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

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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.1 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.4,5 Australia’s culturally diverse Indigenous peoples’ understanding of accessible, appropriate, quality PHC is different and broader than Western notions.5,6 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.1 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 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.3 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

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.
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.7 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 Australia 10 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.10,11 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.13 Of the 203 Indigenous PHC organisations in 2014/15, 68% were ACCHOs, 25% were government-run services, and 18% were mainstream non-government organisations.13 Recent policy14 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 peoples14 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.16

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.14 We followed Joanna Briggs institute (JBI) guidance for systematic review of qualitative evidence21 and the PRISMA reporting guidelines.22 We took two steps to better align with ethical standards relevant to research involving Indigenous Australians23 and enable Indigenous specific contextual and cultural knowledge to inform the evidence appraisal and interpretation:21,22

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 HealthInfoNet (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:

We used meta-aggregation\textsuperscript{20} to synthesise, 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).\textsuperscript{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 (KD, OG). The confirmation of accuracy ensured that Indigenous Australian perspectives were applied in the quality appraisal and data extraction.

Synthesis

We used meta-aggregation\textsuperscript{20} 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.\textsuperscript{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 categories,\textsuperscript{20} 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,\textsuperscript{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,\textsuperscript{20} seven were rated good quality,\textsuperscript{27,29,34} and one, reported in two articles, was rated moderate quality.\textsuperscript{21,22} 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,\textsuperscript{25,27,31,33,34} Four used focus groups and interviews,\textsuperscript{27,31} four used only interviews,\textsuperscript{25,26,28,32} and one used only focus groups.\textsuperscript{25} Five of the studies adjusted their methodology to align with the unique ethical and methodological standards relevant to research with Indigenous Australians.\textsuperscript{2,26,31,32} Based on an estimation of 75 participants in one study that employed focus groups,\textsuperscript{25} a total of 811 study participants informed the meta-syntheses (including 640 from one study).\textsuperscript{32} 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,\textsuperscript{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
delivered care in a way that was responsive to their background\(^2\) by people who understood them.\(^2\) Clients also reported that the way staff provided care made them feel: known,\(^2,31\) less isolated (belonging),\(^2,31\) more confident,\(^2\) less anxious,\(^2\) cared for,\(^2\) accepted,\(^2,28,31,32\) supported,\(^2\) and encouraged.\(^2\) The third category was provision of information in a way that was understandable.\(^2,28\) Continuity of care was the last category, described as ongoing care and support for various problems in a client’s life over time.\(^2,29\)

**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;\(^2\) staff taking time to know the client’s background and listen to their needs;\(^2\) sensitivity, kindness and reassurance;\(^2,26\) and trustworthiness.\(^2,28\) One said the way ACCHO staff allowed clients to talk about anything made you “feel at home”.\(^2\) The second category concerned how clients valued the Aboriginal identity of some ACCHO staff,\(^2,31\) and the employment of AHWs.\(^2\) 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.”\(^2\)

**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,\(^3\) and group activities such as diabetes camps\(^3\) and bush camps,\(^3\) 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.\(^3,31\) One client described the group-based activities as “a really great healing process”.\(^3,31\) The second category of findings acknowledged and described perceived positive impacts of ACCHOs on client wellbeing.\(^2,28,31,32\) The impacts identified were: increased confidence,\(^2,28\) enhanced knowledge about how to manage conditions and actively engage in health decision-making,\(^2\) pride in being part of the local Aboriginal community and its health service; better health;\(^2,31\) and better mental health.\(^1\)

**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.\(^2,28,31\)

**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"),\(^2\) patronised,\(^2\) assaulted and threatened\(^2\) by staff in mainstream services and contrasted this with staff in ACCHOs, including "behind the door in the clinical consultation space";\(^2\) treating clients with respect and understanding rather than challenging or denying cultural identity.\(^2\) The second category was client-provider and provider-provider relationships in ACCHOs being characterised by high levels of trust,\(^2\) shared similar meanings\(^2\) and caring supportive relationships\(^2\) contrasting with a lack of mutual understanding and an absence of trust in the relationships within mainstream services.\(^2\)

**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.\(^2,28,31,32,34\)

**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”,27 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….”29(p.4-5)

“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.”29(p.15)

“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.”29(p.6)

The second and third categories informing synthesised finding six, concerned differences in the way care was delivered across the two settings.27,29,32

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(p.20) 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,1 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 confidence27,28 on their knowledge about how to manage conditions and actively engage in health decision making;29 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

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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. 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.

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.

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References


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.