Received: 17 December 2022 | Revised: 4 September 2023 | Accepted: 15 September 2023

DOI: 10.1111/ajr.13048

ORIGINAL RESEARCH

AJRH National Rural Health Alliance WILEY

Responsiveness of a rural Aboriginal community controlled health organisation: A qualitative study

Hannah Beks MPH[1] | **Kevin P. Mc Namara PhD**[1] | **Fiona Mitchell (Mununjali) Grad Dip Indigenous Research**[1] | **James A. Charles (Kaurna) PhD**[2] | **Vincent L. Versace PhD**[1]

[1]Deakin Rural Health, Deakin University, Warrnambool, Victoria, Australia

[2]First Peoples Health Unit, Griffith University, Gold Coast, Queensland, Australia

Correspondence
Hannah Beks, Deakin Rural Health, Deakin University, PO Box 423, Warrnambool, Vic. 3280, Australia.
Email: hannah.beks@deakin.edu.au

Funding information
Nurses Board Victoria Legacy Limited; Western Alliance Academic Health Science Centre

Abstract

Introduction: Responsiveness of health care systems is a global concept defined as the ability of systems to function in a manner that meets the expectations of individuals, and is under-studied. In Australia, Aboriginal Community Controlled Health Organisations (ACCHOs) are valued by Aboriginal and Torres Strait Islander Peoples for the provision of holistic culturally safe primary health care and are well positioned to be responsive to community needs.

Objective: To develop a conceptual framework examining the responsiveness of a rural ACCHO to the health care needs of Aboriginal and Torres Strait Islander Peoples in their service region.

Design: A qualitative interview study using abductive reasoning was conducted. Interviews conducted with Aboriginal clients, key informants, and ACCHO health personnel from two evaluations undertaken in partnership with a rural ACCHO located in Victoria, Australia, were analysed through an iterative process of identifying key concepts from the data and evidence. Key concepts were used to develop a conceptual framework.

Findings: Across the two evaluations, 22 participants were involved in data collection and 28 interviews were undertaken. A conceptual framework examining the responsiveness of a rural ACCHO to the health care needs of Aboriginal Peoples within their service region was developed and encompassed three concepts: operating within a complex adaptive system, mechanisms of responsiveness used by the ACCHO, and challenges experienced by the ACCHO when being responsive.

Discussion: The developed conceptual framework expands on research supporting the value of ACCHOs in providing holistic culturally safe health care to their communities, particularly in rural settings. A key finding is the importance for ACCHOs to meet the health care needs of their community whilst navigating needs in the context of the broader health care system. When dissonance is encountered between external system components and community needs,

challenges can be experienced such as adequately resourcing models of service delivery and maintaining the provision of services.

Conclusion: Conceptualising the health care system as a complex adaptive system in which an ACCHO operates and is responsive, highlights the competing demands experienced. Findings expand on mechanisms of responsiveness used at the service–user interface. Future research should examine how the broader health care system can support the role and functions of ACCHOs in being responsive to the health care needs of their communities.

KEYWORDS

Aboriginal Community controlled health Organisations, Australian Aboriginal and Torres Strait islander peoples, complex adaptive systems, health services, indigenous, primary health care, responsiveness, rural health services

1 | INTRODUCTION

Aboriginal and Community Controlled Health Organisations (ACCHOs) provide culturally safe holistic primary health care services to Aboriginal and Torres Strait Islander Peoples in Australia.[1,2] There are over 140 ACCHOs across Australia situated geographically proximal to where Aboriginal and Torres Strait Islander Peoples reside.[3] Redressing health inequity (e.g., chronic disease burden) and barriers to accessing health care (e.g., racism, transport, financial barriers) are key functions of ACCHOs.[4] Evidence supports that ACCHOs are best positioned to deliver primary health care services to the communities they serve, underpinned by the international principle of self-determination.[1,5] Further, ACCHOs are understood to be proactive in responding to the health care and social needs of Aboriginal and Torres Strait Islander Peoples and are a vital part of the Australian health care system.[6]

Responsiveness of health care systems is a global health concept as stipulated by the World Health Organisation (WHO) and is defined as the ability of health care systems to function in a manner that meets the expectations of individuals, including the non-health aspects of providing care to patients (i.e. users) at the service–user interface (e.g., maintaining dignity of patients, timely and accessible care, respectful services).[7] In theory, responsive health care systems have the ability to enhance health care outcomes.[8] Characteristics of a responsive health care system include inclusive and participatory services which promote the rights of users and engage with feedback between users and the health system.[8] The responsiveness of health care systems is much broader than the responsiveness of health care services (e.g., how patients are treated by a service), and includes considering the environment in which users are treated (e.g., policy, funding).[7]

What is already known on this subject

- Aboriginal Community Controlled Health Organisations (ACCHOs) are valued for the provision of holistic culturally safe health care for Aboriginal and Torres Strait Islander Peoples in Australia.
- Responsiveness of health care systems is a global health concept which is under-studied and includes the non-health aspects of providing care to patients at the service–user interface which meets expectations, and by doing so, can enhance the outcomes of health care provided.
- Health care systems are complex adaptive systems, with competing demands and priorities.

What this paper adds

- Identifies that ACCHOs operate within a broader health care system which is a complex adaptive system.
- Multiple mechanisms of responsiveness were used by the ACCHO to identify and prioritise the health care needs of Aboriginal and Torres Strait Islander Peoples residing in their service region.
- Greater support is required to support the responsiveness of ACCHOs to the health care needs of their communities.

At a global and national level, the responsiveness of health care systems is largely under-studied with little consideration of how system components interact to achieve responsiveness.[8] In Australia, examining this in

the context of Aboriginal and Torres Strait Islander Peoples is particularly important given the enduring health inequities experienced.[9] Considering the interactions between different components of the health care system, mechanisms of responsiveness, and outcomes of these mechanisms, is key to examining responsiveness.[8] Further to this, conceptualising the health care system as a complex adaptive system (CAS) which consists of different components interacting in a non-linear manner with competing demands across different system levels,[10] is a starting point to understanding overall system responsiveness. Components include government (e.g., Australian Government and State/Territory Governments), health services (e.g., ACCHOs), other community organisations and institutions (e.g., schools, corrective services), funding bodies (e.g., Government agencies, Medicare Benefits Schedule), and community (e.g., patients). Given the documented strengths of ACCHOs in meeting the health care and social needs of Aboriginal and Torres Strait Islander Peoples,[6] it is likely that examining mechanisms of responsiveness used by ACCHOs as health care services through a lens of CAS would be of most value to beginning to understand the responsiveness of the broader health care system in meeting the health care needs of Aboriginal and Torres Strait Islander Peoples in Australia.

Using a lens of CAS and drawing on key concepts around health care system responsiveness, the purpose of this study was to develop a conceptual framework examining the responsiveness of a rural ACCHO, Budja Budja Aboriginal Cooperative (BBAC, located in Modified Monash (MM) 5—small rural town[11]), to the needs of Aboriginal and Torres Strait Islander Peoples in their service region (Jardwadjali and Djab Wurrung Country, Ararat and Northern Grampians Region, Victoria, Australia), in the context of implementing two models of service delivery (the Tulku wan Wininn mobile clinic, and telehealth services). These models of service delivery have been described in greater detail elsewhere and are summarised in Table 1.[12–14]

Briefly, the concept for this study was developed through an ongoing partnership between BBAC and Deakin Rural Health (a University Department of Rural Health funded by the Australian Government's Rural Health Multidisciplinary Training program),[15] established in 2018. The purpose of the partnership was to implement and evaluate the Tulku wan Wininn mobile clinic for Aboriginal and Torres Strait Islander Peoples residing in the ACCHO service region (an area covering ~10 000 square kilometres which is classified as MM 4—medium rural town (townships of Ararat and Stawell), and MM 5—small rural town [all other areas]).[16] Across Victoria,

TABLE 1 Tulku wan Wininn mobile clinic and telehealth services.

Model of service delivery	Tulku wan Wininn mobile clinic	Telehealth services
Month and year of implementation	July 2019	March 2020
Rationale for implementation	Given the large geographical service region of BBAC (~10 000 square kilometres) and dispersed Aboriginal and Torres Strait Islander client population within this region, accessibility to health care was identified to be a challenge due to travel required and transport barriers (e.g., vehicle, financial issues) experienced by clients. Through a series of community consultation and key stakeholder engagement, a primary health care mobile clinic was identified as a strategy to improve service accessibility	Telehealth services were required to be implemented by BBAC to maintain the delivery of primary health care services in the context of COVID-19 and requirement for physical distancing
Description	A purpose-built van utilised to deliver primary health care services, including general practitioner and allied health services, implemented, and maintained by BBAC	Telehealth services included both videoconferencing and telephone between clients and health professionals, including general practitioners, nurses, and specialist medical practitioners
Funding source(s)	Funding for the mobile clinic van was provided by BBAC, Deakin University, and National Indigenous Australians Agency, (formally the Indigenous Affairs, Department of Prime Minister and Cabinet). Funding support for a Mobile Clinic Coordinator position was provided by the Western Victoria Primary Health Network	Revenue for telehealth services were accommodated for by temporary changes to the Australian Government's Medicare Benefits Schedule item numbers

MM4 comprises 262 005 residents (4.4% of the population) and MM5 comprises 391 735 residents (6.6% of the population).[17] The partnership has been ongoing, spanning clinical placements, and a program of research.[18]

2 | METHODS

2.1 | Study design

A qualitative interview study using abductive reasoning was undertaken to develop a conceptual framework.[19] A similar approach has been used in other research undertaken in the primary care setting.[20] The Consolidated criteria for reporting qualitative research (COREQ)[21] and CONSolIDated critERtia for strengthening the reporting of health research involving Indigenous Peoples (CONSIDER statement)[22] (Appendix 1), were used to report against and was also applied prospectively to inform the research. The CONSIDER statement has also been used to report against in other research undertaken in partnership with a rural ACCHO.[23] Aligning with the research approach and processes described in Appendix 1, researchers traversed the cultural interface (a term used by Torres Strait Islander Professor Nakata)[24] of engaging Indigenous and western ways of undertaking research. Non-Indigenous researchers were guided by the local cultural knowledge of BBAC leadership and the expertise and cultural knowledge of Aboriginal researchers involved in the study design, data collection, and analysis.

Qualitative interviews from the two community-based evaluations (Tulku wan Wininn mobile clinic and telehealth services) undertaken in partnership with BBAC and key concepts from the evidence around health care system responsiveness[7,8] and CAS[10] were used to develop the framework. The study design, methods, and findings of the respective evaluations have been published elsewhere.[12–14]

2.2 | Study participants and recruitment

Health service personnel, external key informants, and Aboriginal and Torres Strait Islander clients were purposively sampled for the two evaluations. Health service personnel were defined as those involved with the delivery of the service models through BBAC, whereas external key informants were those outside of BBAC involved in the development of the service delivery models. Aboriginal and Torres Strait Islander clients were those who had accessed telehealth and/or the mobile clinic. Health service personnel and external key informants were directly approached by researchers and invited to participate in the evaluations. Recruitment of Aboriginal and Torres Strait Islander clients was managed by BBAC in an agreed culturally appropriate manner. This involved a letter with information about the evaluations being posted to clients detailing the opportunity to participate. Interested clients then approached a nominated BBAC person and provided verbal consent for their name and contact to be provided to external researchers. For all participants, a plain language statement was provided detailing the purpose of the evaluations. A mutually convenient time was arranged to meet remotely using the telephone or a videoconferencing platform due to COVID-19 physical distancing restrictions. Clients were provided with a $50 (AUD) voucher in appreciation for their time.

2.3 | Data collection

Data were collected from June 2019 to October 2021 as described elsewhere.[12–14] A written consent form was obtained from all participants prior to commencing the interview. A semi-structured interview guide was used (Appendix 2). External researchers undertaking the interviews had experience in undertaking qualitative research (HB, FM, JAC). Two of the researchers were Aboriginal (FM and JAC) and guided the cultural conduct of interviews undertaken with clients. Interviews were audio-recorded and transcribed verbatim by the researchers. Copies of transcripts were provided to participants which provided an additional opportunity to receive feedback. Researchers engaged in a debrief after undertaking interviews to discuss emerging concepts and how the positioning of researchers may have shaped the dialogue (reflexivity).[25] This was important as some participants were known to the researchers, including clients who were acquainted with the researchers through community events held by BBAC.

2.4 | Data analysis

Abductive reasoning guided data analysis which involved an iterative process of identifying key concepts from qualitative evaluation findings and from the evidence around health care system responsiveness and CAS.[19] This occurred after the related qualitative publications were drafted.[12,14] As a pragmatist qualitative approach with the aim of extending or establishing new theories from observations and data,[19] abductive reasoning was selected as an appropriate analysis method to examine the concept of responsiveness in the context of global evidence. Analysis was focused on the organisation level, being the rural ACCHO, and the interplay of mechanisms of

responsiveness used by the organisation in the context of the broader Australian health care system. Using software (NVivo QSR International, Melbourne, version 12) categories and codes within the evaluation thematic frameworks were mapped to key concepts from the evidence around the characteristics of health care system responsiveness[7,8] and CAS,[10] through an iterative process. A conceptual framework was developed through this process.

3 | RESULTS

Across the two evaluations, there was a total of 22 participants involved in data collection and 28 interviews (ranging from 5 to 50 min) undertaken from June 2019 to October 2021 (Table 2). As both evaluations were conducted at a single ACCHO concurrently, there was an overlap in participation and interviews across the two evaluations. Participants included ACCHO personnel (including locum health professionals), external key informants and Aboriginal clients. No clients participated who identified as Torres Strait Islander. Three key concepts were identified which led to the development of a conceptual framework (Figure 1. Conceptual framework of the responsiveness of an Aboriginal Community Controlled Health Organisation). These included: (1) operating within a complex adaptive system, (2) mechanisms of responsiveness used by the ACCHO, and (3) challenges experienced by the ACCHO when being responsive.

3.1 | Operating within a complex adaptive health care system

A key issue that emerged from the two evaluations was the complexities of the ACCHO navigating the external system in the context of implementing the two new models of service delivery (telehealth and mobile clinic) to address community-identified priorities and needs during COVID-19. The external system was mapped as a complex adaptive (CAS) system consisting of different components in which the ACCHO operated (Figure 1). This included governing and advocacy bodies (e.g., Victorian Aboriginal Community Controlled Health Organisation [VACCHO]), funding bodies (e.g., Medicare Benefits Schedule [MBS]), government departments (e.g., Victoria Department of Health), competitive grant opportunities, partnered community organisations and health care services (e.g., schools, local health care services), and outreach services (e.g., Rural Workforce Agency Victoria [RWAV]). Although not exhaustive, the relationship between these key system components and the rural ACCHO in the context of the two evaluations is presented in Figure 1.

Receiving support from other system components was identified as a key strength from operating within a CAS. For example, VACCHO played an important role in supporting the ACCHO in implementing telehealth services (e.g., providing technical support) and advocating for changes to the temporary COVID-19 MBS item numbers to include Aboriginal and Torres Strait Islander clients who had been clients <12 months (telehealth was initially for clients attending a practice >12 months).

> So I wrote to them (VACCHO) and said, Look we can't, our Aboriginal health services can't be constrained by that [initial COVID-19 telehealth rule] because we have a lot of itinerant and other people moving through our community. We can't reject people saying we don't know you, we haven't had you on our books for 12 months so, we can't help you. Luckily that was overturned on the weekend and on Monday it said we'll accept Aboriginal organisations.
>
> – ACCHO personnel

In the context of the mobile clinic, RWAV funded by the Australian Government, was key in supporting the ACCHO to maintain a general practitioner locum workforce in the context of rural workforce recruitment challenges (i.e. recruiting a permanent general practitioner [GP]).

A key issue for the ACCHO when operating within a CAS, was navigating funding and reporting obligations,

TABLE 2 Participant characteristics.

Participant group	Tulku wan Wininn and telehealth evaluations (merged) participant number (males: females: other gender, number of interviews)
ACCHO Personnel	12 (1:11:0, 15)
External Key Informants	2 (1:1:0, 2)
ACCHO clients	8 (3:4:1, 11[a])
Total	22 (28 interviews)[b]

[a]Three interviews were repeated with Community Members to develop rapport.

[b]A proportion of interviews served a dual purpose for both evaluations.

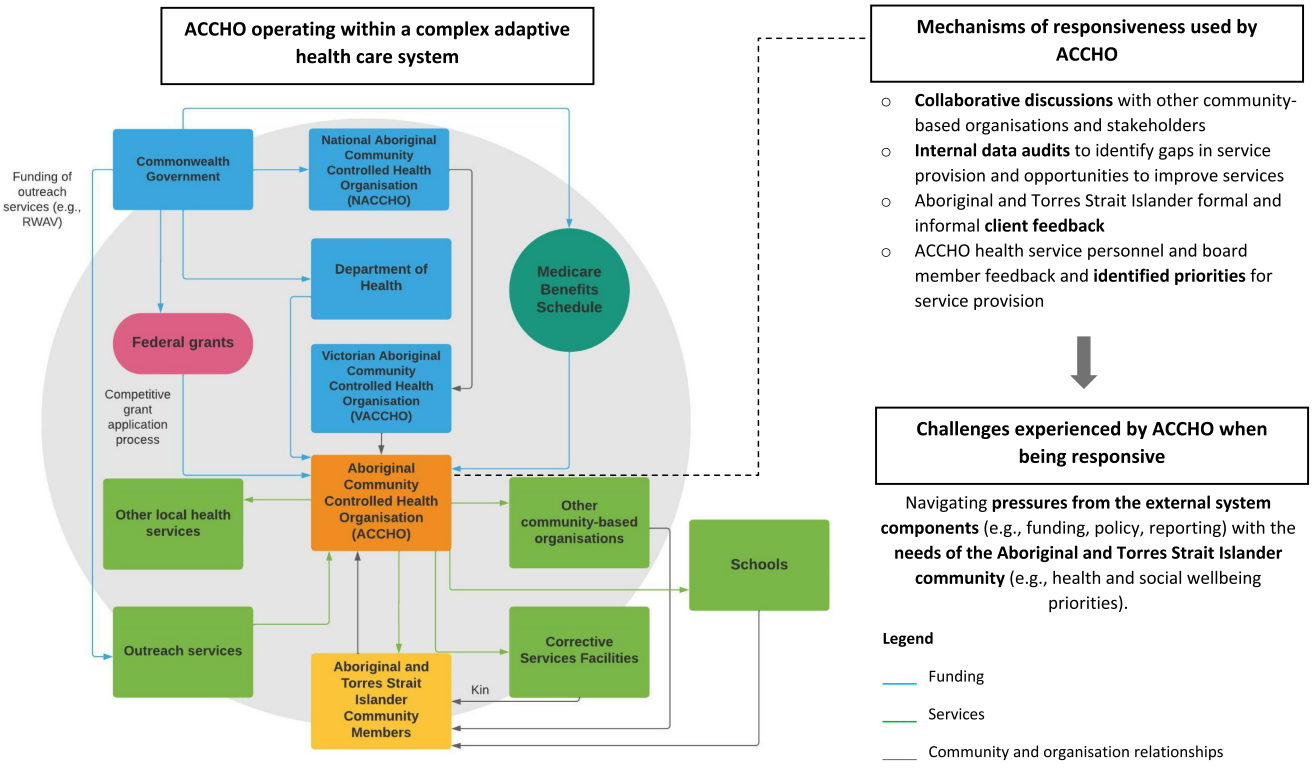

FIGURE 1 Conceptual framework of the responsiveness of an Aboriginal Community Controlled Health Organisation.

particularly when seeking to implement new models of service delivery in response to community needs and priorities, such as the mobile clinic. As a single funding opportunity was not available to the ACCHO for the purchase of the mobile clinic van, the support of multiple stakeholders was required to support the process. This included the co-development of a service and evaluation plan in partnership with a Deakin Rural Health and other stakeholders (e.g., Primary Care Partnership, Victorian Department of Health). It was through these partnerships that multiple funding sources were received for the manufacturing of the mobile clinic and for the position of mobile clinic coordinator to guide implementation (e.g., BBAC, Deakin University, National Indigenous Australians Agency, and Western Victoria PHN).

3.2 | Mechanisms of responsiveness used by the ACCHO

Mechanisms were identified as often iterative processes to identify community priorities and health care needs (including social needs), and to develop potential solutions to meet these needs. Multiple mechanisms of responsiveness to Aboriginal and Torres Strait Islander client needs were used by the ACCHO. These included: obtaining Aboriginal and Torres Strait Islander client feedback, and receiving ACCHO health service personnel feedback, having collaborative discussions with other community-based organisations and stakeholders, undertaking internal data audits to identify gaps in service provision and opportunities to improve services, and obtaining board member feedback on service priorities.

Both informal (e.g., conversation between clients and ACCHO personnel) and formal (e.g., feasibility study for mobile clinic concept) feedback from Aboriginal and Torres Strait Islander clients were obtained by the ACCHO. ACCHO personnel frequently cited receiving verbal feedback from clients and offered reflections on how this feedback was received or acted upon. Client feedback was key to informing ACCHO priorities and guiding discussions with other organisations (both government and community-based) in addition to identified community priorities by ACCHO board members (also community members) and ACCHO health service personnel. Further, internal clinical data audits (e.g., using aggregated ACCHO data) and external analysis of data (e.g., Australian Bureau of Statistics [ABS] Aboriginal and Torres Strait Islander population data) were undertaken by ACCHO personnel (e.g., reach of mobile clinic).

> We're going to look at the data. Look at where we need to improve and then try and target some of our services around what's going on. Where are people not getting the health care

> service they need? What can we do in the next three months? What's important at this time? We will be able to see then how the health van [mobile clinic] has helped, if we're using it to help our data and to improve. Whatever we do in the health van around that will also impact on what we're trying to do in the medical centre and with mental health and with our clients.
>
> – ACCHO personnel

In the context of the mobile clinic, feedback from clients (e.g., around transport and travel barriers) were captured formally through a funded feasibility study undertaken by an external consultant as shared by an ACCHO personnel in an interview. This knowledge coupled with the feedback from the ACCHO board and personnel (e.g., insufficient health services offered by non-Indigenous organisations), contributed to identifying the need for a mobile clinic. An analysis of ABS population data and internal clinic data identified that there were Aboriginal and Torres Strait Islander Peoples residing in surrounding localities that were not accessing ACCHO services. This informed a goal of attracting 75 new Aboriginal and Torres Strait Islander clients to the mobile clinic service which was formally included in the service plan. Feedback and gaps in service provision were communicated to other system components (e.g., Victorian Department of Health) through a regional sub-committee forum, leading to the eventual implementation of the mobile clinic.

> ...on the excel spreadsheet I've got the date, who went, where we went, how long we went for, half a day or a day, and how many patients we saw. How many were new. How many we did Aboriginal and Torres Strait Islander health assessments on, how many just saw myself, a nurse or an allied health practitioner. I try to keep track of numbers because I need to report to the board and various bodies about what is happening.
>
> – ACCHO personnel

In the context of telehealth, the ACCHO, like many other ACCHOs, was an early adopter of telehealth to meet the concern in the community around accessing a GP during the COVID-19 pandemic lockdowns. An analysis of internal clinic data identified that there was a higher utilisation of telephone consultations when compared with videoconferencing consultations by Aboriginal and Torres Strait Islander clients. Informal and formal feedback obtained indicated that clients generally were not familiar with the technological requirements for videoconferencing and had a preference for face-to-face care during COVID-19, followed by telephone consultations. ACCHO personnel were creative in responding to this feedback in light of changeable conditions (e.g., COVID-19 lockdowns), and implemented a temporary hybrid model of using both telehealth and the mobile clinic to provide care to clients (e.g., those with complex co-morbidities or requiring a physical assessment and unsure about using videoconferencing) during the COVID-19 lockdowns.

> Well probably like if the doctor deems that patient to be seen and we physically can't go pick them up and they can't physically come in themselves, then that's a huge issue. So that's where our van [mobile clinic] has come into place and it has been fantastic because we have actually been able to take the doctor out on that van and see those patients so, without having to you know, go and pick them up in our little cars, which we are not able to do [due to COVID-19 lockdown restrictions], they can come to the van in the towns
>
> – ACCHO personnel

Mechanisms of responsiveness used by the ACCHO were generally valued by clients with many examples of actions implemented by ACCHO personnel cited by clients in interviews (e.g., maintaining face-to-face GP services through the mobile clinic, food hampers delivered to clients during COVID-19 lockdowns, generally following up clients over the telephone or in person, facilitating social connection between community members to alleviate social isolation).

> I like the social side of going out to Halls Gap, to Budja, but with this COVID thing, the bus [mobile clinic] has been a blessing, otherwise we wouldn't of been able to see the doctor. We couldn't of done without it during this COVID thing.
>
> – ACCHO client

> I like it when they [ACCHO] come to [locality] with their buses [mobile clinic] and all that. If I have to see [name of GP] for anything like that. If I need helping hand, I'm not a pretty well-educated person, I get anything and I don't understand it, I just ask them [ACCHO personnel]. You know what I mean. Nothing important, then I tear it up and throw it in the rubbish bin.
>
> – ACCHO client

3.3 | Challenges experienced by the ACCHO when being responsive

Challenges were experienced by the ACCHO when operating within a CAS and being responsive to community needs. Many of these challenges were attributed to dissonance between pressures or constraints from external system components (e.g., funding and policy arrangements) and the needs of the community (e.g., health and social priorities and needs). A key example in the implementation of the Tulku wan Wininn mobile clinic was the inability to use MBS home care item numbers for the delivery of mobile clinic services due to the current funding arrangements. To generate MBS revenue through the mobile clinic, there was a reliance on GP MBS item numbers which did not factor in travel time. Due to this, reliance on multiple revenue streams to maintain the mobile clinic service was required which was identified as a challenge for maintaining the service. This is particularly important as the ACCHO maintains a no co-payment service for clients.

> ...one of the goals is that we want to be able to make money on it [mobile clinic] eventually. It doesn't have to happen now, we've got funding to get it up and going, but it would be great, if the funding was pulled or at the end of the funding period, if it wasn't continued, that we could make money off it and keep running it ourselves.
>
> – ACCHO personnel

A key challenge in the implementation of telehealth services were reactive changes to the MBS temporary COVID-19 telehealth item numbers at the Commonwealth level, which had direct impacts on service delivery. This included the removal of the MBS item for telephone consultations (the most frequently utilised telehealth item number at the ACCHO). Through a process of advocacy and in partnership with the PHN, a letter was drafted to the Australian Minister for Health detailing preliminary findings from the evaluation of telehealth at the ACCHO and requesting this decision be reversed. Subsequently, telephone consultation item numbers were restored shortly after.

4 | DISCUSSION

A contribution to the literature around the responsiveness of a rural ACCHO to the health care needs of Aboriginal and Torres Strait Islander Peoples in their service region in the context of implementing two models of service delivery, is provided. By conceptualising, the ACCHO as a health organisation operating within a CAS, mechanisms of responsiveness and challenges were identified. This informed the development of a conceptual framework. A key finding illustrated by this conceptual framework is the importance for the ACCHO to meet the health care needs of the community they serve and navigate the prioritisation of these needs in the context of the broader health care system. When dissonance is experienced between external system components in the CAS (e.g., MBS funding) and being responsive to community needs and priorities, challenges can be experienced such as adequately resourcing models of service delivery (e.g., mobile clinic) and maintaining the provision of services (e.g., telephone consultations). This issue has been identified elsewhere in the context of primary health mobile clinics implemented for Indigenous Peoples where the reliance on philanthropic funding to establish and maintain the service is common.[26]

Findings expand on other literature supporting the value of ACCHOs in acting on the social determinants of health and in being proactive in addressing the needs of the communities they serve.[1,5,6] Due to this, a one size fits all approach for ACCHOs does not work as each community has different needs,[5] some of which can be attributed to the geographical location of the community as identified in this study (e.g., being in a rural area with limited transport). The rigidity of external system components in the CAS, can make it difficult for ACCHOs to act on identified community needs and priorities (e.g., when implementing models of service delivery that are not supported by the MBS).[18] Greater support at a health care system level is required to enable ACCHOS to be responsive to the needs of their communities[18] which has been highlighted by other Australian research.[27] This includes the need for a full range of funding pathways to support the role and functions of ACCHOs within their communities[2] and support to navigate the numerous revenue streams that do exist.[28] For example, this includes flexible funding for holistic health promotion activities undertaken by ACCHOs that are reflective of the resources required to achieve this.[6]

Findings also expand on a systematic international evidence synthesis around the responsiveness of health systems[8] which conceptualises responsiveness as feedback between users and the health care system, by identifying mechanisms used to obtain feedback from users (i.e. Aboriginal and Torres Strait Islander clients). Other mechanisms of responsiveness described in the literature include patient satisfaction surveys, complaint processes, incident reporting, and social media,[8] however, these mechanisms can be reactionary rather than proactively applied

as illustrated by this study (e.g., community consultation undertaken to identify the need for a mobile clinic model of service delivery). In this way, the developed conceptual framework addresses a gap in knowledge by providing examples of proactive mechanisms of responsiveness, (e.g., using population data to identify gaps in service provision) used at a health organisation level.

As literature around the responsiveness of health care systems, particularly for population groups who experience health inequity such as Aboriginal and Torres Strait Islander Peoples, is largely in its' infancy, further research is required around responsiveness and how to embed responsiveness as a national health care system performance goal as stipulated by the WHO.[8]

4.1 | Limitations

This research is limited in its scope in developing a conceptual framework using qualitative data from a single rural ACCHO. Mechanisms of responsiveness identified may not be generalisable to other ACCHOs, however, the challenges identified by this study have been cited elsewhere by other research examining ACCHOs.[24] Future research should expand on these mechanisms and challenges experienced by ACCHOs when operating within a complex health care system. This will be of value to informing the need for responsiveness to be an embedded health care system performance goal in Australia.

Further, the Indigenous research method of yarning was originally going to be used to engage with clients and obtain feedback about the mobile clinic model of service delivery. Given the physical distancing requirements during COVID-19, this was not possible as the yarning process requires face-to-face communication and interaction.

5 | CONCLUSION

The developed conceptual framework expands on research supporting the value of ACCHOs in providing holistic and culturally safe health care for their communities by examining the concepts of responsiveness and complexity. Conceptualising the health care system as a complex adaptive system in which ACCHOs operate and are responsive to community need highlights the competing demands and requirements of ACCHOs as community-based primary care organisations. Findings expand on mechanisms of responsiveness used at the service-user interface at a health organisation level. Challenges are identified which can be attributed to the complexity of the external system. The focus of future research should examine how the broader health care system can support the function of ACCHOs in being responsive to the health care needs of their communities.

AUTHOR CONTRIBUTIONS

Hannah Beks: Conceptualization; investigation; funding acquisition; writing – original draft; methodology; validation; visualization; writing – review and editing; formal analysis; project administration; data curation; resources. **Kevin P. Mc Namara:** Methodology; funding acquisition; writing – review and editing; writing – original draft; formal analysis. **Fiona Mitchell (Mununjali):** Conceptualization; investigation; funding acquisition; writing – original draft; methodology; writing – review and editing; formal analysis; data curation. **James A. Charles (Kaurna):** Conceptualization; investigation; funding acquisition; methodology; writing – review and editing; formal analysis; data curation; supervision. **Vincent L. Versace:** Conceptualization; investigation; funding acquisition; writing – review and editing; supervision.

ACKNOWLEDGEMENTS

The authors wish to thank Budja Budja Aboriginal Cooperative (BBAC) for the ongoing research and clinical training partnership. We wish to thank all participants, including BBAC health service personnel and clients for their generosity in contributing to the two evaluations. Open access publishing facilitated by Deakin University, as part of the Wiley - Deakin University agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Data from the two evaluations is protected by ethics and was collected only for the purpose of evaluation in partnership with Budja Budja Aboriginal Cooperative.

DISCLOSURE STATEMENT

For the evaluation of telehealth services at Budja Budja Aboriginal Cooperative, funding was received from the Western Alliance Academic Health Science Centre through the COVID-19 grants. Funding was also received from the Nurses Board Victoria Legacy Limited for the evaluation of the Tulku wan Wininn mobile clinic as part of HB's PhD. HB, FM, KPM, and VLV were funded by the Rural Health Multidisciplinary Training (RHMT) program through the Australian Government Department of Health and Aged Care.

ETHICS STATEMENT

Ethical approval for the two evaluations were obtained from Deakin University Human Research Ethics

Committee (DUHREC 2019–432). Letters of support were provided by Budja Budja Aboriginal Cooperative to support the evaluations.

ORCID

Hannah Beks https://orcid.org/0000-0002-2851-6450
Vincent L. Versace https://orcid.org/0000-0002-8514-1763

REFERENCES

1. Pearson O, Schwartzkopff K, Dawson A, Hagger C, Karagi A, Davy C, et al. Aboriginal community controlled health organisations address health equity through action on the social determinants of health of aboriginal and Torres Strait islander peoples in Australia. BMC Public Health. 2020;20(1):1859.
2. Campbell MA, Hunt J, Scrimgeour DJ, Davey M, Jones V. Contribution of aboriginal community-controlled health services to improving aboriginal health: an evidence review. Aust Health Rev. 2018;42(2):218–26.
3. National Aboriginal Community Controlled Health. Annual report 2020–2021. 2021. Available from: https://www.naccho.org.au/app/uploads/2022/10/NACCHO_AnnualReport2021-22_website.pdf. Accessed 10 Jun 2022.
4. Panaretto KS, Wenitong M, Button S, Ring IT. Aboriginal community controlled health services: leading the way in primary care. Med J Aust. 2014;200(11):649–52.
5. Harfield SG, Davy C, McArthur A, Munn Z, Brown A, Brown N. Characteristics of indigenous primary health care service delivery models: a systematic scoping review. Global Health. 2018;14(1):12.
6. The Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE). Aboriginal community controlled health Organisations in practice: sharing ways of working from the ACCHO sector. Wardliparingga aboriginal health equity theme: south Australian health and medical research institute, Adelaide; 2020. Available from: https://create.sahmri.org/wp-content/uploads/2020/02/ACCHO_Interactive_Resource2020.pdf. Accessed 20 Jun 2022.
7. Mirzoev T, Kane S. What is health systems responsiveness? Review of existing knowledge and proposed conceptual framework. BMJ Glob Health. 2017;2(4):e000486.
8. Khan G, Kagwanja N, Whyle E, Gilson L, Molyneux S, Schaay N, et al. Health system responsiveness: a systematic evidence mapping review of the global literature. Int J Equity Health. 2021;20(1):112.
9. Beks H, Binder MJ, Kourbelis C, Ewing G, Charles J, Paradies Y, et al. Geographical analysis of evaluated chronic disease programs for aboriginal and Torres Strait islander people in the Australian primary health care setting: a systematic scoping review. BMC Public Health. 2019;19(1):1115.
10. Braithwaite JCK, Ellis L, Long J, Clay-Williams R, Damen N, Herkes J, et al. Complexity science in healthcare. Macquarie University: Australian Institute of Health Innovation; 2017. Available from: https://www.mq.edu.au/__data/assets/pdf_file/0012/683895/Braithwaite-2017-Complexity-Science-in-Healthcare-A-White-Paper-1.pdf. Accessed 30 Mar 2022.
11. Australian Government Department of Health. Modified Monash Model. 2022. Available from: https://www.health.gov.au/health-topics/rural-health-workforce/classifications/mmm. Accessed 13 Jun 2022.
12. Beks H, Mitchell F, Charles JA, Mc Namara KP, Versace VL. An aboriginal community-controlled health organization model of service delivery: qualitative process evaluation of the Tulku wan Wininn mobile clinic. Int J Equity Health. 2022;21(163):1–10.
13. Beks H, Versace VL, Mitchell F, Charles JA, Chatfield T, Zwolak R. Redressing barriers to accessing primary health care for aboriginal and Torres Strait islander peoples: preliminary findings from the Tulku wan Wininn mobile clinic. Public Health Res Pract. 2023;33:33012301. https://doi.org/10.17061/phrp3012301
14. Beks H, Mitchell F, Charles J, Wong Shee A, Mc Namara K, Versace VL. Implementation of telehealth primary health care services in a rural aboriginal community-controlled health organisation during the COVID-19 pandemic: a mixed-methods study. Rural Remote Health. 2023;23(3):7521. https://doi.org/10.22605/RRH7521
15. Australian Government. Rural health multidisciplinary training (RHMT) program. 2022. Available from: https://www.health.gov.au/initiatives-and-programs/rhmt. Accessed 13 Jun 2022.
16. Budja Budja Aboriginal Cooperative. Mobile clinic Van – great outcomes and strong support from community and Deakin University. 2022. Available from: https://budjabudjacoop.org.au/new-mobile-clinical-health-van-april-2019/. Accessed 13 Jun 2022.
17. Versace VL, Skinner TC, Bourke L, Harvey P, Barnett T. National analysis of the modified Monash model, population distribution and a socio-economic index to inform rural health workforce planning. Aust J Rural Health. 2021;29(5):801–10.
18. Beks H, Versace VL, Zwolak R, Chatfield T. Opportunities for further changes to the medicare benefits schedule to support aboriginal community controlled health organisations. Aust Health Rev. 2022;46(2):170–2.
19. Tavory I, Timmermans S. Abductive analysis: theorizing qualitative research. Chicago, IL: The University of Chicago Press; 2014.
20. Beks H, Hernan AL, Giles S, Malakellis M, Mc Namara KP, Versace VL. Theorizing factors mediating with the implementation of a patient feedback on safety intervention implemented in the primary care setting. Qual Health Res. 2021;31(12):2260–73.
21. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International J Qual Health Care. 2007;19(6):349–57.
22. Huria T, Palmer SC, Pitama S, Beckert L, Lacey C, Ewen S, et al. Consolidated criteria for strengthening reporting of health research involving indigenous peoples: the CONSIDER statement. BMC Med Res Methodol. 2019;19(1):173.
23. Beks H, Amos T, Bell J, Ryan J, Hayward J, Brown A, et al. Participatory research with a rural aboriginal community controlled health organisation: lessons learned using the CONSIDER statement. Rural Remote Health. 2022;22(1):6740.

24. Nakata M. Disciplining the savages, savaging the disciplines. Canberra, ACT: Aboriginal Study Press; 2007.
25. Finlay L. "Outing" the researcher: the provenance, process, and practice of reflexivity. Qual Health Res. 2002;12(4):531–45.
26. Beks H, Ewing G, Charles JA, Mitchell F, Paradies Y, Clark RA, et al. Mobile primary health care clinics for indigenous populations in Australia, Canada, New Zealand and the United States: a systematic scoping review. Int J Equity Health. 2020;19(1):201.
27. Nolan-Isles D, Macniven R, Hunter K, Gwynn J, Lincoln M, Moir R, et al. Enablers and barriers to accessing healthcare services for aboriginal people in New South Wales, Australia. Int J Environ Res Public Health. 2021;18(6):3014.
28. KPMG. Available funding sources and resources for the Aboriginal Community Controlled Health Services Sector. Department of Health; 2020. Available from: https://www.health.gov.au/resources/publications/available-funding-sources-and-resources-for-the-aboriginal-community-controlled-health-services-acchs-sector. Accessed 10 Dec 2022.

How to cite this article: Beks H, Mc Namara KP, Mitchell (Mununjali) F, Charles (Kaurna) JA, Versace VL. Responsiveness of a rural Aboriginal community controlled health organisation: A qualitative study. Aust J Rural Health. 2023;31:1214–1228. https://doi.org/10.1111/ajr.13048

APPENDIX 1
Application of the CONSIDER statement[22]

Domain	Process evaluation of the Tulku wan Wininn mobile clinic
Governance	
*1. Describe partnership agreements between the research institution and Indigenous-governing organisation for the research, (*e.g.*, Informal agreements through to MOU (Memorandum of Understanding) or MOA (Memorandum of Agreement))*	Deakin University (DU) and Budja Budja Aboriginal Cooperative (BBAC) do not have a MOU. Rather multiple letters of support were provided by BBAC to submit with ethics and funding applications which reflect the nature of the partnership which includes clinical placements, evaluation work and cultural competency training.
2. Describe accountability and review mechanisms within the partnership agreement that addresses harm minimisation	Part of working in a respectful partnership means that all work, including drafts of manuscripts, is reviewed by BBAC prior to dissemination.
*3. Specify how the research partnership agreement includes protection of Indigenous intellectual property and knowledge arising from the research, including financial and intellectual benefits generated (*e.g.*, development of traditional medicines for commercial purposes or supporting the Indigenous community to develop commercialisation proposals generated from the research)*	The project had little scope for commercial benefit. The NHMRC Human Research Ethics Application (HREA) submitted to DUHREC was focused on how cultural knowledge would be managed through the project.
Prioritisation	
4. Explain how the research aims emerged from priorities identified by either Indigenous stakeholders, governing bodies, funders, non-government organisation(s), stakeholders, consumers, and empirical evidence	The two evaluations were designed in conjunction with BBAC leaders in the context of needing to understand the acceptability of the mobile clinic and telehealth as models of service delivery. This is part of a larger body of work led by BBAC in partnership with Deakin Rural Health (DU) around evaluating different ACCHO service models to improve health care accessibility for Aboriginal and Torres Strait Islander community members in the region.
Relationships (Indigenous stakeholders/participants and Research team)	
5. Specify measures that adhere and honour Indigenous ethical guidelines, processes, and approvals for all relevant Indigenous stakeholders, recognising that multiple Indigenous partners may be involved, e.g., *Indigenous ethics committee approval, regional/national ethics approval processes*	As there is no formal process for having research projects involving Aboriginal and/or Torres Strait Islander Peoples reviewed by an Indigenous-specific ethics committee in Victoria, local processes were used to ensure the cultural appropriateness and safety of the research project. This involved having BBAC review all documents prior to submitting a formal ethics application to DUHREC and discussing other ethical issues at length.

Domain	Process evaluation of the Tulku wan Wininn mobile clinic
*6. Report how Indigenous stakeholders were involved in the research processes (*i.e., *research design, funding, implementation, analysis, dissemination/recruitment)*	Evaluation design was agreed upon by BBAC and DRH, with input from Aboriginal academics from DU. The funding submission had input from BBAC and DU researchers, including Aboriginal academics.
7. Describe the expertise of the research team in Indigenous health and research	The DU research team included public health and clinical experience in Aboriginal and Torres Strait Islander health. This included a participatory action research project which was undertaken in collaboration with another rural ACCHO to engage the perspectives of Aboriginal and/or Torres Strait Islander community members around chronic disease.
Methodologies	
8. Describe the methodological approach of the research including a rationale of methods used and implication for Indigenous stakeholders, e.g., *privacy and confidentiality (individual and collective)*	A community-based qualitative evaluation methodology guided by the CONSIDER statement was used. This involved having BBAC personnel involved in the study design, interviews, and recruitment of Aboriginal and Torres Strait Islander clients to the interviews. Due to the overlap of BBAC personnel in the study components, strict ethical data management protocols were adhered to. This included storing de-identified interview transcripts on a DU password-protected computer drive and only sharing this with the respective participants. Data analysis and interpretation were also only shared with BBAC personnel in the form of summaries and an evaluation report to protect the confidentiality of all participants.
*9. Describe how the research methodology incorporated consideration of the physical, social, economic and cultural environment of the participants and prospective participants. (*e.g., *impacts of colonisation, racism, and social justice). As well as Indigenous worldviews*	A community-based qualitative methodology guided by the CONSIDER statement ensured all aspects of the study were overseen by BBAC personnel. Further, the leadership of Aboriginal academics in the study ensured the study was conducted in a manner which was culturally appropriate. In the context of ongoing COVID-19 lockdowns and the inability to meet face to face with Aboriginal and/or Torres Strait Islander community members, this involved having BBAC health service personnel invite clients to the study, meeting via telephone, and sometimes having multiple telephone interviews with clients to develop rapport.
Participation	
*10. Specify how individual and collective consent was sought to conduct future analysis on collected samples and data (*e.g., *additional secondary analyses; third-parties accessing samples (genetic, tissue, blood) for further analyses)*	Prior to each interview, consent forms with plain language statements were provided to participants. The content of these were also agreed upon by BBAC and DU Aboriginal academics.
11. Describe how the resource demands (current and future) placed on Indigenous participants and communities involved in the research were identified and agreed upon including any resourcing for participation, knowledge, and expertise	As the evaluation received funding, resourcing demands were considered and accounted for. This included funding for reimbursement for Aboriginal and/or Torres Strait Islander clients participating in the interviews.
12. Specify how biological tissue and other samples including data were stored, explaining the processes of removal from traditional lands, if done, and of disposal	Not applicable to this study.
Capacity	
*13. Explain how the research supported the development and maintenance of Indigenous research capacity (*e.g., *specific funding of Indigenous researchers)*	Not applicable to this study.
14. Discuss how the research team undertook professional development opportunities to develop the capacity to partner with Indigenous stakeholders?	This process took place through regular meetings between BBAC and DRH during the evaluation timeline and following. Non-Indigenous researchers also participated in cultural awareness training hosted by BBAC to develop skills and an understanding of the local community.

Domain	Process evaluation of the Tulku wan Wininn mobile clinic
Analysis and interpretation	
15. Specify how the research analysis and reporting supported critical inquiry and a strength-based approach that was inclusive of Indigenous values	Research analysis and reporting were supported by an Aboriginal Associate Research Fellow which guided interpretation of findings within a strengths-based approach.
Dissemination	
16. Describe the dissemination of the research findings to relevant Indigenous-governing bodies and peoples	A one-page summary of evaluation findings was provided to clients who participated in the interviews to inform them of how their feedback was understood. An internal evaluation report with all findings was provided to BBAC for each evaluation.
*17. Discuss the process for knowledge translation and implementation to support Indigenous advancement (*e.g., *research capacity, policy, and investment)*	Findings from the evaluations were provided to BBAC in the form of a report and to clients in the form of a one-page summary.

APPENDIX 2
Interview guides

TULKU WAN WININN MOBILE CLINIC EVALUATION

Interview guide for health service personnel

Topic: Contextual factors

1. Tell me about your role and how you have been involved in the implementation of the Tulku Wan Wininn mobile clinic

Prompts—What clinical services do you provide? How long have you been working with Budja Budja Aboriginal Cooperative?

2. What is your understanding of the circumstances which initiated the need for a mobile clinic van?

Prompts—What was your involvement in the conceptualization of a mobile clinic van? How involved were Community members in discussions around the need for a mobile clinic van?

3. How would you describe the initial implementation of the mobile clinic?

Prompts—What are some contextual barriers and enablers to implementation? What cultural factors have affected implementation? Were there any teething issues?

Topic: Implementation

4. What changes to the mobile clinic service plan have been made since implementation?

Prompts—Why were these changes made? How have these changes impacted service delivery? Do you foresee any further changes being made?

Topic: Adoption

5. How engaged do you think Community members are with the mobile clinic?

Prompts—Do you have any specific examples you could share with me? How could other Community members be engaged in accessing services? Why do you think Community members may not be accessing the mobile clinic services? How could engagement issues be overcome?

6. What are your observations regarding Community acceptability of the mobile clinic as a model of health care?

Prompts—Do you have any specific examples you could share with me? Have any Community members expressed dissatisfaction with the mobile clinic? Are there any changes which need to be made?

Topic: Maintenance

7. What is required for the ongoing implementation of the mobile clinic?

Prompts—How important are partnerships between health services and universities? How important is funding, local support and engagement or other factors?

8. What challenges do you foresee for the ongoing implementation and sustainability of the mobile clinic?

Prompts—How could these challenges be addressed?

Any other comments or thoughts to share?

Interview guide for clients

- Introduce researcher and purpose of evaluation
- Discuss PLS and consent form

If community member is happy to proceed, then ask following questions. Also provide community member with the option to have the interview at another time which is more convenient.

1. **Could you please tell us about your experience of visiting the Tulku wan Wininn mobile clinic?**

(Optional prompts—how important is having health care available nearby, to you? Do you feel comfortable attending the mobile clinic?)

2. **What changes do you think need to be made to the Tulku Wan Wininn mobile clinic that would help you to look after your health?**

(Optional prompts—what do you like about the service? What do you not like?)

Option to proceed to question 3.

3. **How do you think the Tulku wan Wininn mobile clinic is being received by your community?**

(Optional prompts- would you recommend the mobile clinic to friends and family?)

Is there anything else you would like to share?

Thank you for your time. We look forward to meeting with you in person once COVID-19 lockdown has been lifted.

TELEHEALTH EVALUATION
Interview guide for health service personnel

1. Tell me about your role and experience of delivering health care services during COVID-19.

Prompts—What clinical services do you provide? How long have you been working with Budja Budja Aboriginal Cooperative?

2. How would you describe the initial implementation of telehealth services during the COVID-19 lockdown?

Prompts—Is this the first time you have delivered health care services through a telehealth modality? What are some contextual barriers and enablers to implementation?

3. What are the strengths of delivering health care through telehealth services for Aboriginal and Torres Strait Islander people?

Prompts- What are some weaknesses? What cultural factors have affected implementation? Were there any teething issues?

4. What adaptations were made to the delivery of telehealth services during the COVID-19 lockdown?

Prompts—Why were these adaptations made? What other adaptations are required?

5. How engaged do you think Community members are with a telehealth mode of health care delivery?

Prompts—Do you have any specific examples you could share with me? Why do you think Community members may not be engaged with a telehealth mode of health care? How could engagement issues be overcome?

6. What are your observations regarding Community acceptability of telehealth as a mode of health care delivery?

Prompts—Do you have any specific examples you could share with me? Have any Community members expressed dissatisfaction with telehealth?

7. What is required for the ongoing implementation of a telehealth mode of health care delivery?

Prompts—Do you have any specific examples you could share with me?

8. What challenges do you foresee for the ongoing implementation of a telehealth mode of health care delivery for Aboriginal Community members?

Prompts—How could these challenges be addressed? Do you have any further feedback?

Interview guide for Community Members

- Introduce researcher and purpose of evaluation
- Discuss PLS and consent form

If community member is happy to proceed, then ask following questions. Also, provide Community Member with the option to have the interview at another time that is more convenient.

1. What was it like to access health care through the phone or via a computer (telehealth) during COVID-19?

(Optional prompts—How did this compare with going into the clinic and seeing the doctor/nurse/health professional?)

2. What are your thoughts about telehealth in general?

(Optional prompts—What do you like about the service? What do you not like?)

3. If telehealth was to be ongoing, how could it be made better for community who use it?

(Optional prompts- What changes are required?)

Is there anything else you would like to share?

Thank you for your time. We look forward to meeting with you in person once COVID-19 lockdown has been lifted.