

PUBLISHED VERSION

Judith Streak Gomersall, Odette Gibson, Judith Dwyer, Kim O'Donnell, Matthew Stephenson, Drew Carter, Kootsy Canuto, Zachary Munn, Edoardo Aromataris, Alex Brown
What Indigenous Australian clients value about primary health care: a systematic review of qualitative evidence

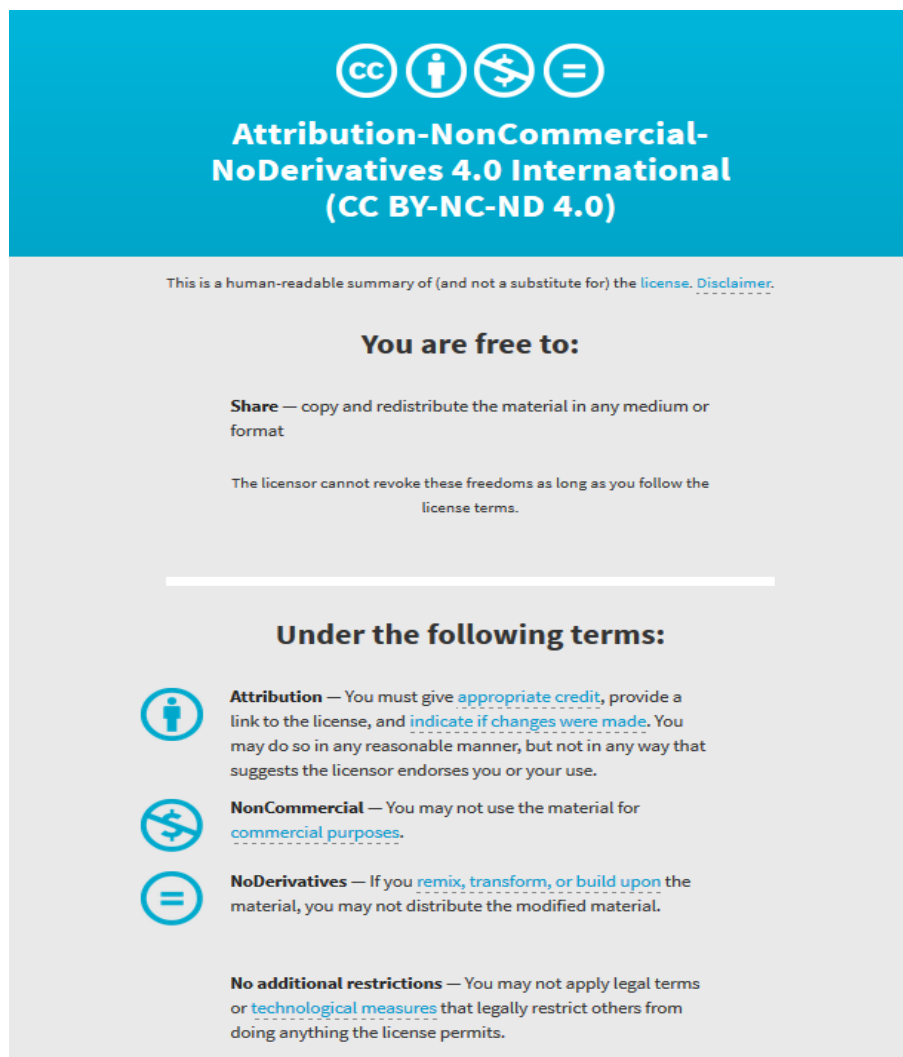
Australian and New Zealand Journal of Public Health, 2017; 41(4):417-423

© 2017 The Authors. This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

Published version <http://dx.doi.org/10.1111/1753-6405.12687>

PERMISSIONS

<http://creativecommons.org/licenses/by-nc-nd/4.0/>



The image shows the Creative Commons Attribution-NonCommercial-NoDerivs 4.0 International (CC BY-NC-ND 4.0) license graphic. It features a blue header with the CC logo, a person icon, a crossed-out dollar sign, and an equals sign. Below the header, the text reads "Attribution-NonCommercial-NoDerivs 4.0 International (CC BY-NC-ND 4.0)". A disclaimer states: "This is a human-readable summary of (and not a substitute for) the license. [Disclaimer.](#)". The main content is divided into two sections: "You are free to:" and "Under the following terms:". Under "You are free to:", it lists "Share" (copy and redistribute) and notes that the licensor cannot revoke these freedoms. Under "Under the following terms:", it lists "Attribution" (provide credit and link), "NonCommercial" (no commercial purposes), "NoDerivatives" (no remixing or building upon), and "No additional restrictions" (no legal or technological measures).

This is a human-readable summary of (and not a substitute for) the [license](#). [Disclaimer.](#)

You are free to:

Share — copy and redistribute the material in any medium or format

The licensor cannot revoke these freedoms as long as you follow the [license terms](#).

Under the following terms:

Attribution — You must give [appropriate credit](#), provide a link to the license, and [indicate if changes were made](#). You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use.

NonCommercial — You may not use the material for [commercial purposes](#).

NoDerivatives — If you [remix, transform, or build upon](#) the material, you may not distribute the modified material.

No additional restrictions — You may not apply legal terms or [technological measures](#) that legally restrict others from doing anything the license permits.

31 August 2017

<http://hdl.handle.net/2440/107455>

What Indigenous Australian clients value about primary health care: a systematic review of qualitative evidence

Judith Streak Gomersall,^{1,2} Odette Gibson,³ Judith Dwyer,⁴ Kim O'Donnell,⁴ Matthew Stephenson,⁵ Drew Carter,¹ Kootsy Canuto,³ Zachary Munn,⁵ Edoardo Aromataris,⁵ Alex Brown^{1,6}

Wide disparities remain between the health status of Aboriginal and Torres Strait Islander peoples (hereafter Indigenous Australians) and non-Indigenous Australians.^{1,2} Chronic diseases, including cardiovascular disease, diabetes and psychosocial illness caused by the history of colonisation, account for the bulk of the disparities.³ Inadequate access to primary health care (PHC) services responsive to Indigenous clients' holistic needs, modifiable socioeconomic factors including low income, poor education, poor living conditions and social exclusion are principal contributors to the higher chronic disease burden in the Indigenous population.¹⁻³ Increasing Indigenous Australian engagement with effective PHC, conceived in the comprehensive Indigenous Australian sense, is critical to reduce chronic disease in Indigenous communities and mitigate the disparities in health.^{3,4} Australia's culturally diverse Indigenous peoples' understanding of accessible, appropriate, quality PHC is different and broader than Western notions.^{3,5} From the Indigenous Australian perspective it is care conceived in the holistic Aboriginal way, that incorporates body, mind, spirit, land, environment, custom, socioeconomic status, family and community.⁵ The Indigenous Australian construct includes essential, integrated care based upon practical, scientifically sound and socially acceptable procedures and technology made accessible to communities as close as

Abstract

Objective: To synthesise client perceptions of the unique characteristics and value of care provided in Aboriginal Community Controlled Health Organisations (ACCHOs) compared to mainstream/general practitioner services, and implications for improving access to quality, appropriate primary health care for Indigenous Australians.

Method: Standardised systematic review methods with modification informed by ethical and methodological considerations in research involving Indigenous Australians.

Results: Perceived unique valued characteristics of ACCHOs were: 1) accessibility, facilitated by ACCHOs welcoming social spaces and additional services; 2) culturally safe care; and 3) appropriate care, responsive to holistic needs.

Conclusion: Provider-client relationships characterised by shared understanding of clients' needs, Indigenous staff, and relationships between clients who share the same culture, are central to ACCHO clients' perceptions of ACCHOs' unique value. The client perceptions provide insights about how ACCHOs address socio-economic factors that contribute to high levels of chronic disease in Indigenous communities, why mainstream PHC provider care cannot substitute for ACCHO care, and how to improve accessibility and quality of care in mainstream providers.

Implications for public health: To increase utilisation of PHC services in Indigenous Australian communities, and help close the gaps between the health status of Indigenous and non-Indigenous Australians, Indigenous community leaders and Australian governments should prioritise implementing effective initiatives to support quality health care provision by ACCHOs.

Key words: primary health care; Indigenous Australians; community control; accessibility; culturally safe care; client perspectives.

possible to where they live through their full participation in the spirit of self-reliance and self-determination and a comprehensive approach to supporting health.⁵

Importantly, all Indigenous Australians have the right to easily accessible, comprehensive, PHC delivered in a way that is respectful

of Indigenous cultures, as well as to be involved in design and delivery of the PHC services they receive.^{6,7} International evidence investigating factors that increase accessibility and quality of PHC for Indigenous people, points to maximising community ownership and control, a robust

1. School of Public Health, University of Adelaide, South Australia

2. Healthy Mothers, Babies and Children, SAHMRI, South Australia

3. Wardliparingga, SAHMRI, South Australia

4. Health Care Management, School of Medicine, Flinders University, South Australia

5. Joanna Briggs Institute, University of Adelaide, South Australia

6. Sansom Institute, University of South Australia

Correspondence to: Dr Judith Streak Gomersall, School of Public Health, University of Adelaide, Level 7 / North Terrace, Adelaide, South Australia 5005; e-mail: Judith.gomersall@adelaide.edu.au

Submitted: October 2016; Revision requested: February 2017; Accepted: April 2017

The authors have stated they have no conflict of interest.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

Aust NZ J Public Health. 2017; 41:417-23; doi: 10.1111/1753-6405.12687

indigenous managerial and clinical workforce, and the ability to deliver models of care that embrace Indigenous knowledge systems.^{3,8}

Aboriginal Community Controlled Health Organisations (ACCHOs) are incorporated organisations, governed by boards of members elected by local Indigenous communities that aim to meet basic needs in Indigenous communities.⁵ ACCHOs function as knowledge and resource bases for Indigenous communities to advocate for their rights.^{5,9} The first ACCHO was established in 1971 in Redfern, in response to the failure of mainstream services to cater for the needs of its Indigenous peoples' and desire for self-determination.^{5,9} By 2015 there were 138 ACCHOs in Australia¹⁰ diverse with respect to their years of operation, budget and workforce sizes, and their governance, funding and service delivery models.^{10,11}

Some ACCHOs employ medical practitioners and other staff, including Aboriginal Health Workers (AHWs) and provide a range of clinical and other services; others do not have a locally based medical practitioner, and rely only on AHWs.^{5,9,10} Assessments of health care quality based on Western informed measures have established that quality of clinical standards varies across ACCHOs and that many ACCHOs are achieving best practice standards.¹² In addition to ACCHOs, state and territory funded Indigenous health organisations, which are concentrated in the Northern Territory and have varying degrees of community control, also play a role in providing culturally appropriate services in Indigenous communities.¹⁰ Of the 203 Indigenous PHC organisations in 2014/15, 68% were ACCHOs, 25% were government-run services, and 18% were mainstream non-government organisations.¹⁰

Recent policy¹³ for improving Indigenous health in Australia reflects a strong commitment by government to implementing community control to enable better PHC quality and access, as well as to provide ACCHOs with the support they require to help achieve this goal. The policy commitment to building ACCHOs has been in place for more than 25 years.¹⁴ However implementation of the policy has been fraught with ongoing difficulties.^{11,14} ACCHOs rely on government funding, which they receive largely through three main Commonwealth sources: Medicare; contract funding for core PHC services; and contract funding for specific programs. Whilst some ACCHOs access the funding and workforce

they require to deliver services that are responsive to community needs, and have been identified as offering exemplar models of care for Indigenous peoples¹⁵ the evidence relevant to the implementation of Indigenous control of health care in Australia,^{11,14,16-18} shows that many, particularly emerging organisations, struggle to navigate complex funding and accountability arrangements. Evidence points to various inefficiencies in the funding and governance arrangements and questions their ability to support quality care provision that is responsive to each community's unique needs and meets needs of all clients within communities.¹⁴

In the context of increasing debate regarding the merits of mainstreaming Aboriginal PHC, we systematically reviewed qualitative evidence to document and understand how ACCHO clients perceive the characteristics and value of care provided by ACCHOs compared to care provided in mainstream PHC. Our motivation was that the findings from existing qualitative studies, in academic and grey literature, on how ACCHO clients' experience and perceive the nature and value of care provided in ACCHOs, and compared to in mainstream PHC services, had not yet been synthesised, yet synthesising the qualitative client perceptions might offer insights for health practitioners and policy makers on how best to improve Indigenous Australians' access to PHC services that offer appropriate, quality care.

Method

This review forms part of a larger systematic review project.¹⁹ We followed Joanna Briggs institute (JBI) guidance for systematic review of qualitative evidence²⁰ and the PRISMA reporting guidelines.²¹ We took two steps to better align with ethical standards relevant to research involving Indigenous Australians²² and enable Indigenous specific contextual and cultural knowledge to inform the evidence appraisal and interpretation:^{23,24} 1) Indigenous and non-Indigenous personnel were included in the review team; and 2) input was sought, at key stages in the review, from a reference group of Indigenous Australian community leaders and Indigenous people with expertise in PHC service delivery in Indigenous Australian communities.

Population and context: Indigenous clients (including family members, all ages) of ACCHOs.

Phenomena of interest: Perspectives on the characteristics and/or value of care provided by an ACCHO and the characteristics and/or value of care provided by one or more ACCHOs compared to the characteristics and value of care provided by one or more mainstream PHC services. ACCHOs were defined as non-government organisations operated by an Indigenous community, through an elected board of management. Mainstream providers were defined as general practitioner services. A service 'characteristic' was defined as a client identified attribute or feature of the PHC service, and a value as a client expressed experience of the worth or impact of the PHC service. Only perspectives evidenced by client voice were included.

Search and study selection

We searched electronic sources for peer reviewed and grey literature studies meeting the inclusion criteria published in English, between April 1971 (date of first ACCHOs) and 30 April 2015. We searched the following databases using database specific search strings: Pubmed; Scopus; Healthbusinesselite; Econlit and Informit (Indigenous peoples databases). Using generic search terms, we searched Google Scholar (advanced), Indigenous Health/InfoNet (Health Bibliography and Australian Indigenous Health Bulletin), Australian Policy Online, the Centre for Economic Policy website and Lowitja Institute websites. We hand searched references of two recent literature reviews, and the included studies. The search strategy is provided in Supplementary File 1, available online. The PubMed search string was:

```
((health services, indigenous[mh] OR
community health services[mh] OR primary
health care[mh] OR rural health services[mh]
OR community networks[mh] OR delivery of
health care[mh] OR health planning[mh] OR
community controlled health service*[tiab]
OR indigenous health service*[tiab] OR
community health service*[tiab] OR primary
health care[tiab] OR rural health services[tiab]
OR community networks[tiab] OR delivery of
health care[tiab] OR health planning[tiab])
AND ((Aborig*[tw] OR Indigenous[tw] OR
(Torres Strait[tw] AND Islander*[tw]) OR
Oceanic Ancestry Group[mh] OR koori[tw] OR
tiwi[tw]) AND (.au[ad] OR australia*[ad] OR
Australia[mh] OR Australia*[tiab] OR Northern
Territory[tiab] OR Northern Territory[ad] OR
Tasmania*[tiab] OR Tasmania[ad] OR New
South Wales[tiab] OR New South Wales[ad]
```

OR Victoria*[tiab] OR Victoria[ad] OR Queensland[tiab] OR Queensland[ad])) AND (“1971/01/01”[PDat] : “2015/12/31”[PDat])

The search results were imported into an Endnote database (Thomson Reuters), where duplicates were removed. Title and abstract of the remaining records were then screened by JG for eligibility against the inclusion criteria, and full texts of potentially relevant studies set aside for further examination. JG, OG, DC independently reviewed the full-text articles against the inclusion criteria, noting reasons for exclusions. Uncertainty about whether the organisation was an ACCHO was resolved by contacting authors.

Quality assessment and data extraction

We used the critical appraisal and data extraction tools in the JBI Qualitative Assessment and Review Instrument (JBI-QARI).²⁰ Two of the non-Indigenous authors (JG, DC) independently assessed quality of the studies that met the inclusion criteria, and two of the Indigenous Australian authors (OG, KK) crosschecked a 20% sample of the assessments for uniformity and accuracy. One reviewer (JG) extracted descriptive study data from the included studies. Three non-Indigenous members of the review team (JG, ZM, MS) extracted findings from the included studies for the phenomena of interest. Only client perceptions that were supported by an illustration, in the form of a client voice, were extracted. A 20% sample of the extracted findings was checked for accuracy by two of the Indigenous Australian authors (KO, OG). The confirmation of accuracy ensured that Indigenous Australian perspectives were applied in the quality appraisal and data extraction.

Synthesis

We used meta-aggregation²⁰ to synthesise, separately, the client perceptions on the: 1) characteristics and value of care provided by ACCHOs; 2) characteristics of care provided by ACCHOs compared to mainstream PHC providers; and 3) value of care provided by ACCHOs compared to mainstream PHC providers. Meta-aggregation is grounded in the philosophic traditions of pragmatism and Husserlian transcendental phenomenology. The overall emphasis in this approach is on producing findings from existing studies that are credible in the sense that they reflect the meaning of the included studies, and inform practice-level lines of action that

have applicability to healthcare policy or practice. Meta-aggregation embodies the complex nature of critical understanding, while ensuring the findings developed from the synthesis of study findings are meaningful and practical.²⁰ For each synthesis, we followed the two-step thematic analysis approach of meta-aggregation. First, we developed categories of findings with similar meaning, and second, we developed synthesised findings describing the categories. To develop the categories, the first two authors (who led the synthesis), working independently, read and re-read the assembled findings with their supporting illustrations to understand their meaning, and grouped them into categories of similar findings, reflecting the main themes in the findings relating to the phenomena of interest. They then compared and discussed the two interpretations, and developed consensus-based categories of the identified themes. To develop the synthesised findings, which in meta-aggregation represent overarching descriptions of the categories²⁰, these same authors (OG and JG) first worked individually, and then together. OG's interpretation of category meanings, and appropriate synthesised findings was privileged to ensure that the synthesised findings were informed by unique knowledge of Aboriginal and Torres Strait Islander culture and the context surrounding Aboriginal PHC, held by Indigenous Australians. AB guided the first author through the process of identifying the key cross-cutting themes in the synthesised findings, thereby ensuring that the second level analysis was also informed by Indigenous Australian expert knowledge. The draft categories, synthesised findings and interpretation of the themes emergent in the synthesised findings, were reviewed by all the other authors.

Results

Description of studies

Our search identified 4,405 records. From these, 816 duplicates were removed, leaving 3,589 for title and abstract screening against the review eligibility criteria. We excluded 3,468 of these for not meeting the inclusion criteria, leaving 112 for full text examination. Of these, six were not accessible, 19 did not offer findings for the phenomena of interest, 36 did not use qualitative methods, and for 51 we were uncertain whether participants were ACCHO clients. This left nine articles reporting nine studies. An additional article reporting

one of the nine studies was identified in the references of one included article, resulting in 10 included articles,^{25,34} reporting nine studies. Supplementary file 2 provides the search results and study selection. The list of citations excluded at full text examination is available from the corresponding author.

The results from the methodological quality assessment are provided in Supplementary file 3. One was rated high quality,²⁸ seven were rated good quality,^{27,29,34} and one, reported in two articles, was rated moderate quality.^{25,26} A lack of clarity about how researchers' values and prior knowledge influenced studies was the main methodological concern potentially undermining the credibility of the findings that informed our syntheses. It is not possible without further information to comment on whether researchers' values and knowledge enhanced the validity of findings or introduced bias.

Details on the characteristics of each included study are provided in Supplementary File 4. All the studies were published between 2004 and 2014. Six used mixed methods.^{25-27,30,31,33,34} Four used focus groups and interviews,^{27,31-33} four used only interviews,^{25,26,28,30} and one used only focus groups.³⁴ Five of the studies adjusted their methodology to align with the unique ethical and methodological standards relevant to research with Indigenous Australians.^{28-30,33,34} Based on an estimation of 75 participants in one study that employed focus groups,²⁷ a total of 811 study participants informed the meta-syntheses (including 640 from one study).³¹ There was good geographic representation in the ACCHO sample.

Synthesised findings

A diagrammatic representation of the three meta-aggregations of the ACCHO client perceptions is provided in Supplementary File 5.

Care in ACCHOs

Our synthesis of the client perceptions on the characteristics and value of ACCHO care, extracted from the nine included studies,²⁵⁻³⁴ produced four synthesised findings.

Synthesised Finding 1: ACCHOs' accessibility was highly valued. Clients identified ACCHOs' transport services, proactive service provision, culturally safe care, range of services and welcoming environment as contributing to ACCHOs' accessibility. Five categories

informed this synthesised finding; each of them described a different characteristic that, from the clients' perspective, contributed to accessibility. Proactive service provision was described as ACCHOs having outreach services (e.g. home visits), staff who were easily contactable, and staff meeting patients in public areas such as shopping centres.²⁵⁻²⁷ Culturally safe care was described as care delivered by providers who were good,²⁸ who understood clients and knew how to meet their needs,²⁹ who spent sufficient time with patients and who respected culture,²⁹ in an environment that made clients feel comfortable.³⁴ ACCHOs' welcoming environment was described as including an emotional and relational dimension.^{27,29,33} The relational dimension was reflected in clients' relating how they felt welcome in ACCHOs because they saw people who were familiar to them, and who understood them, both in the waiting room and in the clinical space.^{27,28} Clients indicated that they valued this because it gave them a sense of belonging.^{27,28} The emotional dimension of the welcoming environment was evidenced in descriptions of ACCHOs as social meeting places, where friends offered and received support.^{28,29} The following client voices are illustrative of how clients described ACCHOs' welcoming environment:

"I just, just ah come here on my one day off and sit out here, have a talk with my mates... there's always someone you know here... it's a social event too..."^{29(p200)}

"We share a lot. You know when you meet people you talk about things... If we go in and I know someone we'll have a good yarn..."^{29(p200)}

Synthesised Finding 2: The way ACCHOs delivered care was highly valued. Clients valued staff taking the time to know and care for clients; personalised care tailored to self-perceived need; continuity of care; and appropriate communication. Clients related that they experienced feelings of belonging and confidence when accessing services with these service qualities. Four categories of findings informed this synthesised finding. The first was that clients experienced and valued staff, including doctors, taking their time with them.²⁹ In the words of one client: "That's the thing AMSs do really well, they take their time. There are not time limits"²⁹ ACCHOs providing healthcare in a personalised way tailored to client needs was the second category. These findings indicated that clients perceived ACCHOs as

delivering care in a way that was responsive to their background²⁷ by people who understood them.²⁹ Clients also reported that the way staff provided care made them feel: known;^{29,33} less isolated (belonging);^{29,33} more confident;²⁸ less anxious;³⁰ cared for;³⁰ accepted;^{28,29,30} supported;²⁹ and encouraged.³⁰ The third category was provision of information in a way that was understandable.^{27,30} Continuity of care was the last category, described as ongoing care and support for various problems in a client's life over time.^{27,29}

Synthesised Finding 3: Particular qualities of ACCHO staff were highly valued. These included Aboriginal identity of some of the ACCHO workforce, including AHWs; and staff who understood Indigenous clients and therefore behaved respectfully. Two categories informed this synthesised finding. The first was that clients valued the following behavioural qualities of staff: respectful and non-judgemental behaviour;²⁷ staff taking time to know the client's background and listen to their needs;²⁹ sensitivity, kindness and reassurance;^{25,26} and trustworthiness.^{28,29} One said the way ACCHO staff allowed clients to talk about anything made you "feel at home"²⁷ The second category concerned how clients valued the Aboriginal identity of some ACCHO staff^{29,33} and the employment of AHWs.²⁸ The following client voice illustrates how some clients described the value of AHWs:

"It was a whole new world... she was like a social worker I guess, we could talk to them individually, she was lovely. She explained everything, she took you in to how you know it all worked and was going to happen... you couldn't have found so much difference between her, and the doctors who just tell you."^{28(p6)}

Synthesised Finding 4: A comprehensive, holistic approach to PHC was highly valued. The inclusion of non-clinical care, such as community events, group activities and enhanced supports available through community networks, had a positive impact on peoples' wellbeing. Two categories informed this synthesised finding. The first was that non-clinical services, including ACCHOs' social services, cultural events,³³ and group activities such as diabetes camps³⁰ and bush camps,³³ were a valued characteristic. Clients pursued the opportunity group programs gave them to spend time with people who shared similar experiences, and to connect with community and culture.^{30,33} One client described the group-based activities

as "a really great healing process."^{33(p359)} The second category of findings acknowledged and described perceived positive impacts of ACCHOs on client wellbeing.^{27,28,30,32} The impacts identified were: increased confidence;^{27,28} enhanced knowledge about how to manage conditions and actively engage in health decision making;³⁰ pride in being part of the local Aboriginal community and its health service; better health;^{28,32} and better mental health.³²

Comparisons of the characteristics of care in ACCHOs and mainstream PHC

Synthesis of the findings from three included studies contrasting the client perceptions of the characteristics of care in ACCHOs and mainstream PHC produced one synthesised finding which identified two differences between ACCHOs and mainstream PHC providers.^{28,29,33}

Synthesised Finding 5: While relationships were characterised by respect and understanding in ACCHOs, in mainstream services there was often a lack of respect and no shared understanding between providers and clients, or among clients. ACCHO clients described being discriminated against (also couched as being treated "differently"),²⁸ patronised,²⁸ assaulted and threatened²⁹ by staff in mainstream services and contrasted this with staff in ACCHOs, including "behind the door in the clinical consultation space"²⁹ treating clients with respect and understanding rather than challenging or denying cultural identity.²⁹ The second category was client-provider and provider-provider relationships in ACCHOs being characterised by high levels of trust,²⁹ shared similar meanings²⁹ and caring supportive relationships³³ contrasting with a lack of mutual understanding and an absence of trust in the relationships within mainstream services.²⁹

Comparisons of valued characteristics of care in ACCHOs and mainstream

Synthesis of findings from six of the included qualitative studies contrasting the value of care across the two sectors, identified three unique highly valued characteristics of care provided by ACCHOs compared to mainstream PHC providers.^{27-29,32-34}

Synthesised Finding 6: ACCHO clients identified three unique highly valued characteristics of ACCHOs compared to mainstream PHC services: (1) accessibility, which clients described in terms of welcoming

and safe spaces; (2) the way ACCHOs delivered care, in a culturally safe way tailored to need; and (3) comprehensive holistic care. The first point was that clients preferred ACCHOs because of their greater accessibility, which was related to additional services and their more welcoming environment.^{27,29,32,34} Clients described ACCHO waiting rooms as meeting and speaking environments “where people happen to be sick”,²⁹ contrasted with mainstream services’ waiting rooms, described as quiet, formal sick places where you felt isolated.²⁹ Clients signalled that relationships and support associated with companionship experienced in ACCHOs’ and Aboriginal staff were key to why ACCHOs were more accessible.³²

“I used to go...all the way into [suburb] to see the AMS workers, and um I’d see a lot of people, it’s a great place to get together with a lot of people, a special place, and you see different ones, and have a yarn to...I’ve been away for a while, and um I always come back... In the [non-Indigenous] service you’re in, you’re out. There’s no friendliness...”^{28(p4-5)}

“There’s always someone that you know, another family member or an old school chum or people you’ve played football with, and you’ve got that companionship there. If you were to go to the doctor’s surgery uptown and then just sitting there, oh god, I’m wishing to get out of there super quick.”^{33(p358)}

“I was going to a doctor in Cleveland, and I didn’t feel comfortable there, but being here, where there’s other people around, yeah I felt comfortable when I came here the first time... there were Aboriginal nurses as well... and you could relate to them a bit more.”^{32(p.6)}

The second and third categories informing synthesised finding six, concerned differences in the way care was delivered across the two settings.^{27,29,3}

Clients indicated they valued how staff in ACCHOs understood their holistic health care needs – signalled for example by references to be able to “talk to the AMS staff about anything and everything” – and were respectful,^{29(p202)} and contrasted this with experiencing lack of understanding and inadequate care in mainstream PHC services.

Discussion

Our systematic review identified a small body of studies reporting qualitative data on client perceptions that when synthesised offers useful insights into how Indigenous clients view the nature and value of care provided in ACCHOs, and comparison to in mainstream

PHC providers. Importantly, the findings from the syntheses contrasting care across the sectors mirrored those from the synthesis of clients’ perceptions of ACCHOs’ characteristics and value. Overall, our synthesis points to three unique, highly valued characteristics of care provided in ACCHOs compared to in mainstream providers. The first is ACCHOs’ unique accessibility. Clients perceive ACCHOs’ welcoming environment, which includes a social, emotional and physical aspect and supports cultural safety; ACCHOs’ flexible, responsive and proactive approach to care provision; and ACCHOs’ additional services, including transport and outreach as factors contributing to ACCHOs unique accessibility. The second unique, highly valued ACCHO characteristic is ACCHOs’ culturally safe care. This was described by clients as care delivered by staff, many Aboriginal, who feel known to clients, understand client needs and respect culture, in an environment where clients feels comfortable, supported and that they belong. The third was comprehensive care, that is, care responsive to holistic health needs.

Relationships, understanding and respect for culture central to clients’ view of accessible, appropriate, quality health care

High levels of trust and mutual understanding in the relationships between clients and health care providers, as well as close relationships between clients, were central themes in our syntheses. The presence of people from the local community, and involvement of Indigenous people in the service, was also central themes. Our synthesis therefore reinforces existing literature that has highlighted relationships,^{3,35} respect for culture and for Indigenous knowledge, and the involvement of Indigenous people in providing care, as central to Indigenous clients’ perceptions of accessible, appropriate and quality health care.

Why care provided by mainstream PHC providers will not substitute for ACCHO care

The description of ACCHOs’ characteristics and value compared to mainstream PHC providers highlights two distinct but equally important reasons why the care provided by mainstream providers cannot serve as a substitute for the care provided by ACCHOs for Indigenous clients. First, as has been previously noted,³ the characteristics of accessible and culturally safe care are such that mainstream PHC providers cannot achieve them using a tick-box approach

and without fundamental change. Key elements, including the support offered by relationships amongst clients, will be difficult for mainstream providers to replicate. Second, mainstream services are not perceived by all Indigenous Australians as offering care that is responsive to holistic health needs. Moreover, mainstream PHC providers are ill-equipped to provide clients with a broad range of PHC programs tailored to self-perceived holistic health needs. They are focused on delivering clinical services designed largely to meet the needs of the majority, non-Indigenous population and to meet business objectives, and they are unlikely to transition to providing the additional services Indigenous Australians seek.

Additional insights on how ACCHOs improve Indigenous health

Our findings offer additional insights into the way ACCHOs contribute to improving the health and wellbeing of Indigenous Australians. Moreover, the clients’ references to positive impacts of ACCHOs on their confidence,^{27,28} on their knowledge about how to manage conditions and actively engage in health decision making,³⁰ on their pride in being part of the local Aboriginal community and its health service; and on their mental health³² supports the conclusion of a recent review on ACCHOs’ impacts on Indigenous health,³⁶ that ACCHOs are important not only because their health care helps to improve Indigenous Australians’ health, but also because of how they help to address the socioeconomic factors that contribute to high levels of chronic disease in Indigenous communities.

Strengths and limitations

The overall quality of the included studies was good. A second strength of our review is the steps we took to align our review methodology with the ethical and methodological requirements relating to research involving Indigenous Australians. These steps are important because they are called for by the unique standards for ethical research with Indigenous Australians, and because incorporating local contextual and cultural knowledge specific to Indigenous people adds to the credibility and relevance of the review findings and should aid their transferability into practice and policy.^{20,21}

The small number of studies contributing to the syntheses, particularly the two comparing care across the sectors, is a limitation of

our review. Neither the included ACCHO population nor the ACCHO client population were representations of their diverse total populations in Australia, potentially limiting the transferability of the findings. Another limitation relates to our inability (given data constraints) to explore potential variations in the perspectives of clients with different characteristics, e.g. males versus female, people of low and high socio-economic status. Third, whilst we did not extract findings from studies in which it was clear that the comparator was care in the hospital setting, we cannot be certain that references to “mainstream services” did not include this setting. We did not consider how clients’ perceptions of the characteristics and value of ACCHOs’ care compare with their perceptions of characteristics and value of other Indigenous PHC provider types. It is expected that Indigenous services, with high levels of local community involvement in the planning and delivery of their services, may be perceived by clients as having similar characteristics and value as ACCHOs. Fifth, there may be studies published since the end date of our search, that meet our review inclusion criteria, which may offer unique additional insights about how ACCHO clients perceive the characteristics and value of care provided by ACCHOs, and compared to mainstream providers, or they may confirm our synthesised findings.

Implications

Mainstream practitioners that seek to improve the accessibility and quality of their care for Indigenous peoples should:

- 1) invest in understanding Indigenous clients’ needs and learn how to be respectful of Indigenous clients’ culture;
- 2) adopt a flexible and proactive approach to providing care for Indigenous people (for example, they need to be prepared to meet clients outside of normal operating hours and engage in outreach activities); and
- 3) invest in making the clinic welcoming for Indigenous clients, for example, by putting up posters and other artefacts that are representative of Indigenous culture.

However, for many Indigenous Australians, the care provided by mainstream PHC providers will not be a substitute for ACCHO care tailored to meet holistic health needs of Indigenous clients and their communities. Australian governments therefore should remain committed to the

implementation of community control and should prioritise reforms to make the funding and accountability arrangements more enabling of rapid growth in the ACCHO sector and more supportive of high-quality, comprehensive, effective service provision by ACCHOs. To this end, government should look to the recommendations offered by recent research on barriers and facilitators regarding implementing Indigenous community control in PHC which offers useful guidance on reforms required in funding and accountability frameworks.^{11,14,16-18} In addition to building better funding and accountability arrangements for the ACCHO sector, governments need to continue to prioritise initiatives, for example best practice guideline development and dissemination, that enable all relevant treatments for comprehensive holistic health care being informed by scientific evidence. Ensuring that all ACCHOs have access to, and have the capacity to use, appropriate continuous quality improvement systems, for identifying their strengths and where system change is required to further strengthen the service and improve the health outcomes for clients accessing these services, is also important.³⁷

Conclusion

The qualitative evidence on how Indigenous Australian ACCHO clients perceive the characteristics and value of care provided by ACCHOs, and compared to in mainstream PHC providers facilitates understanding why mainstream PHC provider care cannot be a substitute for ACCHO care. It also offers insights into how ACCHOs address socioeconomic factors that contribute to chronic disease in Indigenous communities. This sends a cautionary note to policy makers intent on mainstreaming Aboriginal PHC and underscores the importance of implementing the reforms to the funding and accountability arrangements for ACCHOs, that have been identified as important to support ACCHOs’ delivering quality services that are effective and meet holistic needs of clients in Indigenous communities. Mainstream PHC practitioners can learn from best-practice examples in the ACCHO sector how to improve the accessibility and quality of their care for Indigenous clients.

Acknowledgements

Judith Gomersall (JG), Odette Gibson (OG), Judith Dwyer (JD), Alex Brown (AB) and Edoardo Aromataris (EA) led the conceptualisation of the review. JG and OG led the writing of the protocol. The research governance group established to guide the work of the NHMRC Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE) reviewed the protocol. JG performed the search and abstract review. OG, Drew Carter (DC) and EA conducted the full text examination. EA, an experienced systematic reviewer, provided oversight during the search and study selection process. EA and Zachary Munn (ZM) provided technical advice about appropriate review method. Two non-Indigenous Australian members of the review team, DC and JG, assessed the quality of studies. Their assessments were reviewed by two Indigenous Australian members of the team, OG and Kootsy Kanuto (KK). Matthew Stephenson (MS), ZM and JG (all non-Indigenous Australians) extracted the data from the included studies. Two Indigenous members of the review team, OG and Kim O’Donnell (KO), reviewed their data extraction. KO, OG, MS, JG and DC participated in a workshop convened to develop an initial set of categories for the meta-aggregation. OG and JG then worked together on the meta-aggregation with OG’s perspective being privilege due to her unique insider Aboriginal knowledge. AB, a senior Indigenous Australian health researcher with expert knowledge of Aboriginal health and the Aboriginal health sector, guided JG through the second level analysis, the interpretation of the synthesised findings. JG, OG, JD and EA led the writing of the paper, which was reviewed by all authors. The findings of the review were presented to representatives of the CREATE leadership group prior to submission of this article for publication, and feedback received integrated. The authors thank the participants of the CREATE leadership group for the invaluable guidance and time they provided during this review. We also thank Harold Stewart and Stephen Harfield for participating in the workshop held at the beginning of the synthesis stage of the review. Finally, we thank Sandeep Moola for assistance during the data extraction stage of the review.

Funding

The NHMRC (GNT1061242) supported this project. The contents of the published material are solely the responsibility of the Administering Institution, a Participating Institution or individual authors and do not reflect the views of NHMRC.

References

1. Australian Institute of Health and Welfare. *Australia's Health 2012*. The Thirteenth Biennial Health Report of the Australian Institute of Health and Welfare. Canberra (AUST): AIHW; 2012.
2. Australian Health Ministers' Advisory Council. *Aboriginal and Torres Strait Islander Health Performance Framework*. Report. Canberra (AUST): Government of Australia; 2012.
3. Pieres D, Brown A, Cass A. Addressing inequities in access to quality health care for indigenous people. *Commentary. CMAJ*. 2008;179(10):985-2008.
4. Davy C, Cass A, Brady J, DeVries J, Fewquandie B. Facilitating engagement through strong relationships between primary healthcare and Aboriginal and Torres Strait Islander peoples. *Aust N Z J Public Health*. 2016;40(6):535-41.
5. National Aboriginal Community Controlled Health Organisation. (NACCHO). *Definitions and History* [Internet]. Canberra (AUST): NACCHO; 2016 [cited 2016 Feb 10]. Available from: <http://www.naccho.org.au/aboriginal-health/>
6. World Health Organisation. *Primary Health Care: International Conference on Primary Health Care 1978*. Alma Ata (KAZ): Geneva (CHE): WHO; 1978.
7. United Nations General Assembly. *Declaration on the Rights of Indigenous Peoples*. Geneva (CHE): UN; 2007.
8. Crampton P, Davis P, Lay-Yee R, et al. Does community-governed non-profit primary care improve access to services? Cross-sectional survey of practice characteristics. *Int J Health Serv*. 2005;35:465-78.
9. Thompson S, Haynes E, Shahid S, et al. Effective Primary Health Care for Aboriginal Australians. Unpublished observations; 2013.
10. Australian Institute of Health and Welfare. *Aboriginal and Torres Strait Islander Health Organisations. Online Services Report – Key Results 2014-15*. Canberra (AUST): AIHW; 2016.
11. Dwyer J, Martini A, Brown C, Tilton E, Devitt J, Myott P, et al. *The Road is Made by Walking: Towards a Better Primary Health Care System for Australia's First Peoples*. Melbourne (AUST): Lowitja Institute; 2016.
12. Baillie R, Si D, Dowden M, Selvey C, Kennedy C, Cox R, et al. A systems approach to improving timeliness of immunisation. *Vaccine*. 2009;27:3669-74.
13. Department of Health. *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. Canberra (AUST): Government of Australia; 2013.
14. Lavoie J, Dwyer J. Implementing Indigenous community control in health care: Lessons from Canada. *Aust Health Rev*. 2016;40:453-8.
15. Australian Medical Association. *Aboriginal and Torres Strait Islander Health Report Card. Best Practice in Primary Health Care for Aboriginal Peoples and Torres Strait Islanders 2010-2011* [Internet]. Canberra (AUST): AMA; 2011 [cited 2016 Mar 15]. Available from: https://ama.com.au/sites/default/files/documents/Indigenous_Report_Card_2010_11.pdf
16. Alford K. Indigenous health expenditure deficit obscured in closing the gap reports. *Med J Aust*. 2015;203(10):403-3.e1.
17. Dwyer J, Lavoie J, O'Donnell K, Martini U, Sullivan P. Contracting for Indigenous health care: Towards mutual accountability. *Aust J Public Health Adm*. 2011;70(1):34-46.
18. Moran M, Porter D, Curth-Bibb J. *Funding Indigenous Organisations: Improving Governance Performance through Innovations in Public Finance Management in remote Australia*. Closing the Gap Clearinghouse Issues Paper No. 11. Canberra (AUST): Australian Institute of Health and Welfare; 2014.
19. Gomersall J, Aromataris E, Brown A, Dwyer J, Stephenson M, O'Donnell K, et al. Characteristics and value of Aboriginal Community Controlled Health Organisations' primary health care and their financing needs: A protocol for systematic evidence reviews. *JBI Database System Rev Implement Rep*. 2015;13(6):139-67.
20. Lockwood C, Munn Z, Porritt K. Qualitative research synthesis: Methodological guidance for systematic reviewers utilizing meta-aggregation. *Int J Evid Based Healthc*. 2015;13(3):179-87.
21. Liberati A, Altman D, Tetzlaff J, Murlow C, Gotzsche P. The PRISMA statement for reporting systematic review and meta-analysis of studies that evaluate healthcare interventions: Explanation and elaboration. *BMJ*. 2009;339:b2700. Doi:10.1136/bmj.b2700.
22. National Health and Medical Research Council. *Values and Ethics – Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander health Research*. Canberra (AUST): Government of Australia; 2003.
23. Gomersall JS, Canuto, K, Aromataris E, Braunack-Mayer A, Brown A. Systematic Review to inform prevention and management of chronic disease for Indigenous Australians. *Aust N Z J Public Health*. 2016;40(1):22-9.
24. McDonald E, Priest N, Doyle J, Baillie R, Anderson I, Walters E. Issues and challenges for systematic reviews in Indigenous health. *J Epidemiol Community Health*. 2010;64:643-4.
25. Campbell S, Brown S. Maternity care with the Women's Business Service at the Mildura Aboriginal Health Service. *Aust N Z J Public Health*. 2004;28(4):376-82.
26. Campbell S, Brown S. *The Women's Business Service at the Mildura Aboriginal Health Service: A Descriptive Evaluation Study*. Melbourne (AUST): La Trobe University Centre for the Study of Mothers' and Children's Health; 2004.
27. Jan S, Conaty S, Hecker R, Bartlett M, Delaney S, Capon, T. An holistic economic evaluation of an Aboriginal community-controlled midwifery programme in Western Sydney. *J Health Serv Res Policy*. 2004;9(1):14-21.
28. Aspin C, Brown N, Jowsey T, Yen L, Leeder S. Strategic approaches to enhanced health service delivery for Aboriginal and Torres Strait Islander people with chronic illness: A qualitative study. *BMC Health Serv Res*. 2012;12(143):1-8.
29. Jowsey T, Yen L, Ward N, McNab J, Aspin C, Usherwood T. It hinges on the door: Time spaces and identify in Australian Aboriginal health services. *Health Soc Rev*. 2012;21(2):196-207.
30. Kowanko I, Help Y, Harvey P, Battersby M, McCurry B, Carbine R, et al. *Chronic Condition Management Strategies in Aboriginal Communities: Final Report 2011*. Adelaide (AUST): Flinders University and the Aboriginal Health Council of South Australia; 2012.
31. Menzies School of Health Research. *Sentinel Sites Evaluation: A Place-based Evaluation of the Indigenous Chronic Disease Package 2010-2012 Summary Report*. Canberra (AUST): Australian Department of Health; 2013.
32. Baba J, Brolan C, Hill P. Aboriginal medical services cure more than illness: A qualitative study of how Indigenous services address the health impacts of discrimination in Brisbane communities. *Int J Equity Health*. 2014;13:56.
33. Freeman T, Edwards T, Baum F, Lawless A, Jolley G, Javanparast S, et al. Cultural respect strategies in Australian Aboriginal primary health care services: Beyond education and training of practitioners. *Aust N Z J Public Health*. 2014;38(4):355-61.
34. Govil D, Lin I, Dodd T, Cox R, Moss P, Thompson S, et al. Identifying culturally appropriate strategies for coronary heart disease secondary prevention in a regional Aboriginal Medical Service. *Aust J Prim Health*. 2014;20:266-72.
35. Gibson O, Lisy K, Davy C, et al. Enablers and barriers to the implementation of primary health care interventions for Indigenous people with chronic diseases: A systematic review. *Implement Sci*. 2015;10:71.
36. Aboriginal Health and Medical Research Council. *Aboriginal Communities Improving Aboriginal Health: An Evidence Review on the Contribution of Aboriginal Community Controlled Health Services to Improving Aboriginal Health*. Sydney (AUST): AHMRC; 2015.
37. National Aboriginal Community Controlled Health Organisation. *National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care. 2015-2025. Ensuring Long Term Sustainability: NACCHO Position Statement*. Canberra (AUST): NACCHO; 2015 [cited 2016 Mar 1]. Available from: <http://www.naccho.org.au/wp-content/uploads/NACCHO-CQI-Position-Statement-FINAL-Sept-2015.pdf>

Supporting Information

Additional supporting information may be found in the online version of this article:

Supplementary File 1: Search strategy.

Supplementary File 2: Figure 1 – Search results and study selection.

Supplementary File 3: Table 1 – Methodological quality of included studies.

Supplementary File 4: Table 2 – Characteristics of included studies.

Supplementary File 5: Illustration of the three meta-aggregations of client perceptions.