

Slightly more than a quarter of the individuals asked mentioned that they did not have a telephone at home and a third had a phone at home, but could only receive incoming calls. Therefore, less than half had access to a telephone at home with which they could make telephone calls to a health care facility. Slightly less than half of the individuals asked said they had, or sometimes had, difficulties making telephone bookings for a medical appointment. The major difficulty expressed was one of feeling uncomfortable talking on telephones. A significant number of individuals prefer to simply turn up and wait for medical appointments, rather than make a telephone booking ahead of time. The major reason suggested for doing this was because of convenience factors and that they just happened to be there. The researcher also got the impression that some participants did not like the restriction that an appointment time creates, however, no participant specifically stated this. Slightly more than half of the individuals do not get other people to make phone bookings for them. Individuals who did mention that they sometimes asked other people to make bookings for them indicated that this was largely due to practical reasons such as being very unwell, lacking money, or medical receptionists making specialist and dentist appointments. The few that said they always got someone else to ring up for them invariably mentioned that this was because they had difficulties understanding receptionists. Unfortunately, a few individuals said they would rather wait until someone came to their home to visit and then ask them to ring and make the booking, rather than ring themselves.

One third of individuals asked either had difficulties, or sometimes had difficulties, understanding receptionists. The major difficulties were the receptionists’ speaking pattern and accents and to a lesser extent the information content. Similarly, slightly less than a quarter of individuals had difficulties and a further fifth sometimes had difficulties understanding doctors. The difficulties encountered were exactly the same as those posed by the receptionist: not understanding the information content, the doctors’ speaking pattern (e.g., mumbles, talks too softly, does not speak clearly) and accents. One-third of individuals asked said that they could not read, or could read but had some problems. One Aboriginal woman believed that there were Aboriginal people who would not go to the doctors because they were embarrassed by not being able to write and that they would have to do fill out forms. The most disappointing finding is that there appeared to be an equal percentage of Aboriginal participants who could not read ‘okay’ in each of the three age categories, thereby suggesting that the problem was not being addressed adequately. One fifth of individuals asked said that they had difficulties reading the yellow pages to find telephone numbers of doctors. Similarly, 24.1% of individuals asked said that they had, or sometimes had, difficulties reading health pamphlets.
The time participants said they normally visited a doctor varied from early morning to late afternoon in a typical bell-shaped distribution with the most frequently mentioned time period being between 10am and 11am. Nearly one in every five individuals asked said that they would not attend early in the morning (e.g., 9.00am). The major reasons cited for not attending this early were that the family came first, that they did not like to rush and they did not get out of bed early enough to go early in the morning. Even individuals who said that they had actually been to a doctor early in the morning mentioned that they couldn’t get to the doctor early due to still being in bed.

More than three-quarters of individuals asked said that they had not used bush medicine at the same time as western medicine. Some individuals freely noted that they would not want to use both at the same time due to the possibility of unforeseen interactions between both drugs. However some individuals, when questioned directly on this, did not think such interactions were possible. Two-thirds of individuals have never told a doctor that they use bush medicine. Typical reactions were that they did not think it would be necessary to tell a doctor, and that bush medicine should be kept secret to only Aboriginal people. The majority of individuals who have told a doctor that they use bush medicine stated that the doctor’s reactions have been less than favourable. The reluctance of telling doctors about using bush medicine did not appear to be related to perceived likelihood of being punished. For instance, two-thirds of the individuals questioned felt that they would not be punished by non-Aboriginal authority figures if they stated that they used bush medicine. Similarly, two-thirds of individuals asked did not think that if a person was using bush medicine and they were also going to a doctor and the doctor found out, that the doctor would “give them a hard time.” Typical reactions were that it was none of their business that they did not have the right to, and that doctors and non-Aboriginal authority figures would not understand. One barrier Aboriginal participants possibly face in telling doctors that they use bush medicine is a perception they have that western trained doctors do not understand bush medicine. For instance, only one-third of the individuals asked felt that western trained doctors maybe, would, or might understand bush medicine. Not surprisingly, 28.6% of individuals asked said that they would ever go to a doctor specifically to discuss bush medicine.

Of all the potential or actual barriers assessed in this study, the most powerful was not originally expected. During the course of the interviews, the researcher discovered that shame was mentioned frequently, without probing for it. It became increasingly obvious that some participants would not access such services readily, if at all, even if all the other barriers were eliminated. It appears that the situation is more positive for future generations of Aboriginal people in that none of the 20 young adults in this study stated that they felt shame. In fact, many stated that they had pride in themselves. One reason why some of the participants have heightened levels of shame is because they cannot read and/or write well. For instance, one Aboriginal woman always brings her husband with her whenever she visits a doctor, so that he can help her fill out the forms. This woman felt that there were other Aboriginal individuals who would not go to medical centres because they would be
required to fill out forms and that they would thus be embarrassed because of their inability to do so. If an Aboriginal person actually makes it beyond the reception area into the doctor’s office, then the possibility of increasing shame, although real, did not appear to materialise. It appeared that doctors were doing a good job in terms of not increasing the shame felt by their Aboriginal patients. The need for general practitioners to ensure that they continue to act in this manner is important for two reasons. The first is because of the extensive discrimination Aboriginal people experience. The second is because individuals who experience more shaming experiences have poorer health. For instance, Rantakeisu, Starrin, and Hagquist (1999) have noted a link between (a) the degree of financial hardship and the number of shaming experiences, and (b) the social effects of unemployment and health. They also found that unemployed subjects who suffered a greater degree of financial hardship and who also experienced a greater number of shaming experiences, exhibited the poorest health, reported deteriorated health to a greater degree, experienced negative changes in their lifestyle, did less in their free time, and had lower self-confidence than did other unemployed persons. As a number of the participants in this study were unemployed, their findings are all the more important.

The majority of the participants had not been asked whether they would like to have a friend, or family member accompany them to a medical centre when they rang up to make an appointment. Nevertheless, most of them felt that it would be a good idea to be asked this as it might make the visit more comforting, they would have someone to help them get to the medical centre, and someone to help understand the doctor’s comments. Two individuals, who had not had this suggestion put to them, did not think that it would be a good idea. However they did not appear to comprehend why it might be a good idea, nor could they provide a reason as to why it would not be a good idea. There were 8 individuals who indicated that they had been asked this. Of these, 2 individuals said that this depended a great deal on what the medical situation was. Thus, it appears that most Aboriginal people view the suggestion to bring a friend or family member along with them to a medical centre positively, as long as receptionists couch it in voluntary terms. Therefore, receptionists who suggest this to Aboriginal patients may help decrease access barriers if they, as a by-product, cause Aboriginal patients to feel more comfortable in medical centres.

The majority of participants said that having information about Aboriginality and Aboriginal health on the walls of medical centres helped. There were four major reasons put forward as to how such Aboriginal posters helped: (a) that the posters were Aboriginal-specific and thus this provided Aboriginal people with a perception that the staff were culturally aware, caring and understood their situation; (b) that they made people feel comfortable and less fearful; (c) that they informed patients what was happening in the community; and (d) that the artwork was just something that ‘caught their eye’ and that the most important and useful part of the posters was the health-related information and that they could receive help with health matters. One Aboriginal woman was not sure how the Aboriginal posters helped her, but she was sure that they did. Virtually everyone else said that the Aboriginal posters did not make a difference to them. However, some of these people did indicate that such posters might help other Aboriginal people. One Aboriginal woman noted that the
posters might present a false image of Aboriginal health by showing Aboriginal people as being healthier than they really are. One Aboriginal woman found the posters offensive, while another Aboriginal woman indicated that in fact they actually affect her negatively.

A possible solution to the lack of data on whether Aboriginal people actually visit general practitioners was developed. It is suggested that maybe each Aboriginal and Torres Strait Islander person could have the right to choose whether they would like to have either the Aboriginal or Torres Strait Islander flag printed on the top left hand corner of their personal Medicare card. This flag, approximately one centimetre by one centimetre, would indicate that the individual was of such descent and could be used as an aid to collect vital statistical data on an important aspect of Aboriginal health. Only a few participants were asked their opinion about the proposal, nevertheless, virtually everyone asked considered it was a good idea. Two individuals, however, were strongly opposed to the idea. One viewed it as akin to the Star of David during World War II and the other could see many negative consequences.

Participants were relatively evenly distributed between those who would not be affected at all and those who would be affected negatively if Aboriginal medical centres, usually with a reference to Tharawal, were closed down. Of those who said that they would be affected, one said that she would not see a different medical centre, but instead would begin using home remedies. Another participant felt that if Tharawal was closed down, then another Aboriginal medical centre would be quickly created, even if it was just a set of tents in a paddock, and thus the quality of the services offered would not be as good. Of the individuals who said that they would not be affected negatively, many stressed that other Aboriginal people would be affected negatively and thus they believed that such a move would not be a positive initiative.

A substantial number of individuals could not think of anything that they would like to make it easier to see a doctor or other medical service. Two individuals felt that there was nothing extra they needed as the present health care facilities and services suited them well. The remaining 27 individuals’ suggestions consisted of the following: reducing waiting periods in medical centres, opening medical centres for longer hours and as a by-product visits to hospitals would be decreased, doctors providing house-call service and/or free bus service to medical centres, ensuring that confidentiality is not breached at Tharawal’s medical centre, more money provided to Tharawal’s medical centre, but not necessarily administered by Aboriginal people, patients having their own medical database on disc so that they can go from medical centre to medical centre with all their medical records, medical centres using identifiable colours on patients medical cards so that staff know that the patient is Aboriginal “and [an] underprivileged person, [thus] I’m going to try and help him”, more and better doctors in the area, improving communication skills of doctors, providing interpreters if the doctor is a non-English speaking doctor, improving the attitude and service of some receptionists, helping staff in medical centres become more culturally aware, better health education and more pamphlets, and reducing smoking, alcohol and illegal drug usage in the community.
RECOMMENDATIONS

Although they focus on the treatment of diabetes, Funnell et al.’s (1991) comments are particularly relevant with regard to improving the health of Aboriginal people in the Macarthur area. They suggest the “application of knowledge and techniques should be guided by a relevant, coherent, educational philosophy (Funnell et al., 1991, p. 37).” One approach that has received much attention in the last decade has been the notion of wellness (Klepac, 1996). A major strength of the wellness perspective is that it views health in a broad sense; encompassing interrelationships among physical, mental, social, emotional, and spiritual components. Although it is “particularly applicable in diabetes management because diabetes affects all areas of a person's life - work, family, social, and recreational” (p. 225), the Aboriginal people in this study were not pro-active with regards to their health, tended to wait until they had a medical problem and even then, they left it as long as possible before seeking help. Thus a better approach might be that of empowerment (Walker, 1998).

Empowerment focuses on teaching patients, once they have the fundamental knowledge and skills necessary to control their disease, to take responsibility for their condition. For example, Anderson et al. (1991, p. 584) suggest that the approach, when used with diabetes education, “is intended to enable patients to make informed decisions about their own diabetes care and to be fully responsible members of the health-care team.” Empowerment requires the development of critical awareness, increased feelings of self-efficacy, and skills for personal, interpersonal, or social change (Bricker-Jenkins & Hooyman, 1991; Gutierrez, GlenMaye, & DeLois, 1995). Such an approach “has the potential to promote overall health and maximize the use of available resources” (Funnell et al., 1991, 37).

Some authors have even suggested that empowerment programs can address the emotional, spiritual, social, and cognitive aspects of living (Arnold et al., 1995) by helping individuals develop skills and self-awareness in goal setting, problem solving, stress management, coping, social support, and motivation. Thus the wellness approach strengths can also be addressed by the empowerment approach.

Empowerment is not a new approach. It was popular in the 1960s (Freire, 1973; Zippay, 1995), and more recently has seen a resurgence of interest in the 1990s and the new millennium (Butler, et al., 1998; Howorka, et al., 2000). It has been used with a variety of diseases which include asthma (DaSilva, 1996), cancer (Gray, Doan, & Church, 1991), diabetes (Anderson et al., 1995), end stage renal disease (Molzahn, 1996), and hypertension (Opie, & Steyn, 1995). It has also been used with many situations affecting health, either directly, such as with battered women (Elliott, 1997), child welfare (Stein & Frost, 1992), and cholesterol checks (Holt, Johnson, & de Belder, 2000), or indirectly, such as helping people cope with the arson of black churches in the United States (Carter, 1999), correctional programs for juvenile offenders (Hasenfeld, & Chesler, 1989), and women support groups using a clinical sociology and feminist oriented approach (Billson & Disch, 1991). It
has been used effectively in a wide variety of countries: Australia (Rissel, Perry, & Finnegan, 1996), Canada (Herbert, 1996), Italy (Vanelli, 1999), New Zealand (Simmons, et al., 1998), Scotland (McDonald, 1998), South Africa (Opie, & Steyn, 1995), and the United States (Solberg, et al., 1997) and has been adopted by a variety of health professionals including dieticians (Williamson, et al., 2000), nurses (Woollons, 1996), and social workers (Elliott, 1997). Nevertheless, although empowerment has been extensively used and its efficacy validated, as recently as only two years ago an author suggested that it was a radical approach: “the nurses interviewed were working with very wide perceptions of health promotion which included the more radical aspects of health promotion such as negotiation, collaboration and empowerment” (McDonald, 1998, p. 213).

Empowerment has not only been advocated and used at the individual level, such as with schoolchildren (Borup, 1998), but also at the corporate level with managers and administrative staff (Irvine et al., 1999), in Occupational Safety and Health training-of-trainers courses (Fleishman, 1992) and non-governmental health organizations in the Philippines (Lee, 1994). At a macro level, examples of community empowerment are available from Canada (Lomas, 1997), Indonesia (Saludung, 1997) and the United States (Geller et al., 1998). The case of community empowerment in Indonesia is of particular interest. A scheme of social funding, “dana sehat”, devised in the 1960s, has been particularly successful in inducing communities to accept responsibility for health care development decision-making. Empowerment has also been a central theme on a national level (Zippay, 1995). For example, it has been seen in American political campaigning with Vice President Dan Quayle calling empowerment “the heart of the Republican agenda” (Deparle & Appelbome, 1991), President Bush proposing his domestic proposals would “empower people to make their own decisions and control their own destinies” (Zippay, 1995, p. 263), and President Clinton pledging to “change the whole focus of our poverty programs from entitlement to empowerment” (“President’s Address”, 1993, p. A14). Political rhetoric aside, empowerment has actually been pursued at a nation level in the United States with President Clinton promoting an urban development initiative that funds economic planning and social services in neighbourhood “empowerment zones” (DeParle, 1993). When empowerment is seen as a possibility on many levels, it is understandable how “empowerment practice, unlike strategies aimed at helping client systems adjust to or cope with problems, is concerned with increasing clients’ personal, social, or political power so that they are enabled to change their situations and prevent the reoccurrence of problems (Gutierrez, GlenMaye, & DeLois, 1995)” (Carter, 1999, p. 63).

A difficulty with empowerment, however, is that it is not “a term that defies easy translation from English into other languages” (Friedmann, 1996). Although Aboriginal people in the area in which this study was conducted, use English as their

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41 It is not surprising that there are a variety of definitions of empowerment, because empowerment can be pursued at varying levels. For example, Emerick (1996) notes that empowerment can be viewed as a psychological concept used to promote individual change, or a socio-political concept used to promote social change. Barker (1991, p. 74) defines empowerment as “the process of helping a group or community to achieve political influence or relevant legal authority.”

42 In fact Ackerson and Harrison (2000, p. 1044) consider empowerment is a “vaguely defined term.”
first language, translating the concept of empowerment may not be straightforward and may pose some unexpected difficulties. Another difficulty with empowerment is that too often it has been ideological and prescriptive, rather than practical and descriptive (Payne, 1991). This criticism, however, is only warranted in the case of poorly constructed programs. The major impediments to empowerment programs are structural in nature. Winship (1995, p. 113) points out, unfortunately, “that despite the rhetoric of patient empowerment, the present political and ideological climate of individualism works against the realization of empowerment.” He argues that there are a number of factors such as reluctance of professionals to be disempowered; ideological attacks on the achievements of collectivism; rise of individualistic, and prescriptive forms of psychological treatment, which works against patients influencing the treatment they receive. He therefore concludes, “an ideology of patient empowerment exists, but [that it does so] in a body politic that is incapable of facilitating it” (p. 113). Fairhurst and May (1995) provide further support for the view that empowering patients is not without difficulties. They suggest the “thrust towards empowering the patient has had the unintended consequence of marginalizing the doctor's view, in making it difficult for the doctor to operate with independent authority and judgment (Fairhurst & May, 1995, p. 389).” Nevertheless, if the philosophy and techniques of empowerment are taught well, and implementation is attempted in an environment which is supportive politically (not high in structural resistance), then there is every reason to believe that such programs will have the same benefits as those produced by so many other empowerment programs. To be successful, however, such courses need to be conducted by health professionals who both: (a) truly believe in the philosophy of the approach and (b) who have been comprehensively trained and thus have a specific set of skills, with which they can facilitate the learning of empowerment techniques by patients (Anderson et al., 1991).

Health professionals will only be successful in facilitating the development of empowerment skills if they take into consideration the cultural context in which the participants live in (Carter, 1999). In practice, policies and services capitalise on the natural networks of the community (Allen-Meares & Burnam, 1995). For the same reason, many authors explain why modifications may be required in the administration of organisations that presently serve patients. It is quite obvious that if the ultimate goal is for clients and consumers of services to gain greater power, changes in the administration of organisations that service them may be required (Gerschick, Israel, & Checkoway, 1989; Mathis & Richan, 1986; Pinderhughes, 1989; Sherman & Wenocur, 1983). If such steps are taken, then there is every reason to believe that empowerment will be successful with Aboriginal people in the Macarthur area. The success Herbert (1996) has shown with the indigenous Haida Gwaii people in Canada is evidence that such an outcome is likely.

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43 Compounding the confusion is the fact that some people describe “empowerment primarily as a goal, others as a process, [and] others as a form of intervention” (Gutierrez, GlenMaye, & DeLois, 1995, p. 250).
44 Practising in an empowerment manner requires health professionals to work as collaborators, rather than superiors. “Power is shared and clients are helped to experience a sense of power within helping relationships” (Carter, 1999, p. 62). Obviously, if a health professional is not comfortable in such a non-traditional role, or does not truly believe in the philosophy of empowerment, then success will not occur.

What Aboriginal people think about their access to health care.
Techniques that have been found to be successful in health promotion research which adapts an empowerment approach have included not only empowering the patient, along with providing them with modern management and continuous education, but also providing family members with empowerment training. Such an approach has been very effective in attaining excellent glycemic control with patients who have diabetes (Vanelli et al., 1999). In fact, the mothers’ sense of empowerment alone can contribute significantly to their child’s adherence to their diabetes treatment and metabolic control. Not surprisingly, more extensive and culturally appropriate programs have achieved even greater successes. For instance, a two-year church-based diabetes risk reduction programme, utilising lifestyle change, diabetes awareness, and empowerment in a Western Samoan population in New Zealand was successful in reducing risk factors for future Type 2 diabetes (exercise levels, weight control, waist circumference, diabetes knowledge, consumption of fatty foods).

To offer a further example, Funnell, Anderson, and Oh (1994) took a diabetes patient education program, “Life With Diabetes”, and successfully converted it into an undergraduate course, consisting of only seven 2-hour sessions with presentations by a physician, dietician, psychologist, and clinical nurse specialists. The course covered topics such as definition, treatment, nutrition, monitoring, children, older adults, and patient empowerment. At the completion of the short course, the university students who did not have diabetes improved their knowledge about diabetes and their attitude towards the disease. The authors concluded that “a patient education program can be adapted successfully to provide additional training opportunities for diabetes education programs” (Funnell, Anderson, & Oh, 1994, p. 37). The importance of this study is that it clearly demonstrates how the essential features of a health promotion training program, which incorporates empowerment, can be modified to suit the particular characteristics of a group of individuals and achieve favourable outcomes.

Another source of support for the empowerment approach comes from the literature on poverty. Friedmann (1996) notes there are four main ways that poverty is talked about (bureaucratic talk, moralistic talk, academic talk, voices of the poor). He notes that bureaucratic talk (i.e., low-income population, absolute poverty), employs objective (usually income) criteria, with an emphasis on people's ability to consume. Moralistic talk (i.e., destitute, voluntary poor, deserving poor) places the onus of poverty on the poor themselves. Academic talk (i.e., marginalization, exclusion, exploitation) implies that the poor are victims of forces beyond their control. Voices of the poor talk, he suggests, is poor people's own definition, which they see as a form of disempowerment. Such disempowerment consists of three dimensions: social (poor people's relative lack of access to resources), political (poor people's relative lack of a clear political agenda), and psychological (poor people’s internalised sense of worthlessness and passive submission to authority). Friedmann goes on to suggest that “in a climate of public opinion which appears to give its consent to the worldwide triage of poor people, the only viable response to poverty is by the poor themselves” (Friedmann, 1996, p. 165). Similarly, while there are a

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45 Thus in the rest of his article he discusses the empowerment model and suggests the need for new forms of democratic governance if the empowerment model is to work.
variety of improvements that can be made in the accessing of health facilities by Aboriginal people in the Macarthur area, the most effective response to poor Aboriginal health will come from Aboriginal community and Aboriginal people themselves.

It is extremely important that health promotion planners realise that they cannot target only one aspect of Aboriginal health and expect to be particularly successful, because the poor state of Aboriginal health is due to a multitude of problems. Helping Aboriginal people and the Aboriginal community ultimately achieve optimal levels of health will require a multi-disciplinary approach. Thus, any health promotion programs that are developed from this report need to be designed in a way to work with a variety of services. As the core element of empowerment is the development of personal and interpersonal power through a process of self-awareness (Gutierrez, GlenMaye, & DeLois, 1995), health promotion planners, seeking to design a program which would use this approach, need to be fully cognizant of the fact that the program must integrate with existing services, but at the same time these existing services may be required to make some modifications as their clients come to gain and expect greater power.

It is important that a health care strategy is not developed from this study that inadvertently sets back some of the advances that are presently being made in health care for Aboriginal people. For instance, Read (1982, p. 2) in an occasional paper for the Minister of Aboriginal Affairs stated: “White people have never been able to leave Aborigines alone. Children particularly have suffered. Missionaries, teachers, government officials, have believed that the best way to make black people behave like white was to get hold of the children who had not yet learned Aboriginal lifeways. They thought the children's minds were like a kind of blackboard on which the European secrets could be written.” If non-Aboriginal society is to accept the empowerment of Aboriginal people and individuals, then an approach of simply integrating Aboriginal people into a healthcare system, largely designed by non-Aboriginal people is almost certainly set up, from the onset, to fail.

A possible method by which empowerment could be encouraged in Aboriginal individuals in the Macarthur area is by the use of a mobile health unit. Such a unit could be a bus, from here onwards called the ‘Empowerment Bus’, fully decorated with Aboriginal art, and provisioned with the necessary equipment and appropriately

46 One of the many examples of improvements in Indigenous health is provided by Kim and Humphrey (1999) who, using a retrospective observational study, presented a decline in the incidence of gestational diabetes mellitus in Far North Queensland over a 5-year period (1992-1996).

47 Health professionals can accidentally forget this very important point. For example, this study is part of a larger research project. Initially the name of the three-year project was called: “The integration of urban indigenous populations into local primary health care services.” After a number of discussions, the name of the three-year project was changed to: “The access of urban Indigenous populations to local primary health care” Although this name change may seem like a small administrative action, which required very little effort, the philosophical and attitudinal change required is obviously substantially larger. Nevertheless, it is small changes like these that have important impacts.
trained staff. The aim could be to provide Aboriginal people with: (1) full-body check-ups and screenings for major diseases that affect Aboriginal people in the area, and (2) to provide them with an initial introduction to empowerment training, that allows them to leave the ‘Empowerment Bus’ with at least an understanding of what empowerment means and one technique to use so they can act in a more empowered manner.

The use of mobile health units as a health care strategy is not a recent approach. Cowan and James (1981) noted how the armed forces have been using them for decades to provide medical and dental services. They describe a number of examples. For instance, they explain how the United States Naval Dental Research Institute developed a prototype, which was an 8.5 foot van, capable of moving over land, sea, and air. The equipment inside included, amongst other things, two dental chairs and an x-ray machine. They also describe how the Denver VA Medical Center produced a Winnebago Medi-Van. This was designed for a totally different purpose; to serve as a chronic care general medical clinic in nine Colorado counties.

Mobile units have been used to treat a variety of diseases: breast cancer (Kann, Bradley, & Lane, 1998), cervical cancer (Swadiwudhipong, et al., 1999), chronic obstructive pulmonary disease (Harmoncourt, 1990), diabetes (Fisher & Brown, 1990), glaucoma (Kurtz, Goldenfeld, & Melamed, 2000), leprosy (Nebout, 1983), lung cancer (Sone, et al., 1998), sickle cell disease (Duncan, Scott, & Castro, 1982), skin cancer (Krol, et al., 1991), syphilis (Kahn, et al., 2000), and tuberculosis (Pakharin & Edel'shtein, 1985). They have provided a number of services including dentistry (Frenkel, 1997), eye screening (Taylor, 1997), mammography (Gordenne, 1997), prophylactic medical examinations (Bratkov, 1989), screening for osteoporosis (Takeda, et al., 1995), transrectal ultrasonotomography for mass screening of prostatic disease (Watanabe, et al., 1984), and even acupuncture in Russia (Multykh, & Samsygin, 1990). Such services have been very successful. For instance, Sone et al. (1996) screened the thoraxes of 5,483 Japanese individuals, aged between 40 and 74 years, in a mobile unit with a low-dose X-ray spiral computed tomography (CT) scanner and was able to obtain a lung-cancer detection rate significantly higher than using standard mass assessments in the same area. Swadiwudhipong, et al. (1999), using a mobile unit, carried out a systematic screening programme in 1993 and 1996, with the purpose of increasing Papanicolaou smear usage among rural Thai women. The screening techniques used by the mobile unit were extremely successful in that 85.2% of all cervical intraepithelial neoplasia (CIN) III and all invasive cancers identified in the area, between 1992 and 1996, were identified by staff on the mobile unit. More importantly, the proportion of women who had ever had a Pap smear increased from 19.9% in 1991 to 58.1% in 1994 and to 70.1% by 1997. Similarly, Kann, Bradley, and Lane (1998, 188) found that using a mobile van for conducting breast cancer screening had “comparable cancer detection rates to national figures and a fairly stable biopsy recommendation rate from which follow-up resource needs [could] be estimated.”

48 Although Omeri and Ahern (1999) have noted the difficulties in recruiting and retaining Aboriginal nursing students, the author of this study is of the opinion that such an approach requires that wherever possible, the health care professionals on the ‘Empowerment Bus’ be Aboriginal.
The author has not been able to find any evidence of a mobile unit being used to provide empowerment training. There is, however, one reported approach that has a mild similarity. McEwan, et al. (1999), in an innovative approach, converted a double-decker bus and equipped it with a team of specially trained staff. They spent 3.5 years screening more than 20,000 people for cardiovascular risk factors, while travelling all throughout Scotland. The aim of the project “was to assess the incidence of risk factors in healthy individuals and to modify their risk factors by individual counselling” (p. 106). They encountered many difficulties, especially in the planning phase, but concluded their “project provides a model for other screening projects involving a multicentre/scattered cohort” (p. 106).

Mobile health units have been used in a large number of countries: Australia (Saunders, 19990), Austria (Haroncourt, 1990), Belgium (Gordenne, et al., 1997), Britain (Taylor, 1997), the former Czechoslovakia (Kramer, 1984), France (Seguret, et al., 1995), Ireland (Murray, et al., 1992), Israel (Kurtz, Goldenfeld, & Melamed, 2000), Japan (Sone, et al., 1998), Netherlands (Krol, et al., 1991), Russia (Bratkov, 1989), Scotland (McEwan, et al., 1999), Singapore (Yeo, Fan, & Yong, 1993), South Africa (Bailie, 1996), Thailand (Swaddiwudhipong, et al., 1999), United States (Chez, 1998), and several French-speaking African countries (Nebout, 1983). They have been used in rural (Lutsenko & Figurnov, 1985; Pakharin, 1984), semi-rural (van Hal, et al., 1999), and urban areas (Boland, 1982; Cummings, Kutner, & Montes, 1971). They have also been established in some difficult and extremely varied locations: a black ghetto in the United States (Cummings & Kutner, 1971; Cummings, Kutner, & Montes, 1971), remote mountainous regions in Japan (Takeda, et al., 1995), and in the modern city of Singapore (Yeo, Fan, & Yong, 1993).

Mobile health units have been successfully used in divers conditions and countries, with different aims and philosophies, to treat, screen, or prevent the medical illnesses and health conditions of male and female individuals of varying ages. However, this does not mean an approach using an ‘Empowerment Bus’ is destined to be successful. For instance, van Hal, et al. (1999) report on how they implemented a mobile breast cancer screening program in the semi-rural district of Kontich, a province of Antwerp. Unfortunately the attendance rate, compared to international standards, was very low. They provided some suggestions as to how this poor attendance rate could be improved. Their suggestions are applicable to the proposed ‘Empowerment Bus’:

“To increase the attendance rate, the following interventions should be considered: devising the personal invitation letter in a more attractive way, activating and stimulating the important motivational role of the GP in persuading women to attend the organized screening programme and offering the invited population the possibility to have a mammographic examination performed outside business hours.” (van Hal, et al., 1999)

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49 Dr. Nancy Slagg (North Western University), in a personal communication (October 2nd, 2000), suggests: “Your plan to field a mobile health screening and health education bus sounds like a good one… I know that in Chicago, Il. the Chicago Health Dept. does something similar.”
Nevertheless, there are five additional reasons (which will be discussed in more detail below) why this author believes an approach such as the ‘Empowerment Bus’ could be successful: (1) the findings of Kahn et al. (2000), (2) the results of Levin (1997), (3) the fact that mobile dental units have been successfully used since 1980 with Aboriginal people in Australia, (4) the changing socio-political climate in Australia with regards to reconciliation, and (5) favourable comments from the few participants asked about the idea.

Kahn et al. (2000) interviewed 18 community leaders and 38 community members who were at risk for syphilis. All 56 individuals were disadvantaged African Americans. They reported favourable comments about using the services of a mobile health van compared with services provided in their own homes or at a bar. This author believes that if individuals are in favour of using a mobile service for such a sensitive and potentially embarrassing health ailment, then there is a good chance that Aboriginal people in the Macarthur area might be convinced to use a mobile health facility for a check-up and discussion.

Levin, et al. (1997) offered women aged 60 to 84 years, the chance to have a mammogram conducted in a mobile health facility driven to 12 community meal sites sponsored by the City of Los Angeles Area on Aging. Of the 148 eligible women (must not have had a mammogram within the last 12 months), 57% accepted the mammograms. They concluded: “Mobile mammography is acceptable to many older community-dwelling women. Although mobile mammography does not eliminate all barriers that inhibit a woman from receiving a mammogram, it may substantially increase screening for some groups.” Hence, for women who were not expecting to have a mammogram on that day, the majority accepted. Considering the age of the participants, this is an encouraging result.

Saunders (1990) explains how Aboriginal mobile dental units in New South Wales have been successfully operating in Australia since the first one was put into action at Toomelah Reserve near Boggabilla in October 1980. In 1990 there were two mobile dental units. They contained a small waiting area, a small laboratory/work area, full range of equipment, one dentist and two assistants.

Jackson, Brady, and Stein (1999) noted that “currently in Australia, both Aboriginal and non-Aboriginal Australians are attempting to reconcile themselves with a history of colonization/invasion, which resulted in human rights violations against Australia’s Indigenous people” (p. 97). As a result, some health organisations have taken steps to apologise to the Indigenous people of Australia. For instance, the Public Health Association of Australia’s (1997) position statement on Indigenous health reads: “[The association] acknowledges that public health practitioners, health and welfare agencies and hospitals have all been party to the abductions of

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50 For a more in-depth look at steps recently taken by both health organisations and individuals in the spirit of reconciliation, the reader is referred to a recent article entitled “Sense and sensitivity” which appears in the Australian Doctor (18 August, 2000, pages 31-32).
Indigenous children and that among practitioners and policymakers who were not directly involved in the abductions the vast majority failed to speak out against what was being done.” Similarly, the Royal Australian College of General Practitioners in a draft position statement also acknowledge the damage done to Indigenous Australians. Many other health professionals feel the same way personally. For instance, Jackson (L. R.) and Ward (1999, p. 437) suggest that:

“Many health professionals are deeply troubled by the persistent health inequities between Aboriginal and non-Aboriginal Australians. From a social and political perspective it is clear that, for there to be appreciable improvement in Aboriginal health, a process of reconciliation which acknowledges the past in the light of the present needs to be adopted across all sectors of society.”

The author of this study suggests that in such an environment, Aboriginal people may be more willing to attempt things that are outside of their comfort zones, and hence may be willing to use the services of an ‘Empowerment Bus’.

The final reason suggested why the ‘Empowerment Bus’ is likely to succeed comes from the responses of a few participants. As the researcher approached the end of the 55 interviews, it was quite obvious that for some participants ‘shame’ was a barrier to accessing health facilities. It was equally obvious that empowerment was one way to attack this access barrier. However it was not until a participant suggested that doctors should come to the homes of patients, that a mechanism by which empowerment could be delivered was conceived. Since that interview, a number of people, especially the remaining interviewees, were consulted about the idea. All of these interviewees were positive towards the idea. The following four responses were the most articulate:

**I:** How would you feel if there was a mobile bus or mini-bus which came around Airds, over a three-month period, and stopped at a different street each day. And you could go along and be checked out. It wouldn't cost you a cent and maybe you might even get paid $10 to go there. Would you use it?

**A:** “I’d say I think I probably would do it.”

**I:** Would you be embarrassed?

**A:** “No. Because there's a lot of people out there, you know, they’ve felt threatened before and so they feel, you know, they don't have to go to the doctor, because it’s somewhere where they don't feel part of it, you know. So they prefer to stay at home and you know, not treat the illness at all. Whereas, um, this bus coming around the streets, all he has to do is walk out the front door. I'm sure he'll walk out the front door. You know, go and get checked out.”

**I:** Would it be better to have that bus decorated with Aboriginal paintings on the outside, or would it be better to have it plain so that it's not sort of obvious that it's a bus for Aboriginal people?

**A:** “Um, well, doesn't matter really.”

*(Aboriginal Man, Young Adult: 16-25 years)*
I: How would you feel if there was a mobile bus or mini-bus which came around Airds, over a three-month period, and stopped at a different street each day. And you could go along and be checked out. It wouldn't cost you a cent and maybe you might even get paid $10 to go there. Would you use it?

A: “Oh definitely. Yeah, if they were the right medical people.”

I: If the outside of the bus was painted with Aboriginal paintings would that embarrass you?

A: “No, no.”

(Aboriginal Woman, Young Adult: 16-25 years)

I: How would you feel if there was a mobile bus or mini-bus which came around Airds, over a three-month period, and stopped at a different street each day. And you could go along and be checked out. It wouldn't cost you a cent and maybe you might even get paid $10 to go there. Would you use it?

A: “Probably not. If I was sick I probably would.”

I: Say if they were to have a campaign and also have leaflets dropped off in letter boxes around here, so trying to suggest that it's a good idea to have a check up and maybe even pay you $10?

A: “You probably wouldn't need to pay, but if they had things coming around saying that it's good to go for a regular check up every now and then, then I probably would.”

I: Do you think in all honesty though, that money if people were offered $10 to go along, they would see there's some benefits as well. It wasn't a big waste of their time?

A: “Yep.”

(Aboriginal Woman, Young Adult: 16-25 years)

I: How would you feel if there was a mobile bus or mini-bus which came around Airds, over a three-month period, and stopped at a different street each day. And you could go along and be checked out. It wouldn't cost you a cent and maybe you might even get paid $10 to go there. Would you use it?

A: “Yes. Um, and I know a lot of people would use that, because, um, a lot of the Koori community are shy. They are frightened to go out, you know, down to the doctors. Whereas if they had their own facility in their own street and no one is encroaching on their territory and forcing them to do things. If that happened you would get a lot of the Koori woman opening up. Because a lot of the Koori woman are frightened... They are scared to open their mouths, because they've had such bad treatment in the past... They feel because of their level of education and their poor knowledge of health, you know, what's good for them. Um, that they are too embarrassed to go down and say to the doctor, blah, blah, I've got this health problem. I don't know about proper diets, or anything like this, because they feel too stupid to say it.”

(Aboriginal Woman, Senior Adult: 46+ years)

Some readers might assume that now would be the appropriate place to conclude by presenting suggestions as to how the ‘Empowerment Bus’ would best be designed, what goals it should have, what equipment it should contain, what staff would be appropriate to work in it, and what strategies should be used. However to make such suggestions would be totally contrary to the principles of empowerment. Instead, Aboriginal people have to be fully involved in the decision-making regarding how such a health care facility would best be developed. In this way, a ‘culturally safe

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51 Obviously the author can be contacted, at a later date, about his various ideas about how an ‘Empowerment Bus’ could be designed as a public health strategy.
service delivery’, a term Maori\textsuperscript{52} nurses were the first to coin, could can be created (Williams, 1999). Williams suggests that such a culturally safe service delivery ensures that there is no assault on a person's identity and that “the people most able or equipped to provide a culturally safe atmosphere are people from the same culture” (p. 213). In this way, “the reluctance [by Aboriginal people] to access services, especially in times of crisis” (Radford et al., 1999, p. 77) will hopefully be reduced.

To conclude, this author suggests that readers interested in implementing a mobile health care facility should read the following three articles:

Chez, N. (1998). Nursing in the field. Mobile health units are an important part of bringing health care to communities. \textit{American Journal of Nursing}, 98(9), 68-70.


All three authors provide in-depth explanations of the planning and implementation of their mobile health units. They also present the difficulties that they encountered. Their suggestions are invaluable in reducing the pitfalls that subsequent health promotion planners may encounter and will need to overcome.

Readers with a serious interest in facilitating empowerment, are encouraged to read the following article:


Researchers interested in empowerment will be pleased to note that a number of psychological inventories that investigate several aspects of empowerment have recently been developed (Speer & Peterson, 2000). These should be of particular interest to health workers and researchers specialising in Aboriginal health because they are all in areas pertinent to Aboriginal people. For instance, Via and Salyer (1999) have created a Diabetes Empowerment Scale and Rissel, Perry and Finnegan (1996) have completed initial validation on an empowerment inventory which consists of two subscales: general empowerment and alcohol-specific empowerment. They suggest that the alcohol-specific subscale “could be used in the evaluation of community alcohol abuse prevention programmes (Rissel, Perry & Finnegan, 1996, p. 211).” Therefore, researchers interested in learning about the effects of health promotion programs on empowerment are directed to the following:


\textsuperscript{52} Maori people are the Indigenous people of New Zealand

What Aboriginal people think about their access to health care.
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APPENDIX 1

Appendix 1: Original “umbrella” questions used as the basis for the semi-structured interviews

Perceived health status:
How healthy would you say you are?
To what extent are you concerned about your health?
To what extent do you think about your health?
Is your health all that important to you?
Do you have any medical problems (diabetes, high blood pressure, epilepsy, eye problems)?

Previous health treatment seeking behaviour:
When was the last time you sought medical treatment of any kind? Where did you go?
When was the last time you sought medical treatment from a GP?
Why did you choose to go to that medical centre and not another medical centre?
Have you ever had a bad experience with a doctor? Do you still go to this doctor?
Is there any medical centre you will not go to?
Why did you choose to go to that GP and not another GP?
Do you usually ask for a specific doctor, or do you not care who you see?
Do you have a preference in choice of doctor, e.g., Aboriginal, Indian, Chinese, or European? Or, does it not matter?
Do you have a preference in choice of doctor, e.g., young, old? Or, does it not matter?
Do you have a preference in choice of doctor, e.g., male, female? Or, does it not matter?
In general, would you prefer to go to a doctor, chemist, or the hospital for medical problems? Why?
If you are not well, would you prefer to go to a chemist, doctor, hospital, or seek alternative medical treatment?
If you have the flu who would you seek for help: a chemist, doctor, or the hospital? Why?
If you had a rash who would you seek for help: a chemist, doctor, or the hospital? Why?
If you mildly burnt yourself who would you seek for help: a chemist, doctor, the hospital, or bush medicine?
If you have a tooth problem, would you prefer to go to a doctor, dentist or the hospital?
Do you only see a doctor when there is no other option?
If you have a toothache do you immediately seek medical help, or do you wait a few weeks?

Check-up questions:
Have you ever gone to the doctor when you were healthy?
Is it a good idea to see a doctor when you are healthy, or is that a waste of time?
Have you ever had your blood sugar measured?
Do you believe in preventative health?
Do you ever read health pamphlets?
Do you understand what child immunisation is?
Do you believe in child immunisation?
Why do you have your child immunised? Was it because of the law, money on offer, or because you believe it is a good thing for your child?
Do you ever pick up the health pamphlets?
If you have health problems where do you get your information from: parents, friends, pamphlets, and/or doctors?
**Personal feelings about seeing a doctor:**
Are you embarrassed to go to a doctor?
Are you frightened to go to a doctor?
What has been your overall personal experience when seeing a doctor at medical centres?
What is the best thing about seeing a doctor?
What is the worst thing about seeing a doctor?
Does information about Aboriginality on the walls of medical practices help?
Are you affected by traditions of who you sit beside and face in the medical practice?

**Feel at the medical centre:**
How do you feel when you are waiting in the medical centre?
How comfortable do you feel when you are waiting to see the doctor in a medical centre’s waiting area?
Is there anything that could be done to make you feel more comfortable in medical centre’s waiting areas?
Do you feel intimidated in the medical surgery?
Do you feel out of place in the medical surgery?

**Receptionist questions:**
What are the medical receptionists like?
In what ways do you think receptionists make you feel welcome when you arrive at a medical centre?
To what extent are you kept informed if the doctor is running late?
How are you treated if you arrive late for an appointment?
Do you ask the receptionist any questions, or need any further assistance, after you have seen the doctor?
Do you feel the receptionists treat you the same way as a non-Aboriginal person? Or do they treat you differently? In what ways do they treat you differently?
Do you not go and see a doctor because of the way medical receptionists treat you?

**Possible problems getting to a medical surgery:**
Do you have enough money to go to the doctor?
Do you have transportation difficulties getting to a doctor?
Are you concerned about the billing arrangements when you ring up to make an appointment?
Do you have difficulty making a phone booking for a medical appointment?
Would you prefer to ring up for a medical appointment, or simply turn up and wait?
If you ring up to make a medical appointment are you asked whether you would like to have a friend, or family member accompany you?
Is there any thing you would like to make it easier to see a doctor or other medical services.
What time of the day do you normally visit a doctor? Do you ever have an appointment to see the doctor early in the morning, e.g., 9.00am?
Do you get other people to make the booking for you?
Do you wait until someone comes to your place to visit, before making a booking?

**Comparisons:**
How frequently do you think Aboriginal people compared with non-Aboriginal people see General Practitioners? Why do you think that is the case?
Do you think non-Aboriginal people see General Practitioners too frequently?

**Bush medicine:**
Do you feel that it is a good thing to use bush medicine?
Do you feel non-Aboriginal authority figures would punish you if you stated you use bush medicine?
Do you feel that if you use bush medicine and white authority figures found out, then you would get punished?
APPENDIX 2

Appendix 3: Expanded list of “umbrella” questions used as the basis for the semi-structured interviews after 17 interviews were completed

Perceived health status
How healthy would you say you are?
Do you have any medical problems (diabetes, high blood pressure, epilepsy, eye problems)?
To what extent do you think about your health?
To what extent are you concerned about your health?
Is your health all that important to you?

Obtaining health information
Where do you get your information from? Is it from parents, friends, pamphlets, TV, radio, the internet, doctors, or other sources?
Can you get all the health information that you require?
Do you find it easy to get the health information you require?
Do you have problems obtaining the health information you require?
Do you find it embarrassing asking about health issues?

Health pamphlets
Do you ever read health pamphlets?
Do you find health pamphlets worth reading, or do you simply read them to pass time while you are waiting?
Do you know that you can take the health pamphlets from doctors’ surgeries home with you?
Have you ever done that?
Do you find health pamphlets enjoyable to read?
Do you find health pamphlets well written?
Is there anything that could be done to make health pamphlets better?
Would you be embarrassed if health pamphlets were in cartoon format?

Immunisation
Do you understand what child immunisation is?
What is it?
Do you believe child immunisation is a good thing?
Do you have any children?
Did you have your children immunised?
Why did you get your child immunised?
Do you realise that the government pays parents to have their children immunised?
Do you think there are some Aboriginal people who have their children immunised only because of the money on offer?

Check-ups
Do you believe in preventative health?
Have you ever gone to the doctor when you were healthy?
Is it a good idea to see a doctor when you are healthy, or is that a waste of time?
Have you ever had your blood sugar measured?
Have you ever had your blood pressure measured?
Have you ever had your cholesterol measured?
Have you ever had a mammogram?
When was the last time that you had a mammogram?
Alcohol and smoking
Do you drink alcohol?
Do you drink too much alcohol?
Do you smoke tobacco?

Exercise
Are you happy with the amount of exercise you do?
When was the last time you exercised?
How frequently do you exercise?
Do you exercise too little, too much, or about the right amount?
What kind of exercise do you do?
Do you enjoy exercising?

Nutrition
Are you happy with the type of food you eat?
Are you happy with the amount of food you eat?
Do you eat enough healthy food?
Do you enjoy eating in a healthy manner?
How much “junk food” do you eat”?
Do you eat too much fatty food?
Do you eat too much sugary food?
Do you drink too many sugary drinks?

Last medical treatment
When was the last time you sought medical treatment of any kind?
Where did you go?
When was the last time you sought medical treatment from a GP?
Why did you choose to go to that medical centre and not another medical centre?
Why did you choose to go to that GP and not another GP?

Which medical facilities do you use?
In general, would you prefer to go to a doctor, chemist, or the hospital for medical problems?
If you are not well, would you prefer to go to a chemist, doctor, hospital, or seek alternative medical treatment?
If you have the flu who would you seek for help: a chemist, doctor, or the hospital?
If you had a rash who would you seek for help: a chemist, doctor, or the hospital?
If you mildly burnt yourself who would you seek for help: a chemist, doctor, the hospital, or bush medicine?
If you have a tooth problem, would you prefer to go to a doctor, dentist or the hospital?

Bush medicine usage
Do you mind if I ask you questions about bush medicine?
Do you use bush medicine?
Did your parents or guardians treat you with bush medicine?
Do you feel that it is a good thing to use bush medicine?

Speed to seek help
Do you see a doctor immediately, or do you leave it as long as possible before seeing a doctor?
Do you only see a doctor when there is no other option?
If you have a toothache do you immediately seek help, or do you leave it as long as possible before seeking help?
Do you only see a dentist when there is no other option?
Frequency of seeing a doctor compared with non-Aboriginal people
How frequently do you think Aboriginal people compared with non-Aboriginal people see General Practitioners? In other words, if non-Aboriginal people see doctors x number of times per year, how many times per year do Aboriginal people see doctors per year? Is it more times, about the same times, or less times?
Do you think non-Aboriginal people see General Practitioners too frequently?

Feel at the medical practice
How do you feel when you are waiting in the medical centre?
How comfortable do you feel when you are waiting to see the doctor in a medical centre's waiting area?
Do you feel intimidated in the medical surgery?
Do you feel out of place in a medical surgery because you might be the only Aboriginal person there?
Is there anything that could be done to make you feel more comfortable in medical centre's waiting areas?
Are you affected by traditional Aboriginal beliefs of who you can sit beside and face? Do these beliefs affect you when you are waiting to see a doctor in a medical practice?
Are you affected by traditional Aboriginal beliefs of who you can talk to? Do these beliefs affect you when you are waiting to see a doctor in a medical practice?

Personal experiences with receptionists
What are the medical receptionists like?
In what ways do you think receptionists make you feel welcome when you arrive at a medical centre?
To what extent are you kept informed if the doctor is running late?
How are you treated if you arrive late for an appointment?
Do you ask the receptionist any questions, or need any further assistance, after you have seen the doctor?
Do you feel medical receptionists treat you the same way as a non-Aboriginal person, or do they treat you differently? In what ways do they treat you differently?
Do you find it difficult being served by a female receptionist?
Do you refuse to go to a medical practice because of the way a medical receptionist has treated you?
Is there any medical centre you will not go to?

Personal experiences with doctors
What has been your overall personal experience when seeing a doctor at medical centres?
Have you ever had a bad experience with a doctor?
Have you ever been back to this doctor?
Have you ever had an excellent experience with a doctor?

Personal feelings about seeing a doctor
Are you embarrassed to go to a doctor?
Are you frightened to go to a doctor?
Do you enjoy going to the doctor?
What is the best thing about seeing a doctor?
What is the worst thing about seeing a doctor?

Kind of doctor Aboriginal people prefer to see
Do you usually ask for a specific doctor, or do you not care who you see?
Would you rather see an Aboriginal, Indian, Chinese, or European doctor, or does it not matter?
Would you rather see an old, or a young doctor, or does it not matter?
Would you rather see a male, or a female doctor, or does it not matter?
Financial difficulties
Do you usually have enough money to pay for transportation to a medical service?
Do you usually have enough money to pay the medical service fee?
Are you concerned about the billing arrangements when you ring up to make an appointment?
Do you only go to a doctor who bulk-bills?
Do you usually have enough money to buy medications?
If you needed to, do you have enough money to be able to pay for transportation to a medical service and pay the medical service fee today?
If you needed to, could you pay for the cost of medications at a chemist, today?

Transport difficulties
Do you have transportation difficulties getting to a doctor?
Do you, or a close family member, have a motor vehicle?
Does the public transport system go near both your home and the medical centre you usually go to?
Do you use Tharawal’s transportation services often?

Making telephone bookings
Do you have difficulties making a phone booking for a medical appointment?
Would you prefer to ring up for a medical appointment, or simply turn up and wait?
Do you get other people to make the phone booking for you?
Do you simply not make phone bookings to see the doctor, but rather wait until someone comes to your home to visit, and then ask them to make the booking for you?

Language difficulties
Do you have difficulties understanding the receptionist?
Do you have difficulties understanding the doctor?
Can you read okay?
Do you have difficulties reading the yellow pages to find the doctor’s telephone number?
Do you have difficulties reading health pamphlets?

Time of appointment
What time of the day do you normally visit a doctor? Do you ever have an appointment to see the doctor early in the morning, e.g., 9.00am?

Difficulties using bush medicine
Have you ever used bush medicine while also using western medicine at the same time?
Have you ever told a doctor that you are using bush medicine?
Do you feel non-Aboriginal authority figures would punish you if you stated you use bush medicine?
Say a person is using it and they are also going to a doctor, and that doctor found out, would that doctor give them a hard time?
Do you feel that if you use bush medicine and white authority figures found out, then you would get punished?
Are there Western trained doctors who understand bush medicine?
Would you ever go to a doctor specifically to discuss bush medicine?

Making access easier
Is there any thing you would like to make it easier to see a doctor or other medical services?
If you ring up to make a medical appointment are you asked whether you would like to have a friend, or family member accompany you?
Does information about Aboriginality on the walls of medical practices help?

Sum-up Question
If I was to remember only one thing from this interview, what would you like it to be?
Appendix 3: Perceived health status of Aboriginal participants (in age order)

<table>
<thead>
<tr>
<th>Gender</th>
<th>How healthy would you say you are?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aboriginal Participants (16-20 years)</td>
</tr>
<tr>
<td>Male</td>
<td>“Um, not very good.”</td>
</tr>
<tr>
<td></td>
<td>* I: Why is that?</td>
</tr>
<tr>
<td></td>
<td>* “Because I smoke, drink.”</td>
</tr>
<tr>
<td>Male</td>
<td>“About medium.”</td>
</tr>
<tr>
<td></td>
<td>* I: What’s medium mean?</td>
</tr>
<tr>
<td></td>
<td>* “Pretty much healthy as it is. I think it is pretty good, except for the smoking.”</td>
</tr>
<tr>
<td>Male</td>
<td>“Pretty healthy.”</td>
</tr>
<tr>
<td></td>
<td>* I: What does that mean?</td>
</tr>
<tr>
<td></td>
<td>* “I'd say average; halfway.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Oh pretty healthy.”</td>
</tr>
<tr>
<td></td>
<td>* I: What does that mean?</td>
</tr>
<tr>
<td></td>
<td>* “Oh like not that healthy.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Um, I don't know. About 75 percent healthy. I mean I haven't got any diseases, or anything.”</td>
</tr>
<tr>
<td>Male</td>
<td>“Fit.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Um, pretty good.”</td>
</tr>
<tr>
<td></td>
<td>* I: And what's ‘pretty good’ mean?</td>
</tr>
<tr>
<td></td>
<td>* “I haven't been that sick.”</td>
</tr>
<tr>
<td></td>
<td>* I: Are you often quite sick?</td>
</tr>
<tr>
<td></td>
<td>* “No.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Very healthy.”</td>
</tr>
<tr>
<td></td>
<td>* I: What does that mean?</td>
</tr>
<tr>
<td></td>
<td>* “I eat well. I’m pretty fit. I get around. I'd say I’m pretty healthy. Yep.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Average.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Average, pretty healthy for my age.”</td>
</tr>
<tr>
<td>Male</td>
<td>“Not too healthy, but not unhealthy, just a bit in the middle.”</td>
</tr>
<tr>
<td></td>
<td>* I: What does that mean?</td>
</tr>
<tr>
<td></td>
<td>* “To me, that I can still get up in the morning, stretch and go for a run and whatever and I don’t get too puffed out, or I don’t get sick from a cold.”</td>
</tr>
<tr>
<td>Male</td>
<td>---53</td>
</tr>
<tr>
<td>Male</td>
<td>“Pretty healthy.”</td>
</tr>
<tr>
<td></td>
<td>* I: What does that mean?</td>
</tr>
<tr>
<td></td>
<td>* “Healthy enough.”</td>
</tr>
<tr>
<td></td>
<td>* I: Healthy enough for what?</td>
</tr>
<tr>
<td></td>
<td>* “To play sport.”</td>
</tr>
<tr>
<td>Male</td>
<td>“Um, unhealthy.”</td>
</tr>
<tr>
<td></td>
<td>* I: Unhealthy?</td>
</tr>
<tr>
<td></td>
<td>* “Unhealthy.”</td>
</tr>
<tr>
<td></td>
<td>* I: What does that mean?</td>
</tr>
<tr>
<td></td>
<td>* “I'm underweight.”</td>
</tr>
</tbody>
</table>

53 The symbol “---” indicates that the person either was not asked the question, or they could not provide an answer.
Aboriginal Participants (21-25 years)

Female

“Very healthy.”
I: What does that mean?
“Um, I'm a very fit person. I do my exercises every day. I'm never sick. Like I might get migraines from my scar, but that's about it.”

Female

“I don't know. I couldn't really say. I don't think I'm very healthy with all the food I eat. I'm a bit unfit and overweight.”

Female

“Very healthy.”
I: What does that mean?
“I'm healthy.”

Female

“Extremely healthy. I do do a cigarette. I'm a little unfit, but I'm healthy. Extremely healthy.”

Male

“Um, pretty healthy. Don’t get crook very much.”
I: What’s healthy to you?
“Um, don’t catch a cold much. I can run pretty good. That’s about it I reckon.”

Aboriginal Participants (26-30 years)

Female

“Not healthy.”
I: What does that mean?
“Unfit. Does not eat the right food.”

Female

“Pretty fair.”
I: What does that mean?
“Getting along.”
I: Getting along. What does getting along mean?
“I have problems now and then, yep, pretty stressful, tired, tired, bodies really tired.”
I: Anything else?
“No.”

Female

“Not really healthy.”
I: What does that mean?
“Well I smoke, drink.”

Female

“Average.”

Male

“Oh, pretty average fit. Eh, I train twice, three times a week.”
I: Doing what?
“Just jogging, running around the Oval.”

Male

“Average.”

Aboriginal Participants (31-40 years)

Male

“Pretty healthy.”

Male

“Reasonably healthy.”

Female

“Not very healthy at all.”

Male

“Not healthy enough... I found out that I’ve got, I’m diabetic. Um, I do have a sleep apnoea problem.”

Female

“Sort of healthy.”
I: What does that mean?
“Well I know that I have a few problems that need to be seen to.”

Female

“I wouldn’t know. Probably half.”

Male

“Um, not really healthy, I get a bit windy because I smoke a lot. Um, I breakout with
What Aboriginal people think about their access to health care.

Male
“Well I'm still working and I'm pretty active. Yep, I'm pretty healthy.”

Female
“Um, not very. Not very.”
I: What's not very mean?
“Well, I’m an asthmatic. I’ve got an allergy to mildews [mushrooms] and I am not to have milk more than a day old. And, um, I have got to have special bread, because some of the flours have a wheat that has mildew in it and the yeast.”

Male
“Pretty averages sort of health.”
I: What’s average?
“I don’t know. I think pretty fit.”

Aboriginal Participants (41-45 years)

Female
“I think I’m healthy, but I could be healthier if I gave up smoking.”

Male
“Well up until late last year fairly healthy. I’ve led a healthy lifestyle. Played a lot of sport, eat healthy, do a lot of exercise, don’t drink, used to smoke, um never touched drugs, but earlier this year I was feeling a bit sick. Went into hospital and had to have bypass surgery. Since February this year I have had five bypasses. But apart from that, that has been the first time I have been in a hospital.”

Female
“Not very well at the moment. Sort of with the xxxxx.”
I: What does that mean?
“Not very well.”

Male
“Pretty healthy I reckon.”
I: What does pretty healthy mean?
“Well I go walk about. I mean I put in a lot of exercise per day for a bloke who has had three heart attacks. A lot more walk about than most people I know. I mean I would rather walk down to Campbelltown then catch a cab.”

Aboriginal Participants (46-50 years)

Male
“I could be a lot healthier. Out of 100, 45%. 45% out of 100, that’s, I know that’s sort of putting myself down, but out of 100, say 45.”
I: What do you mean by putting myself down?
“I could be a lot of healthier. I could be a lot of healthier. If I took the time to give cigarettes away. Cigarettes, that’s one of my big, um, big habits, bad habits. I have tried to give it away, but it does not seem to work… I haven’t got the self motivation. I’ve tried those Nicobate things, pads, but it’s just doesn’t seem to work for me. I’m a drinker, alcohol. Mainly I’m just a beer drinker. No spirits. I can’t drink spirits, because of the sugar content in it. With the sugar content, I’m a diabetic – Stage 2 diabetic, insulin dependent. That’s why I don’t drink spirits.

Female
“Not.”
I: What's not mean?
“Get knocked up very easily, but I try and walk a lot.”
I: You say get knocked up, what you mean by that?
“Because I'm a smoker.”

Male
---

What Aboriginal people think about their access to health care.
### Aboriginal Participants (51+ years)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>“Very.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Could be better. Need to lose weight.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Not very.”</td>
</tr>
<tr>
<td></td>
<td><em>I: What does that mean?</em></td>
</tr>
<tr>
<td></td>
<td><em>Could be better.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>“Ooh, probably about 50% healthy, really. I've had a few accidents in me live, and, um, they are, you know, when you're a young bloke, sort of thing, you're big and tough, ‘I can handle it’.”</td>
</tr>
<tr>
<td></td>
<td>“… They are injuries, you know, from sport or work that, you know, I never really didn't thought about at the time and now it’s affecting me.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Um, well, I feel pretty good, considering what did happen and what I have been through, all of my experiences. But at the moment I feel very good.”</td>
</tr>
<tr>
<td></td>
<td><em>I: Can you explain what you mean by ‘really good’?</em></td>
</tr>
<tr>
<td></td>
<td>“Um well I am ready to go back to work and at home, here, I’m that good, I’m just cooking and just cleaning. I feel very good.”</td>
</tr>
<tr>
<td>Female</td>
<td>“At the moment I'm not healthy and all.”</td>
</tr>
<tr>
<td></td>
<td><em>I: Why is that?</em></td>
</tr>
<tr>
<td></td>
<td>“I'm overweight. And because I'm overweight, it causes a lot of, you know, to do with blood pressure. And I've got diabetes. And I really didn't look after myself properly, because I thought, you know you don't have to, because you're not on tablets, so that's cool. But then I found out, that I have a lot of problems. Because I've had feet problems, you know, because of the diabetes.”</td>
</tr>
<tr>
<td>Female</td>
<td>“I'm not real healthy. No.”</td>
</tr>
<tr>
<td>Female</td>
<td>“I’d say I’m healthy. I concerned about being overweight, but pretty active.”</td>
</tr>
<tr>
<td>Male</td>
<td>“I need to give up smoking. I don’t feel well, but I am pleased that I’m feeling as well as I am for xxxxx [his age]. I still got that urge to climb trees, surf, skin dive, and I know I can still do those things. But, um, this coughing, and I'm getting more aches and pains every now and again. Now like, you know, I never used to have. Um, I still love the things that I love when I was 20, and I can still do most of them. Um, health wise, I have had a hernia operation. Um, I was told I had an ulcer, but I have always put that down to the way I see things. If I don't see something clear, I'll speak a little bit louder.”</td>
</tr>
<tr>
<td>Female</td>
<td>“I’m not.”</td>
</tr>
<tr>
<td></td>
<td><em>I: What do you mean by that?</em></td>
</tr>
<tr>
<td></td>
<td>“I’m not what you call real healthy.”</td>
</tr>
<tr>
<td></td>
<td><em>I: Are you happy with your health?</em></td>
</tr>
<tr>
<td></td>
<td>“No.”</td>
</tr>
<tr>
<td>Male</td>
<td>“Grade one all the time.”</td>
</tr>
</tbody>
</table>
## APPENDIX 4

Appendix 4: Relationship between individual’s opinions concerning whether seeing a doctor when healthy is a good idea and concern about one’s health (in age order)\(^{54}\)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Is it a good idea to see a doctor when you are healthy, or is that a waste of time?</th>
<th>To what extent are you concerned about your health?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Aboriginal Participants (16-20 years)</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>“Oh, it could be a good idea.”</td>
<td>“Um. I wish that I could give up the smokes, but I can't. It's too hard to give them up.”</td>
</tr>
<tr>
<td></td>
<td><em>I: And why is that?</em></td>
<td><em>I: Have you ever tried?</em></td>
</tr>
<tr>
<td></td>
<td>“Just in case anything is wrong with you, or anything.”</td>
<td>“Yeah, once. But I got straight back on them, because I was around people smoking all the time.”</td>
</tr>
<tr>
<td></td>
<td><em>I: Could you imagine yourself ever doing it? Going along when you think you are healthy?</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Oh yeah one day.”</td>
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<td></td>
<td><em>I: Do you reckon you would do it in the next five years?</em></td>
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<tr>
<td></td>
<td>“Probably, I don't know.”</td>
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<td></td>
<td><em>I: In reality, do you think you would go in the next five years, or not really?</em></td>
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<tr>
<td></td>
<td>“No, not really.”</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>“Waste of time.”</td>
<td>“Not really.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Oh, it’s just a waste of time.”</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>“Waste of time. If you’re not sick, you don’t need to go to the doctor.”</td>
<td>“Yeah, a think so.”</td>
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<tr>
<td></td>
<td><em>I: And why is that?</em></td>
<td><em>I: Why is that?</em></td>
</tr>
<tr>
<td></td>
<td>“…Like if I cut myself, I'll go to a doctor, but some people cut themselves and say ‘Oh, don't worry. It’s only a scratch.’ But it could turn into something else. And like if I think something is wrong, I'll go to the doctor before it gets any worser.”</td>
<td>“Just in case there is something wrong with you and you're not sure of.”</td>
</tr>
<tr>
<td></td>
<td><em>I: Have you ever gone to the doctor</em></td>
<td><em>I: Have you ever gone to the doctor</em></td>
</tr>
<tr>
<td>Male</td>
<td>“Waste of time.”</td>
<td>“That I don’t want to go to waste.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Yeah.”</td>
<td>“Not really.”</td>
</tr>
<tr>
<td></td>
<td><em>I: Why is that?</em></td>
<td><em>I: No?</em></td>
</tr>
<tr>
<td></td>
<td>“Just in case there is something wrong with you and you're not sure of.”</td>
<td>“No.”</td>
</tr>
</tbody>
</table>

\(^{54}\) The order of participants’ comments in this Appendix is exactly the same as in the previous Appendix. Thus readers, if they desired, could make a comparison not only between whether participants believe that seeing a doctor when they are healthy is a good idea or not and the degree to which they are concerned about their health, but they can also compare these viewpoints with how healthy they felt they were.
when you were healthy, apart from when you were pregnant?
“No.”
I: Could you see any point in going to see the doctor when you were healthy, if you weren’t pregnant?
“Oh, sometimes I would.”
I: Why would you go?
“Just to make sure. Check my whole body and that.”

| Female | --- | “I’m not really concerned actually. Like health is a big thing, but I don't really think about it until I'm sick or something is going on.” |
| Female | “Yes. To see if I am all right.” | “I could do a lot, but I don’t. If I knew more, I’d do more and could tell you.” |
| Female | “Good idea.” | “If some things wrong, I go see the doctor.” |
| Male | “Just a waste of time, I reckon.” | “I don’t really think about my health. I mean I eat, I don’t really eat healthy food and think now I can do this and I can do that. I just eat and go out and do whatever I want.” |
| I: Why is that? | “Well there’s nothing really wrong with you, so they’re looking for like nothing really. They’re trying to find if there is anything wrong with you, but there isn’t. Your just getting a check up done.” | I: Do you smoke? |
| I: So you can't see any advantage by actually having a check up. | “No, I mean it would be good if I did, but I really wouldn't take the time out to do it.” | “No.” |
| I: So why would it be good? | “Just to, if they pick up something early. Like, um, your just starting to get some sort of cancer, or AIDS even, anything like that.” | I: Do you drink? |
| I: So you don’t want to know if you’re getting cancer, you’ll just wait till you get it? | “I’d like to know. Yeah, I would like to know. But, um,” | “A bit, yep.” |
| I: You can see what you are doing. You say I’d like to know, but I wouldn’t take the time out to do it. So which is it? | “I’d probably wait until it was too late. It wouldn’t be my choice but.” I: Wouldn’t be your choice? | “No.” |
| I: Can’t you just, right this moment say I have had enough of the interview and go off and see a doctor? Could you not do that? | “Yeah I could.” | I: That all? |
| “Yeah I could.” | “I don’t really think about my health. I mean I eat, I don’t really eat healthy food and think now I can do this and I can do that. I just eat and go out and do whatever I want.” | “Oh, there could be times when I would go like four days a week, but I’ve done over four days.” |
| I: So what are we talking about? | “Bourbon and spirits. That’s all I can drink.” | I: So what are we talking about? |
| Male | “Probably is a good idea.” | “Sort of.” [Later on he explained that he was concerned about his smoking.] |
| Male | --- | “No, not really.” |
What Aboriginal people think about their access to health care.

| Male | “I don't know bloke. Oh, like, it's a good idea to go to the doctor when you're sick eh.” | “I: Why do you reckon that is the case?“
“I'm healthy.”
“‘I'm concerned.’” |
|------|-----------------------------------------------------------------|---------------------------------------------------------------|
| Female | --- | “Oh, I’d love to live longer.”
“I: How long do you think you will lived till?“
“I’d say I should live till about 70 or 80, if I stop smoking.”
“‘I'm not concerned, but I try to do something about it when I can.’” |
| Female | “Why would you go to the doctor if you were healthy.” | “‘No, it’s okay.’” |
| Female | --- | “From head to toe darling, I'm concerned about me health.”
“Mainly getting overweight and stuff. Like I want to stay fit and stuff.” |
| Male | “Um, yeah, I don’t know. I suppose it would be silly. You probably only go see a doctor if you are real crook or something.”
“I: Can you think of any time that you might go if you were healthy?“
“Um, no. Probably if you, I don't know, no not really. There's no point going to the doctor if you are healthy and stuff. I suppose you would if you were starting a family or something.”
“I: So why would you do that?“
“See if your wife is alright.” | “Well not too concerned as you can see.”
“I: What do you mean by 'as you can see'?“
“For myself I don't feel 100 percent fit, but probably 50/60. The size of me is pretty big.” |
| Male | --- | “‘Yes. To see if healthy.’”
“Not really concerned.”
“Waste of time.”
“Yes.” |
| Female | “I just volunteered. I get it done once in a blue moon. Say just make sure my cholesterol is normal. Sugar is normal and all that. You don't want to get it too high. Blood pressure, you don't want to get it too low.” | “‘Yes. For check-ups’”
“‘Yes’” |
| Female | --- | “A bit lately as my mum was diagnosed with diabetes recently.”
“A lot. I watch a lot of programs [on TV].”
“Not really concerned.”
“Yes.” |
| Male | --- | “‘Yes, to see if healthy.’”
“Not really concerned.”
“Waste of time.”
“Yes.” |
| Female | --- | “A bit lately as my mum was diagnosed with diabetes recently.”
“A lot. I watch a lot of programs [on TV].”
“Not really concerned.”
“Yes.” |

Aboriginal Participants (21-25 years)

Aboriginal Participants (26-30 years)
### Aboriginal Participants (31-40 years)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Gender</th>
<th>Quote</th>
<th>Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 – 37y</td>
<td>Female</td>
<td>“Yes, good to see a doctor whether you're healthy or not.”</td>
<td>“I'm starting to get more concerned because I'm getting older. I've had trouble with my neck, but I've had that seen to.”</td>
</tr>
<tr>
<td>28 – 33y</td>
<td>Male</td>
<td>“It's a good idea just to get checked over.”</td>
<td>“Fairly concerned.”</td>
</tr>
<tr>
<td>28 – 33y</td>
<td>Male</td>
<td>“Me, I'm really concerned about it, because um, especially with my diabetes because it runs in the family. Like, you know, it does run in the family, and I'm really concerned about my own, um, diabetes, my own health I should say. I go to the doctors, if I've got appointments to go see a doctor, then I'll go see him. It doesn't matter if I am working or not, you know. If I have an appointment, I'll go and see him, especially if it comes to my health.”</td>
<td></td>
</tr>
<tr>
<td>31 – 40y</td>
<td>Male</td>
<td>“Well it would be a waste of the doctors time as well as my time if I'm healthy. Because if I'm healthy I wouldn't have to go see a doctor, because what for, you know, what for, what do you want to go see a doctor.”</td>
<td>“Live your life as far as it is suppose to go.”</td>
</tr>
<tr>
<td>31 – 40y</td>
<td>Female</td>
<td>“All depends. Sometimes, sometimes not.”</td>
<td>“I’m alright how I am, but rather be fatter, than skinny like I am now.”</td>
</tr>
<tr>
<td>31 – 40y</td>
<td>Male</td>
<td>“It’s a good idea just to get checked over.”</td>
<td>“Now that I am getting older, yes I am starting to worry about my health.”</td>
</tr>
<tr>
<td>31 – 40y</td>
<td>Male</td>
<td>“Me, I'm really concerned about it, because um, especially with my diabetes because it runs in the family. Like, you know, it does run in the family, and I'm really concerned about my own, um, diabetes, my own health I should say. I go to the doctors, if I've got appointments to go see a doctor, then I'll go see him. It doesn't matter if I am working or not, you know. If I have an appointment, I'll go and see him, especially if it comes to my health.”</td>
<td></td>
</tr>
<tr>
<td>31 – 40y</td>
<td>Female</td>
<td>“Yes.” “Fairly concerned.”</td>
<td>“Now that I am getting older, yes I am starting to worry about my health.”</td>
</tr>
<tr>
<td>31 – 40y</td>
<td>Male</td>
<td>“It’s a good idea just to get checked over.”</td>
<td>“Fairly concerned.”</td>
</tr>
</tbody>
</table>
**Aboriginal Participants (41-45 years)**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Response 1</th>
<th>Response 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>“Yes.”</td>
<td>“Not very concerned.”</td>
</tr>
</tbody>
</table>
| Male   | “I have been back, like I have been back to a doctor and they have recommended comeback in two weeks for a further check up. So I have done that”  
  I: You also mentioned that you went to have your diabetes checked up and your heart checked up. From what I remember, you said you also thought you had gone there for another reason as well?  
  “Yes.” | “Very concerned. My mother passed away four years ago so that leaves me and my brothers and sisters as the oldest generation. Um, as it is fairly important to pass down history. We have to get history recorded.”  
  I: Tell me a little about that?  
  “Well, like my great grandfather was born of French parents in the Seychelles Islands. Now, although we know where he died, we don’t know when and we don’t know exactly where he is buried. The oldest brother was a SIDS case, so I don’t know where he is buried. I just feel that those sorts of things, plus my father’s side of things, he being born in England. I just feel it’s important for the next couple of generations that are here for them to know.” |
| Female | “I go just for a check-up… just to see if I have Hep C, AIDS, or anything like that. Just for your own safety, like you don't have heart attacks. Like a lot of my people, girlfriends that I have known, they die from cancer. They never go to the doctor. They would rather die with the cancer, then go to a doctor. A lot of them died and same with alcoholism.”  
  I: And why do you think that they [interrupted by the Interviewee]?  
  “Because they don't like going to the doctor. Aboriginal people don't like being probed. You know, people just think they are animals to be probed around with and things like that and that sort of puts you down.”  
  I: Are you scared to go to a doctor?  
  “To be honest, yeah. I don't like him probing around with me. I mean the first doctor that I ever went to, like a gynaecologist, he was very rude and | “No.” |
| Male   | --- | “Oh when I end up in hospital mainly. I know my limits when I drink and that. See I am able to pull up when I have had enough. I am not everyday, but once a fortnight I have a drink, that’s about all.”  
  I: Do you smoke?  
  “Everyday, but with my alcohol say every fortnight.”  
  I: Touch any other stuff, but we won’t mention what it is?  
  “Oh, once in a blue moon. I’m not addicted to it.” |
What Aboriginal people think about their access to health care.

<table>
<thead>
<tr>
<th>Aboriginal Participants (46-50 years)</th>
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<tbody>
<tr>
<td>Male</td>
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<tr>
<td><strong>“Before I was diagnosed with diabetes I was pretty fit, pretty fit. I couldn’t run half a marathon, but I was pretty fit. I was health-conscious, you know, health conscious. When I was diagnosed with diabetes I sort of said, ‘That doesn’t hurt. You’ve can handle it.’ You know, that sort of attitude. So I’m very picky, fussy, and I’ll go to a person who I know treats me with the right attitude and with respect like I would with you.”</strong></td>
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<tr>
<td><strong>“I suppose ending up in hospital, that would be it, just ending up in hospital. Like I said, next heart attack I have I hope I am straight to the morgue, there’s no stop off at the hospital and trying to revive me. Because I don’t want no needles stuck in me to keep me alive.”</strong></td>
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<tr>
<td><strong>“Yeah, it’s more like a waste of time.”</strong></td>
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<tr>
<td><strong>I: So if you had to go to a doctor right this moment, how would you get there?</strong></td>
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<tr>
<td><strong>“No I wouldn't even bother about trying. Yeah I wouldn't bother about trying. I just would be taking it really easy.”</strong></td>
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<tr>
<td><strong>I: So you can’t think of any time when you would need to go to a doctor now?</strong></td>
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<tr>
<td><strong>“No. No. Well they always tell you to calm down. They always tell you to, you know, make yourself nice and quiet, so you are not making yourself any movements, or anything like that. And that's exactly what I do. Just keep the movements down to a minimum.”</strong></td>
</tr>
<tr>
<td><strong>“Well they have done that for the last three heart attacks I’ve had. And for every pain in the chest I’ve got stuck in an ambulance, they kept on wanting to stick needles into me to. Most of my elders, including my brothers and sisters and cousins, the ones that have died in the last five years have all died from being in the care of doctors. And it is a continual years that they have messed around with their bodies until they are just dead.”</strong></td>
</tr>
<tr>
<td><strong>I: Is that what had to happen in the past?</strong></td>
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<tr>
<td><strong>“Yes.”</strong></td>
</tr>
<tr>
<td><strong>I: But if they get help quick enough and get you to a hospital, they could possibly keep you alive?</strong></td>
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<tr>
<td><strong>“Yes, might, yes.”</strong></td>
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<tr>
<td><strong>I: But you don’t what that?</strong></td>
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<tr>
<td><strong>“No, not really, because like I said, doctors have been poking around with my relatives, you know, for the last five years you could say, and members of my family have died.”</strong></td>
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<tr>
<td><strong>I: But if they save your life by putting you in an ambulance, taking you to hospital and doing what they have to do [interrupted by interviewee]?</strong></td>
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<tr>
<td><strong>“And then killing me. No, no. I don’t feel like going to the doctor no more. I’ve had enough of them. They want to do blood tests. They want to do, and they already have all that information, um, but it’s just like continual paperwork. I hate continual paperwork. Medicine is the same way too. On top of that I would like to use the bush medicine.”</strong></td>
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<table>
<thead>
<tr>
<th>Female</th>
<th>“Well I think it's a good idea to go see a doctor even though you are healthy, or even if you are not healthy, to make sure that everything is ticking. At least you would be prepared if you do come down with something. The alternatives will be there.”</th>
<th>“Overweight, smoker, but I don't drink.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>“Good idea.”</td>
<td>---</td>
</tr>
<tr>
<td>Female</td>
<td>“I think so.”</td>
<td>“I worry about it.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Yes. Good idea. Keep track on you.”</td>
<td>“Should be healthier. I think everyone should be concerned.”</td>
</tr>
<tr>
<td>Female</td>
<td>“Yes. Just to check.”</td>
<td>“Greatly. I think it's very important. You don't realise until it's too late.”</td>
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<table>
<thead>
<tr>
<th>Aboriginal Participants (51+ years)</th>
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</thead>
<tbody>
<tr>
<td>Female</td>
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<tr>
<td>Male</td>
</tr>
</tbody>
</table>

I: How old were you when it happened? “1997 I was diagnosed with diabetes. Christmas 1997. That sort of knocked my arse in there. My first initial reaction was ‘why me?’, you know. Out of millions of people, why should I have diabetes. We had Christmas at Canberra and it took me the whole Christmas period to realise that I am not the only person with diabetes. I took it the wrong way. I took it to heart. Why, why, why me. Out of all these people, why me. Out of my whole family, why me. Then my doctor asked me if any of my family had diabetes and my mother has diabetes and it’s a hereditary kind of thing. So I have accepted it. I still have an intake of sugar now and then. That’s when I’m low in my glucose…”
| Female | “No, um, I think that check-up, well if you, um, your healthy, like every six or 12 months just to go for a check up in case anything that finds wrong that you can, um, get it earlier.” | “I was very scared, very frightened. Actually I felt like taking a whole lot of sleep tablets. Then I woke up one morning and said ‘Hey, I’ve got one leg, just make the most of it’. And I just snapped out of it. And from that day to this I’m just ready to live life to the fullest like I did before.” |
| Female | “To me, I think it’s a waste of time.” | “Well the last six months I’ve become really concerned. I’m starting to really, you know, worry about and start to, you know, pay more attention, go up to Tharawal, you know.” |
| Female | --- | “Oh, you know, as long as I feel it in me self that I am all right, you know what I mean?” |
| Female | “Yes.” | “Think about it more as I am getting older.” |
| Male | “No, I, I, I don't have enough time in this life to, to, like I say, waste their time, waste my time. I can see no benefit. If I am interested in my health, there are journals, or if I do have specific questions to ask, then I would go see a doctor and get that information, but I wouldn't go to a doctor for no reason. There would have to be a question in my mind, I mean to, have to get the answer of a doctor, if I couldn't read the MIMS or whatever, like, you know.” | “[Long pause]. I've got a lot of things I want to do before I die. I'm not frightened of death. Um, you know, if anybody harms my children I will kill them straight away. Um, I, I've got a lot of fixing up to do. I was an alcoholic for 20 years of my life. I've destroyed a lot of friendships. I've destroyed a marriage. I've destroyed a lot of trust. Um, and I'm still rebuilding with my ex-wife, also with my children who are adults now. Um, and I still haven't reached where I'm fully accepted by a lot of people properly and I'm accepted partly by a lot of people. I want everyone to know that the person that they knew when I was drinking and violent, that I'm not that person now. I don't need anyone to forgive me, but I need for them to be able to form a relationship with me on a friendship that I can offer now. Not with remembrance of that I was an arsehole then, so therefore I must be an arsehole now. I have progressed from that alcoholic state to thinking of what I am today. I might be pig-headed today, but that's my belief in what I say, that I’m right, until someone tells me that I’m wrong, or can prove to me that I am wrong, I won’t change my way.” |
| Female | “That’s a good idea. But I don’t have the time to go when I’m working.” | “Really concerned… Like, when I was younger, if I had a pain, or felt something was wrong with me, it wouldn't be a problem for me to take meself off to the doctor. Um, I don't know if it's because, like when you get older you've got a fear of dying, or whatever, but like I tend to put off going to the doctor, like I sort of try different things me self. I know I suffer a lot.” |

I: What sort of things would you try?
“Well if I think I have got, I’ve had antibiotics given to me before and I think tried those sorts of things, or sometimes I just bare it. Well like, well see I was diagnosed with xxxxx about two years ago and I was supposed to go back to the doctor with that to get something done about it, but I haven’t been back.”

I: And the reason for not going back?
“I just get scared, I don’t like being in hospital, or don’t like being sick. And I worry because, like if I have to have an operation, like with me xxxxx [a separate medical condition] the way it is.”

I: Does it worry you that by delaying it, going to see a doctor you may cause yourself more problems. Yes, that worries me also. That concern isn’t big enough for you to go see somebody now?
“Well it is getting to a stage, like before it wasn’t giving me any problems. Like I just found out by accident that I had the xxxxx, because I had to go down and have an x-ray for something else and that’s when they discovered, and of course I wasn’t having any problems then, I didn’t bother going back. But I’m now starting to get problems, like pain and things like that, that I’ve got to go back. But it’s something I can’t put off any longer.”
Appendix 5: Participants responses to: “In general, would you prefer to go to a doctor, chemist, or the hospital for medical problems?”

1. RESPONSES FROM PARTICIPANTS WHO WOULD UTILISE DOCTORS:

I: Why is that?
A: “Well the chemist cannot tell you very much can they. The hospital makes you sit there for four to six hours.”
(Aboriginal Woman, Senior Adult: 46+ years)

I: Why is that?
A: “Well, if I need any medicine, um, if I need any certificates, whatever, I can get it all from the doctor.”
(Aboriginal Man, Adult: 26-45 years)

A: “Um, sometimes I do just go to the chemist and ask them to save me going to the doctors. And if they don’t know, then I’ll get an appointment with the doctor and I’ll go see the doctor. But if the chemist fella can help me, well.”
I: Why do you want to save yourself from having to go to the doctor?
A: “Just sometimes it’s just a long waiting period for you, you know. Like, I’m sick that day, or that week, you know. Then he can’t see me for another two weeks. Well I can’t put up with the pain and that, you know. That happened to me a couple of times, eh. And, oh, I was a bit crook and I can’t see the doctor until about two weeks and I said ‘I can’t’, but they said ‘We’re all booked in. So you’ll have to find another doctor.’ So I rang two, three, but they were all booked out, so I just went to the chemist and told him my problem and he gave me some tablets to ease the pain and that for a while, until I saw the doctor.”
(Aboriginal Man, Adult: 26-45 years)

I: And why is that?
A: “So that way, I will tell him my problems and he can tell me what’s going on with me I suppose.”
(Aboriginal Woman, Adult: 26-45 years)

“Doctor. I’d rather go to a doctor, before a chemist, so, so the doctor can examine, check me all out, see what the problem is. Because you can’t go to a chemist and they say ‘oh’. You know, I come here to see if he can help me out with me problem, me medical problem. He’s not going to turn around and say ‘take a seat please sir and I will get you the right tablets’ and that. Ain’t he.”
(Aboriginal Man, Adult: 26-45 years)

I: Why is that?
A: “Chemist – never. I will go there for advise only. I will never go there to be treated. I’d just go there for advise. I’d get it confirmed by a doctor anyhow. At a hospital, it is too impersonal. They, they, they have, it’s like a little factory in a hospital. You know, you have doctors coming in and out. Not just
What Aboriginal people think about their access to health care.

patients, but you have doctors coming in and out. You have nurses coming in and out, like you know. No one knows you personally unless you are an inmate in a hospital, you know. And, um, then it is too late, because you're already admitted, like you know. And, and you're just a, you're just a number, ready to kick out. True. Plus there’s those other factors too. Like the waiting time. With Aboriginal people, they haven't got time to wait around. They’ve got this life to live. Got to live it to the fullest.”

I: Why would that be different for Aboriginal compared with non-Aboriginal people?
A: “Because we are frightened that some white bastard might come along and take it off us. For me, and my brothers and sister and a lot of my family, I can safely say this without, but we grew up fearing that if we were going to be doing something that’s good, some white person is going to say ‘well, that's not good for you and take it off us’, or ‘who gave you permission to do this or that.’…God forbid having a milkshake outside the shop. Or going for a swim. Everything was granted to us, in a sense that our land, which basically was ours, had to be, we had to more or less get permission to use it, or we had to get that little nod of the head that it was okay.”

(Aboutinian Man, Senior Adult: 46+ years)

2. RESPONSES FROM PARTICIPANTS WHO WOULD UTILISE CHEMISTS FIRST:

A: “I prefer the chemist first. And then if they don't have the cure, to the doctors then, you know. He’s brilliant. He tells you the bare facts. I use to question him, but not now… He’s more informative than the doctor. He speaks in a language that I can understand and, um, he doesn't give me crap that he knows is going to, you know, affect my long-term health.”

I: Whereas the doctor?
A: “Well the doctor gives me, the doctor speaks in terms that I can't understand. He gives me, he's given me stuff in the past that, um, you know is detrimental to my health in the long run.”

(Aboutinian Woman, Senior Adult: 46+ years)

3. VARIES:

A: “I'd rather go see a doctor, um, but if the doctors not available, or if there isn't a doctor's surgery open, I'd go to the hospital.”

I: Why would you do that?
A: “Um, well, the chemists, they really haven't got the experience, like to, like to tell you the symptoms and everything. Whereas the doctors in the hospitals and the Mediclinics have done their training, whereas the pharmacists haven't.”

(Aboutinian Woman, Adult: 26-45 years)

A: “Doctor, I suppose.”
I: Why is that?
A: “It’s just one on one and hospitals and that you’d probably just sit there laying there crook, waiting for someone.”
I: What about a chemist?
A: “Chemist, yeah, they’re not too bad. You can go in there and get all the things you want I suppose. Like tablets and all that. Just ask the fella behind the thing.”
I: So why would you go to the doctor and not a chemist?
What Aboriginal people think about their access to health care.

A: “Um, I don’t know. It depends on what my illness is. If I was real crook I suppose I would go to a doctor, but if I just got a headache, or something, I’d just go to the chemist.”

(Aboriginal Man, Young Adult: 16-25 years)

“Um, normally I’d go to the doctor, you know. If I knew it was something, you know, like say a small sniffle, or a cold coming on, well then yes I would approach my local chemist, um, and, um, for some small, you know, whatever it is from there, that you can buy off the shelf. That, um, if the chemist, I always ask the chemist, you know, would that be a problem taking it, you know, especially because I am on other medication.”

(Aboriginal Man, Senior Adult: 46+ years)

“It wasn’t any thing serious, like if I had a cut or a bleed, or something, I’d go to hospital, or a broken bone I’d go to a hospital. but if it was a normal illness I’d go to a doctor. If I just want something for a cold sore or a runny nose, I’d just go to a chemist.”

(Aboriginal Man, Young Adult: 16-25 years)

4. RESPONSES FROM PARTICIPANTS WHO WOULD UTILISE BUSH MEDICINE:

“No. No. I wouldn’t, I wouldn’t. I’d rather just stay in bed until I had to be carted there. And if I wasn't going to be carted there, well I would be looking for bush doctor. Bush medicine.”

(Aboriginal Man, Adult: 26-45 years)
Appendix 6: Participants responses to: “Is there anything that could be done to make you feel more comfortable in medical centre's waiting areas?”

1. RESPONSES FROM PARTICIPANTS WHO FELT THAT THERE WAS NOTHING ELSE THAT COULD BE DONE TO MAKE THEM FEEL MORE COMFORTABLE IN MEDICAL CENTRE WAITING AREAS:

“Nothing really. You’ve got no choices, you’ve got to see them.”
(Aboriginal Man, Adult: 26-45 years)

“No. It’s just me feeling like that. They could be feeling intimidated themselves.”
(Aboriginal Man, Young Adult: 16-25 years)

“No. If anybody looks at me, then I just turn around and say ‘do you own this top that I have on.’ And you will say no and so I will say in that case ‘stop staring at me.’”
(Aboriginal Woman, Senior Adult: 46+ years)

“No not really. It's all what you make of it, when you walk into a medical centre. You know, if you feel afraid, well you probably aren't going to sit there, you’re just going to turn around and walk out. If you are happy with it, you’ll sit there waiting to see a doctor.”
(Aboriginal Man, Adult: 26-45 years)

“Not the particular medical centre that I go to, no. No, we are all on first name basis and you can't get any better than that.”
(Aboriginal Man, Senior Adult: 46+ years)

“No, I don't think so, because most of the receptionists and, you know, they make sure your are attended to, you know. I don't feel...”
(Aboriginal Woman, Senior Adult: 46+ years)

“I’ve never really had any problem.”
(Aboriginal Woman, Young Adult: 16-25 years)

“Not really with a GP medical centre. There's not much you can really do there, because most GPs see you within a short time. Um, so that's not a real problem. Hospitals, the other end of the scale, would be I suppose, I've only use them after hours, when I can't get to my local GP. And I think that's, you know, I think that's the general public's fault in that they tend to use the hospital, instead of the GP, you know. Some of them will travel outside of their area to go to a hospital, instead of walking around the corner to their local doctor. You know, or even finding out if the local GP does a home visit.”
(Aboriginal Man, Senior Adult: 46+ years)

“No. They’ve got practically everything there now. You’ve got TV, books, nice couch, sofas to sit on.”
(Aboriginal Man, Adult: 26-45 years)


<table>
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<tr>
<th>Quote</th>
<th>Participant Details</th>
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<tr>
<td>“No, I’m pretty comfortable in there.”</td>
<td>Aboriginal Man, Young Adult: 16-25 years</td>
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<tr>
<td>“Ours is pretty good. He's Indian he's black.”</td>
<td>Aboriginal Woman, Adult: 26-45 years</td>
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2. RESPONSES FROM PARTICIPANTS WHO FELT THAT THERE WAS SOMETHING THAT COULD BE DONE TO MAKE THEM FEEL MORE COMFORTABLE IN MEDICAL CENTRE WAITING AREAS:

“Yeah, um, I have often thought that a little bit of music wouldn't be bad. Um, and the lights could be a little bit dimmer, because I have found that sometimes, you know, I have gone in there, generally when I feel sick, the last thing I want is some bright lights in my face.”
(Aboriginal Man, Adult: 26-45 years)

A: “Oh, yeah, mainly they should have videos, sort of TV videos, you know, going for the kids. Sort of like, about medical, things and that, about the health.”
I: Okay, so that might help the kids, what about for yourself?
A: “Oh, you know, I’m there, some, some of it you can watch and learn at the same time while waiting.”
(Aboriginal Man, Adult: 26-45 years)

A: “Shit [pause], yeah the nurse come out and do a woogie woogie in front of us.”
I: Anything else they could do?
A: “Probably a cuppa after you leave. After you leave the doctor. You know a cup and a biscuit, that would be alright.”
(Aboriginal Man, Adult: 26-45 years)

“Well they could, some of them having got TVs. Like, like people like to sit there, because… Yeah if they had TVs, yeah. That way you can watch the TV as well as waiting. Instead of looking at everyone else that comes in through the door, all sitting there waiting as well and you're not thinking about other people, or other things, or whatever else is going through your mind, you know.”
(Aboriginal Man, Adult: 26-45 years)

A: “Oh, maybe if they put a few more tissues around and that, because sometimes you have to go up to the counter and get them.”
I: What else?
A: “Up-to-date reading matter in there, instead of 95, 96, that you’ve already read.”
(Aboriginal Woman, Adult: 26-45 years)

“Give me something to read while I’m waiting.”
(Aboriginal Man, Young Adult: 16-25 years)

“A Treat us all the same. We are all the same people, no matter what colour we are.”
(Aboriginal Woman, Adult: 26-45 years)

“Koori artwork, posters.”
(Aboriginal Woman, Senior Adult: 46+ years)
“More Aboriginal literature.”
(Aboriginal Woman, Senior Adult: 46+ years)

“Have Aboriginal receptionists.”
(Aboriginal Woman, Adult: 26-45 years)

“I'm not saying that there's none. I enjoy reading a book while I'm waiting for a doctor. I enjoy looking at paintings. These are my personal thoughts... If they want different people, you know, Aboriginal people included, to access their services, they should put in appropriate reading material. It's the same as if they have Lebanese, Chinese, whatever. If they want those customers into their services, they should have things there that are compatible with everyone, or a middle of the road think. You don't have to have a Chinese book, you sure as heck as soon as I had picked the thing up, I would want to know what they heck was going on [laughs]. But something that's on a light theme, instead of just heavy reading material... My main concern with GPs is that they give you a 2 o'clock appointment and when you arrive, at 5 to two, there are three or four people still in front of you. And it pisses me off that they can't run a system whereby if you have a 2 o'clock appointment, you are seen at 2 o'clock. You know, if you arrive at 5 past, you deserve to wait, or come back another day, or to be roused on... But I think that if you make a 2 o'clock appointment, you should be seen at very, very close, unless there has been an emergency. But that happens to many times. Doctors give everyone a half past 12 appointment, 25 to 1, quarter to, and they spend too much time with the clients within that timeframe and slowly but surely it builds up. And therefore when you come in, like if doctors want to give each patient a half-hour, they shouldn't put in another one in 15 minutes after.”
(Aboriginal Man, Senior Adult: 46+ years)

“Aboriginal posters.”
(Aboriginal Woman, Young Adult: 16-25 years)

“Peoples' attitude more than anything. I suppose being Aboriginal and no legs now, I don't like people doing ‘ttt’, ‘ttt’, ‘ttt’ and they stare. I get a lot of Chinese people smiling at me.”
(Aboriginal Woman, Senior Adult: 46+ years)

“No. TV, that’s it. If they have a TV I'll just sit back and watch telly.”
(Aboriginal Man, Young Adult: 16-25 years)
APPENDIX 7

Appendix 7: Participants’ suggestions of things that would make it easier to see a doctor or other medical services

1. OPERATIONAL PROCEDURES OF MEDICAL CENTRES

a) Reducing waiting periods in medical centres:

“Um, mainly the waiting time, the waiting periods.”
( Aboriginal Woman, Adult: 26-45 years)

“More workers; wouldn't have to wait as long.”
( Aboriginal Woman, Adult: 26-45 years)

“Get in and out quicker. Play room for children.”
( Aboriginal Woman, Adult: 26-45 years)

“See my doctor is pretty good. Just get him to move the patients quicker.”
( Aboriginal Woman, Adult: 26-45 years)

b) Opening medical centres for longer hours:

“Probably the worst thing that happens is, um, sickness doesn't have a time. Um, as in, you are restricted to, I know, I’d prefer to see my local GP, that he’s human the same as the rest of them. But finding a doctor at any time during the day, you know, 24 hours a day, is a hard thing. You know, and really it comes down probably you have to attack the hospital, and um, I feel sorry for the hospital staff, but where else can you go? Even some of those large medical centres, they got signs out the front saying 24 hours service, but they close at 10 and they open at 8. You know, so I think they should need a kick in the backside. Change their sign, or provide the service of what they’re advertising.”
( Aboriginal Man, Senior Adult: 46+ years)

c) Doctors providing house-call service and/or free bus service to medical centres:

“I’d like better transport so that I can get to a doctor and not have to walk when sick… I went down to Tharawal… Well first I rang up there and asked if someone could pick me up and they said ‘no-one could come and pick me up’. I had to walk down sick and then I seen the doctor, I had to walk down, and I was, when I was speaking to the receptionist, I asked her if I could get a lift home, because I wasn't feeling well and she said that I couldn't because I wasn't booked in and I never made an appointment. Any thing could have happened. Like I could have fainted on the way home. A closer medical place. Should be two doctors, so that you can get a second opinion.”
( Aboriginal Woman, Young Adult: 16-25 years)

“Need better transport to pick you up.”
( Aboriginal Man, Adult: 26-45 years)
A: “What about the doctor coming to see me.”
I: That’s one way, the doctor coming to see you. Anything else?
A: “I suppose you could get picked up. And, um, that would probably be with other people that probably needed the same sort of treatment as well, you know, get picked up at the same time as somebody else. So they wouldn’t be just coming around for me, you know, to pick up somebody else along the way as well.”
I: And the reason for doing it this way?
A: “Just don’t like wasting peoples’ time, especially if it’s got to do with medical stuff. I suppose it would be, you know, somebody else is in the same situation and is going the same place, you know, rather than come pick me up, take me down there, then go pick them up, and then take them down there, you know.”
I: But say there was nobody else who needed treatment on the day, or that time, or whatever, do you think that it is a waste of time for them to come and pick you up and take you down to the doctor and take you back?
A: “Yeah. I reckon it is. Yeah.”
I: Why is that?
A: “Because, it’s, um, sooner or later I would get down there myself.”
I: When was the last time that you went to a doctor did you say?
A: “Um, about a month ago, something like that.”
(Aboriginal Man, Adult: 26-45 years)

A: “Some of the doctors should have their own private little buses and that.”
I: Why do you say that?
A: “Well they’ve got enough business there going there, they should have there own bus to go and pick you up. Not just me, but older people who cannot make it further. It’s their service for people who keep going to the doctor all the time.”
(Aboriginal Man, Adult: 26-45 years)

d) Ensuring that confidentiality is not breached at Tharawal’s medical centre:

“No I don’t, but I think with a lot of people they think if I go here, like, um, for instance a lot of Aboriginal people will not go to Tharawal due to it being, like a lot of people feel comfortable going there because it's with Aboriginal people. But a lot of other people think, okay, like, if I go up there, people are going to be talking about me. It's a big breach of confidentiality, whatever… A lot of Aboriginal people won’t go to a non-Aboriginal medical centre because they think, ‘Okay, I don't feel comfortable around these people.’ It’s just depending how the person themselves feel about, like what they want to know. If they are too scared to find out about it.”
(Aboriginal Woman, Young Adult: 16-25 years)

e) More money provided to Tharawal’s medical centre:

“More money be put into Tharawal to, to develop it further. I’m not saying necessarily to give the money to the Koori’s themselves, but to give it to someone with responsibility that will give us the services we need within our community.”
(Aboriginal Woman, Senior Adult: 46+ years)

f) Patients having their own medical database on disc:

A: “Um, I think because, like down here, I’ve moved around a lot, I would like to see, um, and this is something that I have been talking about for a while. I would like to see where, um, people actually have, like a disc, that has medical
information on it, all of their medical information. That they can just hand to a
doctor, he can scan through it, whatever, um, yeah, type in whatever he needs
to, so that you have always got that with you.”
I: Sorry to interrupt, do you have your Medicare card on you?
A: “Yes I do.”
I: What percentage of the people in this building do you think would have their
Medicare cards with them?
A: “Females, I don't think, ever would, because they keep everything in their bags.
Whereas, like, I have my cards, I have a series of cards, that doesn't leave my
sight… because I have been to a number of doctors, because I’ve moved
around, um, I mean some of them, um, have been required to sort of, like take
my x-rays with me. Um, to keep my x-rays at home. That sort of stuff, where
if it was, say on a database, or something, to me that would be a hell of a lot
more help.”
(Aboriginal Man, Adult: 26-45 years)

g) Medical centres using identifiable colours on patients medical cards:

A: “Medical cards can have Aboriginal people with the Aboriginal identified
colours on those medical cards.”
I: Explain that to me?
A: “Well when they go and see a doctor, they can see that they are Aboriginal on
their health card and they might take that first step to say, ‘well he’s a
underprivileged person, I’m going to try and help him.”
I: Would you feel embarrassed having a card, if it was a different card, because
you are Aboriginal?
A: “No, not if it was the same card, but that little symbol in the corner.”
(Aboriginal Man, Adult: 26-45 years)

2. DOCTORS, ESPECIALLY COMMUNICATION ISSUES

a) More and better doctors in the area:

“More doctors in the area. Cheaper medication. Get in at the time you made the
booking.”
(Aboriginal Woman, Adult: 26-45 years)

A: “Better doctors. Some of them are smartarses.”
I: And why are they smart arses?
A: “I don't know. That's just the way they are.”
I: And are they smart arses because you are Aboriginal, or are they smart arses
to everybody?
A: “They're smart arses to everybody.”
(Aboriginal Man, Young Adult: 16-25 years)

b) Improving communication skills of doctors:

A: “I don't think they explain themselves right, you know. They need to ask do
you understand what I'm talking about. You don't do you. Do you want me to
go over what's going on and that, you know. We shouldn't have to ask.”
I: Is there anything else they could do to improve?
A: “Um, don't just have women's books in there. Have something for men there
too.
(Aboriginal Man, Adult: 26-45 years)
c) Providing interpreters if the doctor is a non-English speaking doctor:

A: “Well, if they have a non-English speaking doctor, I'd rather they have an interpreter, or someone that understands what they are saying.”

I: That's not the first time that you have mentioned that, have you encountered times when people don't speak English well?

A: “Yeah, yeah.”

I: Is that here [Tharawal]?

A: “Here, there’s been a couple here and, um, you get it wherever you go. I mean, taxis, buses. I mean, if it's for a medical reason, you know, they should be able to have some sort of a degree in English… Like at types they are saying stuff and I am thinking this stuff is important, so try and listen. And then you are concentrating on trying to understand and you don't actually listen to what they are saying.”

(Aboriginal Man, Young Adult: 16-25 years)

3. ATTITUDE, SERVICE AND CULTURAL AWARENESS OF RECEPTIONISTS

a) Improving the attitude and service of some receptionists:

“No, it's just the attitude of the receptionists, that by the large are excellent, because they know that they are in the business and they know they are not going to last very long if they don't perform and keep the customers happy.”

(Aboriginal Man, Senior Adult: 46+ years)

“It's really, really, all, it's, um, the service that you get really. Like, just say when you ring up if she’s nice and helpful, or he or she is nice and helpful and um, they don't, you know, they don't make you feel, um, threatened or any thing that's when um yeah.”

(Aboriginal Man, Young Adult: 16-25 years)

b) Helping staff in medical centres become more culturally aware:

“Make medical centres more culturally aware and more friendly. Music.”

(Aboriginal Woman, Senior Adult: 46+ years)

“Have Aboriginal appropriate literature. Me, myself, I do pick up Aboriginal stuff.”

(Aboriginal Woman, Senior Adult: 46+ years)

4. HEALTH EDUCATION AND HEALTH INTERVENTION STRATEGIES

a) Better health education and more pamphlets:

“More pamphlets.”

(Aboriginal Woman, Adult: 26-45 years)

“Better education. They need funding to have things.”

(Aboriginal Woman, Young Adult: 16-25 years)
“Workshops so that people can go in and learn about health issues.”

(Aboriginal Woman, Young Adult: 16-25 years)

b) Reducing smoking, alcohol and illegal drug usage in the community:

“Get rid of smokes, alcohol. Give them more interests and things to do, instead of like, around here there’s nothing to do. So they think, there's nothing to do, I might as well drink and get on the alcohol. If there was more like parks, like more activities for them, …go out and stuff, there wouldn't be as much drinking and stuff.”

(Aboriginal Woman, Young Adult: 16-25 years)

A: “Well I know that drugs and alcohol cause a lot of problems in this area.”

I: When you say drugs, what type of drugs do you mean?

A: “All sorts of drugs. Oh well, like a lot of them are using needles and marijuana. Tablets, taking tablets. And I think, like if there’s somewhere, like if there’s something like a rehab centre, or something. Because, you know, if you’ve got a drug user and an alcoholic in the family, it not only affects them, but it affects the whole family. Like I don't drink. My kids they drink. It has a big effect on me. And I see what it’s doing to my grandkids.”

I: It does have a big effect on you?

A: “It sure does. You known, I worry about them. I worry about the grandkids. It just, it does have a big effect on me.”

(Aboriginal Woman, Senior Adult: 46+ years)

“Well in a lot of cases there’s a big drug problem going around. Like that's a lot of people’s own problem.”

(Aboriginal Woman, Young Adult: 16-25 years)