

The experiences of a regional Aboriginal community accessing primary health care during times of crisis

Rebecca Woodland MBusMgt¹  | Paula Morgan RN² | Sarah MacLean PhD³ | Heather Downey PhD³ 

¹Gippsland Lakes Complete Health, Lakes Entrance, Victoria, Australia

²Lakes Entrance Aboriginal Health Association, Lakes Entrance, Victoria, Australia

³La Trobe University, Melbourne, Victoria, Australia

Correspondence

Rebecca Woodland, Gippsland Lakes Complete Health, Lakes Entrance, VIC, Australia.

Email: rebeccaw@glch.org.au

Abstract

Introduction: The importance of primary health care (PHC) to Aboriginal Australians is widely acknowledged, as is the underservicing of the Aboriginal Australian population. Aboriginal People continue to face significant obstacles when accessing and using health care services.

Objective: This study identifies environmental factors (beyond personal and service delivery) that functioned as barriers and enablers to Aboriginal Australians' experiences accessing PHC during crises and recommends approaches during future events.

Design: This research utilised a case study approach. Data were collected through in-depth interviews and analysed using thematic analysis. The study was set in Lakes Entrance, a regional Victorian locality with a sizable Aboriginal community, which was affected by bushfires during 2019/2020 and COVID-19 restrictions during 2020-2021. Participants were 18 Aboriginal People over the age of 18 living in the locality during either bushfires or COVID-19.

Findings: The barriers identified included the impact on PHC access of priorities other than health, including housing; financial constraints; difficulties with transport; medical bureaucracy and the physical environment of the health care setting, including appointment-making processes; interactions with medical reception staff; and waiting room environments. Enablers identified included the supportive role of the local Aboriginal Community Controlled Health Organisations (ACCHO) and their staff, which was highlighted in participant responses.

Discussion: The preference of many Aboriginal people to access PHC via their local ACCHO, rather than mainstream health care services, appears even more salient during crises than in normal times. This research identified that ACCHOs are ideally placed to promote and protect the health of Aboriginal communities during crises.

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Conclusion: Results may help direct interventions to improve PHC access and experiences for regional Aboriginal communities both during and outside periods of crisis.

KEYWORDS

Aboriginal and Torres Strait Islander health, barriers and enablers, health access, primary health care

1 | BACKGROUND/INTRODUCTION

1.1 | Aboriginal people's health status

A gap in the life expectancy and health outcomes of Aboriginal and Torres Strait Islander People (hereafter respectfully referred to as Aboriginal) compared to non-Indigenous Australians is widely acknowledged.¹ Against virtually all health and social status markers across the lifespan, Aboriginal Australians are the most marginalised and disadvantaged in Australian society.² These disparities are a result of the ongoing devastating impact of colonisation expressed as racism, discrimination, and for many, loss of identity, language, culture and land, all of which result in trauma and directly impact health care outcomes.³

Further, Aboriginal People continue to face significant obstacles when accessing and using health care services and this exacerbates poorer health outcomes.⁴ As a result, Aboriginal people tend to access the health care system late in the disease process and in emergency situations, and are less likely to engage in PHC prevention services.^{1,5} This exacerbates poorer health outcomes.

1.2 | Aboriginal people and access to PHC

Aboriginal People often cannot access appropriate mainstream PHC to effectively meet their needs, for myriad reasons.^{6,7} Identified barriers include high costs of health care; experiences of racial discrimination; distance/travel time and availability of transport; lack of availability of culturally appropriate services and culturally sensitive health care professionals.^{4,8,9}

Ensuring access to PHC is widely accepted as key to improving health outcomes.^{10,11} Access to high-quality primary care can help to address social determinants of health and redress health inequities.¹² ACCHO service provision is associated with positive health outcomes^{13,14} for Aboriginal Australians, through intersectoral action which supports improving health literacy, improving screening and treatment, and managing acute and chronic illnesses.⁵

What is already known on this subject

- Aboriginal and Torres Strait Islander People suffer disproportionately from poor health outcomes and chronic disease compared to the broader Australian population.
- Access to general practitioners and other PHC providers is acknowledged as essential to improving Aboriginal people's health outcomes.

What this paper adds

- This paper identifies environmental factors that impacted the experience of regional Aboriginal community members when accessing PHC during crises.
- This paper highlights the positive role Aboriginal Community Controlled Health Organisations (ACCHOs) played in supporting the community with PHC access during crises.

1.3 | PHC during crises

Equitable, reliable and consistent access to PHC is a critical foundation of health and well-being at every stage of life, and is crucially important during public health crises.¹⁵ When disaster strikes, the impact on Aboriginal people is disproportionate to that of the general population.¹⁶ Crises shift how PHC is delivered, and regular care is often postponed.¹⁶ When health systems are overwhelmed during crises, deaths caused by lapses in routine care can increase dramatically.¹⁶

1.4 | Crises during the study period

The crises referred to in this paper are the active period of the 2019/2020 bushfires, henceforth referred to as the bushfires, and the restrictions associated with the COVID-19 pandemic in 2020/2021.

The bushfires in East Gippsland resulted in loss of life, displacement of thousands of people and the temporary isolation of numerous communities.¹⁴ By the time, all significant fires across Victoria were contained in February 2020, over 1.5 million hectares was burnt, including over 1000 registered Aboriginal heritage places.¹⁴ In Eastern Victoria, the fires impacted 248 Aboriginal people, with 42 homes destroyed or made unliveable.¹⁴ Further, businesses, community facilities and thousands of kilometres of roads and fences were damaged or destroyed. Key regional industries such as agriculture, tourism, forestry and retail were severely affected.¹⁶

Barely a month after bushfire containment, the first COVID-19 restrictions came into effect in Victoria, Australia. The state of emergency, declared in March 2020, led to mandatory directions to stay at home and isolate when diagnosed with COVID-19.

Direct impacts of crises can include injuries and death from extreme events; indirect impacts can affect human systems, including mental health, productivity and damage to housing and health care facilities.¹⁷ Due to their isolated locations, infrastructure, economic resources, limited transport, and existing health vulnerabilities, regional and remote Aboriginal communities are additionally vulnerable to the impacts of disasters and the associated health effects.¹⁴ Crises are projected to increase due to the impacts of climate change,¹⁸ thus making crisis planning increasingly essential.

Environmental factors comprise the physical and social environmental conditions impacting health, including housing conditions and the physical environment in which health care is delivered. Conceptualising environmental health factors this way, as encompassing a range of human made physical or social features, contrasts with traditional environmental health approaches which focused primarily on toxic substances in air, water and soil.¹⁹ In this research, the environmental themes addressed included priorities other than health, transport, and medical bureaucracy and the physical environment.

The literature has little to say about experiences of regionally located Aboriginal People accessing PHC during crises. The only two articles addressing this topic²⁰ describe the acceptability to a rural Victorian Aboriginal community of a primary health care mobile clinic for Aboriginal People during the COVID-19 restrictions; and a grounded theory study of the success of a locally led, holistic, comprehensive and culturally safe response by an ACCHO to the COVID-19 pandemic in an Aboriginal community, Yarrabah.²¹ We have chosen to address environmental factors in this paper because they emerged in our analysis as critical to PHC access during the periods

of crisis under study. Additionally, some of these factors (such as transport access) are more amenable to change than factors pertaining to individual histories and professional cultures, offering potential to improve the service response.

2 | METHODS

As a study led by a non-Aboriginal researcher conducting research in an Aboriginal community, it was important all aspects were informed and approved by the local Aboriginal community. A formal partnership was created between the lead author and Lakes Entrance Aboriginal Health Association (LEAHA), to ensure local Aboriginal community input and oversight of the research proposal, methodology, analysis and dissemination, and usage. The second author is a Gunai woman who provided critical input and was the project cultural advisor.

2.1 | Setting

The Lakes Entrance community is in far East Gippsland, Victoria, Australia, the traditional land of the Gunaikurnai people. The population of Lakes Entrance is 8524, including residents of Lakes Entrance, Lake Tyers and the Lake Tyers Trust.²² East Gippsland's Aboriginal and Torres Strait Islander population is 1683, or 3.5% of the total population.²³ PHC services are provided by two ACCHOs, LEAHA and Lake Tyers Health and Children's Services (LTHCS), and a community health clinic and private medical clinic in Lakes Entrance.

2.2 | Design and methods

The research design entailed a qualitative case study approach aligned with that outlined by Stake.²⁴ In Stake's approach, "...knowledge is constructed rather than discovered".^{22(p. 99)} Consequently, case study researchers are interpreters who report their constructions of the knowledge they gather. The qualitative case study research design provided rich data and highlighted previously unstudied aspects of disaster health care for a minority and marginalised cohort.

2.3 | Eligibility and recruitment

Inclusion criteria for participants were adults aged over 18, who identified as Aboriginal. Research participants

were required to have accessed or attempted to access PHC during the crises specified above. Recruitment was through advertisements at LEAHA and LTHCS, with some participants approached on advice from the project cultural advisor.

2.4 | Participants

Fifteen participants were female, and three were male, as described in Table 1. Four participants were ACCHO employees and community members, and the remaining 14 were community members and users of PHC. Some participants had a community connection relationship with the second author, who facilitated some interviews, but not with the primary author.

2.5 | Data collection

All interviews were conducted by the first author. Sixteen interviews were conducted face-to-face at the local ACCHOs, with two interviews conducted in pairs at the request of the interviewees. Two interviews were conducted by telephone. Only participants and researcher were present during interviews. Interviewees were difficult to source after conducting 18.

Interviews were semi-structured, and were recorded and transcribed, with participants offered the opportunity

to review their transcripts. Interviews ranged in length from 40 to 93 min, and a \$25 Coles/Myer voucher was provided to participants in acknowledgement of their time.

2.6 | Analysis

Data analysis strategies utilised in this research were those proposed by Miles and Huberman,²⁵ which involve broad coding; pattern coding or memoing, distilling and ordering and testing executive summary statements and developing propositions. Analysis was performed throughout the data collection process to inform further interviews.

NVivo 12 was used as a data management tool and data were coded by the first author. The cultural advisor and second author reviewed identified themes. Participant anonymity was ensured through use of pseudonyms. Participants' quotes have been used verbatim to prioritise their voice, and support claims made.^{26,27}

2.7 | Ethics

The La Trobe University Human Research Ethics Committee (HEC20390) provided ethics approval for this research project, and the NHMRC Guidelines on Ethical Conduct in Research with Aboriginal and Torres Strait Islander People and Communities: Guidelines for researchers and stakeholders²⁸ were followed.

TABLE 1 Participant Table: Aboriginal People's Perspectives on Accessing Primary Health Care During Crises: A Case Study of the Lakes Entrance Community. Woodland, R. (2023).

Pseudonym	Location of interview	Age	Gender
Anne	Lakes Entrance, LEAHA	40–50	F
Betty	Lakes Entrance, LEAHA	40–50	F
Carol	Lakes Entrance, LEAHA	20–30	F
Dolly	Lakes Entrance, LEAHA	20–30	F
Elaine	Lakes Entrance, LEAHA	20–30	F
Flora	Lakes Entrance, LEAHA	70–80	F
Gwen	Lakes Entrance, LEAHA (phone)	60–70	F
Holly	Lakes Entrance, LEAHA (phone)	50–60	F
Ian	Lakes Entrance, LEAHA	50–60	M
John	Lakes Entrance, LEAHA	40–50	M
Karen	Lake Tyers Trust, LTHCS	40–50	F
Linda	Lake Tyers Trust, LTHCS	30–40	F
Molly and Nina	Lake Tyers Trust, LTHCS, (group interview)	70–80 70–80	F F
Orla and Penny	Lake Tyers Trust, LTHCS, (group interview)	60–70 60–70	F F
Quinn	Lake Tyers Trust, LTHCS	50–60	M
Rachel	Lake Tyers Trust, LTHCS	50–60	F

3 | RESULTS

We identified the following themes as environmental factors in PHC access, competing priorities; transport issues and the influence of medical bureaucracy and physical environment of health care settings. Although there was considerable overlap between themes, for ease of presentation they are discussed separately below.

3.1 | The influences of competing priorities on PHC access during times of crises

Participants indicated that accessing health care and focusing on their health needs during the 2019–2020 bushfires and COVID-19 restrictions were simply not priorities for many community members. Meeting basic needs such as shelter and food took higher priority, as Anne explained:

...the plain old thing that health's not a priority...I think the thing because obviously a lot of them have got shit going on in their lives, whether its...god knows what it is...whether it's trauma, or elder abuse, or there's just so much going on in their lives, so the main thing is to keep a roof over their heads and make sure they've got a meal, got lunch and tea tonight so their health is like way down the list.

Some participants named housing as a priority above health care during crises. Following the 2019–2020 bushfires, there was greater competition for the already limited supply of local housing. The high demand led to increased rental prices, and as a result private rental options became even more unobtainable for Aboriginal community members, many of whom have comparatively low incomes. Several participants described couch surfing, or moving from couch to couch, instead of stable, permanent accommodation, as the reality for family members and friends. John said, "I stay with 'em till they kick me out', then I stay with 'nother one, and I'm thinkin' about who I can crash with next". Further, participants spoke of the problems arising from COVID-19 social distancing requirements, within houses occupied by extended families.

Several participants described prioritising their own health needs below those of others during crises. Karen explained: "Priorities are a big thing, cause our mob are all about looking after everyone else, and it's like a mum thing isn't it, looking after everyone else and you're last". Several participants described how during the 2019–2020 bushfires, their concern for family and community

members who had been evacuated outweighed thoughts of their own health needs.

Further, participants privileged concern for the health of family and community members, particularly Elders and older family members over their own, during COVID-19 isolation periods. Participants also expressed concern for other matters they were prioritising above personal health needs, such as having to home-school children, an inability to travel for sorry business [bereavement] due to lockdown, and concerns relating to finances.

Participants described a lack of financial resources as a major factor influencing health care access choices and health care experience. Betty described:

That would be one of our biggest barriers, cause nowadays it's \$5 for the nurse, um, and they don't know whether they're going to be bulk-billed [fully funded by the federal health scheme] or not when they see the GP, and that sort of thing. So, they won't go.

Participants incurred extra expenses when they evacuated from their homes during the 2019–2020 bushfires. This meant they had less money for health care. These experiences were echoed later when participants' usual health care arrangements with ACCHOs were interrupted due to government-mandated COVID-19 lockdowns and staff shortages. This uncertainty led to concern and fear of whether people would be bulk-billed or charged at mainstream medical clinics. Rather than have these uncomfortable conversations, participants chose to wait until health care was available via the ACCHO. it.

3.2 | The influence of transport issues on PHC access during times of crisis

Many participants identified lack of transport as a barrier to accessing PHC. During the 2019/2020 bushfires, the public transport bus did not travel its regular route due to road closures, and unacceptable risks of fire and falling trees. The lack of public transport hindered participants' capacity to travel. Participants also reported limited medical transport services during the bushfires and immediate aftermath. Some ACCHO staff had evacuated, and the medical transport service could not be staffed. However, this was a short-term scenario and both ACCHOs had medical transport services running as usual soon after.

Participants explained how during the COVID-19 restrictions, low car ownership rates among the Aboriginal community acted as a barrier to accessing health care. The Department of Health organised COVID-19 testing for the public, delivered via drive-through clinics. Such

service delivery presented difficulties for many of the Lakes Entrance Aboriginal community who did not own or have access to a car. Consequently, some of the Lakes Entrance Aboriginal community, who were also among the most disadvantaged due to their pre-existing health conditions, were excluded from accessing much-needed testing. COVID-19 restrictions also prohibited people from being physically close to others who were not from their households. As a result, Aboriginal community members could not share cars with other community members to access health care, obtain a COVID test or access treatment.

For participants who were car owners, the high costs of petrol, insurance, registration and car maintenance were raised as additional barriers. Holly explained:

Most of our mob don't have cars, or reliable cars, and then the same deal, if they have got an appointment in Bairnsdale say, they might have a car, but they haven't got the money for petrol to get there.

A strategy local ACCHOs LEAHA and LTHCS used to overcome these transport barriers, was using a medical driver service as soon as they were able to. This service drove Aboriginal clients to health care appointments in Lakes Entrance, throughout Gippsland, and to Melbourne. Participants appreciated medical transport services, and acknowledged the critical role they played in health service access during difficult times.

3.3 | The influence of medical bureaucracy and the physical environment of health care settings on the health care experience during times of crisis

Participants described issues with medical bureaucracy and processes when accessing health care being exacerbated during the 2019–2020 bushfires and the COVID-19 restrictions. First, managing referral letters and imaging or pathology slips appeared to impact participants' health care experience. As explained by Karen, difficulties associated with arrangement of imaging and testing acted as barriers to accessing health care:

...it's too hard, too much, too much stuffing around, you've gotta get the appointments like, and then get there, and then get home, and you dunno how much it's gunna cost, and is it worth it even? And then you've gotta go back to the doctor again....

Participants expressed gratitude for both LEAHA and LTHCS's support in managing medical referrals, testing, and imaging. ACCHO staff kept track of medical appointments and arranged medical transport for clients, sent referral letters, arranged appointments and assisted with booking and accessing medical imaging and testing. In this way, ACCHOs were a key enabler of health care access for the participants, yet participants constructed mainstream health services differently.

Participants' concerns and issues about interacting with mainstream medical reception staff were exacerbated during the bushfires and COVID-19 restrictions. During times when ACCHOs were not open and fully staffed, due to working from home restrictions during COVID-19, and staff shortages due to the impact of bushfire, some participants could not access their usual health care arrangements via their ACCHOs, so were forced to engage with mainstream health care providers.

Participants spoke of their experiences at mainstream PHC clinics during this period, particularly medical reception staff's behaviour and attitudes. Many participants described receiving poor treatment from reception staff at medical clinics, which were variously described as "rude" and "unhelpful". Karen explained, "...they was uppity, you know? Just like they was better than us, and we was nothin'." Ian explained how the reception staff's behaviour impacted participants:

You just feel like, unwanted. You just feel like they don't want to treat you, it just becomes... I don't know if those are the right words, but it just feels so like – is racism playing its part again in that? Intimidation was the word, but you just feel like you know, you're not worthy of going in to see a doctor, which puts a lot of people off.

Some participants offered a different perspective on the medical reception staff's attitudes. They posited that it could be challenging to distinguish racist behaviour from poor customer service, as stated by Anne, "...some of those staff are like that whether it's you or I or someone that's Black or white – you know what I mean?". Another participant agreed and added, "...but it just means that the intimidation's more felt by us because we've always had these knock-backs, if you know where I'm coming from". Some participants recounted that they preferred to forego health care, rather than engage with medical reception staff at mainstream services.

As noted above, during the 2019–2020 bushfires and COVID-19 restrictions, issues with appointment-making processes at mainstream services were heightened because usual health care arrangements via the ACCHOs were compromised. Participants explained how usual

appointment-making processes at their local ACCHOs met their needs. At LTHCS appointments are not made, and the clinic works on a “come and wait” system. At LEAHA, clients can make appointments to see the doctor at the community health clinic through LEAHA, rather than directly calling the community health clinic.

In contrast, participants described their difficulties with mainstream health care appointment making, and seeing their preferred doctor. Participants recounted explaining to reception staff they were happy to wait for a medical appointment with their preferred doctor, as continuity of care was important to them. Participants advised that receptionists could have been much more helpful in working with them to make an appointment with their preferred doctor. Molly summarised her experiences: “They just make ya feel like ya troublin’ them, and they don’t care”.

Mainstream health services waiting rooms were described by participants as deterrents to accessing PHC via mainstream services. The lack of Aboriginal reception staff, and the lack of Aboriginal people in the waiting room, including being “...the only Black face in the place...”, as Elaine said, meant that participants were not comfortable in that environment.

4 | DISCUSSION

This study identified the barriers and enablers described by a regional Aboriginal community accessing PHC during crises, a topic largely ignored in the literature to date.

Diverse environmental factors that impacted Aboriginal community residents’ access to health care during crises were identified, including: the influence of priorities other than health on the health care experience, including housing and other priorities; transport issues; and the influence of medical bureaucracy including managing medical documentation, medical reception staff, managing the appointment making process and physical health spaces such as medical waiting rooms.

First, PHC access and experiences were found to be impacted by factors other than health, including housing needs, prioritising others above themselves and financial constraints. These findings reflect the findings of a growing body of literature,^{3,29} however have not been researched in the context of a crisis. The research findings indicate that during times of crisis, support mechanisms are required to facilitate the Aboriginal community’s access to housing and finances, therefore, enabling primary health issues to be addressed. Participants clearly communicated their preference

for accessing support through the local ACCHOs, with whom they shared strong pre-existing relationships. Therefore, housing, and financial services support could be delivered through local ACCHOs.

Second, transport issues played a significant role in impacting participants’ experiences. Communities in regional areas face transport barriers due to greater geographic distances to travel^{3,7}; limited PHC options nearby⁷; minimal public transport options^{3,7}; and higher travel costs such as petrol.^{3,7} Findings concerning participants’ exclusion from COVID-19 testing due to lack of vehicle ownership, strongly suggest that car access and car ownership is even more important than usual to access PHC during crises, and that testing options for people without cars should be available.

Third, findings show that unhelpful medical bureaucracy in the form of medical documentation, medical reception staff, making appointments and physical spaces such as medical waiting rooms impacted health care access during crises. Thus, there are implications for future crisis planning relating to the provision of culturally appropriate and acceptable care for the Aboriginal community.

While acknowledging the importance of identifying barriers to accessing care in the context of participants’ experiences, in writing this study we did not want to contribute to the deficit discourse characterising much research on Aboriginal health.³⁰ Consequently, we highlight the critical role ACCHOs have played as enablers of health care access both during usual conditions and crises.

The key role ACCHO staff play in supporting communities is recognised in the literature^{31,32} however, no research to date has focused on the role of ACCHOs during crises. This research found ACCHO staff appeared to be a critical enabler, assisting Aboriginal participants to manage medical bureaucracy issues by providing support with making medical appointments, arranging medical imaging and testing, and providing transport. During crises, therefore, it is critically important for ACCHOs to be supported to continue service provision to communities.

Overall, participants clearly preferred to access PHC via the local ACCHOs rather than mainstream health providers during crises. Several characteristics define Aboriginal PHC service delivery models, including accessible health services, community involvement, culturally appropriate and skilled workforce, holistic health care and wellness, self-determination and empowerment, connection to culture, and coordination of intersectoral and multidisciplinary collaboration.¹⁰ A substantial body of evidence demonstrates the better performance and outcomes of ACCHOs compared to mainstream general practice.^{33–35}

ACCHOs are ideally placed to promote and protect the health of Aboriginal communities during times of crisis due to their unique characteristics, as demonstrated by participant responses. ACCHOs pre-existing links and proximity to communities and networks mean they are well-placed to understand the environmental, social and cultural elements affecting health, and deliver context-appropriate care and effective risk communication.³⁶ Due to their relationship with the community and their ongoing presence, ACCHOs can continue PHC delivery and support throughout crises and into the recovery phase.

Findings also demonstrate the considerable efforts of the ACCHO sector, as a PHC provider, to address both the social determinants of health and health inequity factors experienced by Aboriginal communities during crises. The enablers promoted and supported by ACCHOs during crises included financial assistance with medical appointments; providing transportation options; supporting interagency communication and coordination for medical referrals, imaging, and testing; continuity and consistency of care as far as possible during unprecedented times, in-depth knowledge of community members and the local context and family dynamics, and respect for, and understanding of, factors competing with health care access. Here, the community's strong relationships with ACCHO staff, and the appreciation for the support and care the ACCHO staff provided were evident.

5 | STRENGTHS AND LIMITATIONS

Strengths of this study include the codesign process with the local ACCHO and cultural advisor and the use of a cultural advisory panel to identify and verify the themes arising from the participants' experiences. An additional strength of this study is that it amplifies Aboriginal participants' experiences and voices.

Limitations of this study are that only three men were interviewed from 18 interviews, which may discount the male voice and experience. Additionally, there were few young adult participants in the study. Research into the perspectives/experiences of young adults accessing health services during periods of crisis would also provide valuable insights.

To address the issues that Aboriginal communities face when accessing PHC during a crisis, further, larger scale studies could be undertaken, and the results synthesised for government and policy-makers to utilise for future crisis planning.

6 | CONCLUSIONS

The conclusions drawn from the present study are as follows. The preference of many Aboriginal people to access PHC via their local ACCHO rather than mainstream health care services appears even more salient during crises than in normal times. Accessing services from unfamiliar providers was not an acceptable option for the Aboriginal community.

The enablers the ACCHOs provide to their local communities during crises built and expanded on the positive experiences of cultural safety they provided during usual times; the trust participants displayed in the ACCHOs; addressing distance and travel barriers through the provision of medical transport drivers; supporting the community with assistance managing medical bureaucracy, such as appointment making, managing referrals and support with medical testing and imaging, and the cultural safety provided during uncertainty and the chaos of crises, that addressed distance and travel barriers.

Interventions could both build on the supportive environment and comprehensive care already provided by ACCHOs, and address some of the barriers to access that people experience when using mainstream health services – for example, through provision of cultural safety training for all PHC staff, including reception staff in private clinics and government health centres, and by building stronger links between different health care providers in the region.

Identifying the above barriers and enablers and the role played by the ACCHOs, assists in identifying strategic options to improve PHC accessibility during crises. Findings from this study highlighted the potential of ACCHOs to mobilise and meet the needs of clients and the local community during crises. ACCHOs' response during the 2019–2020 bushfires and the COVID-19 restrictions period has demonstrated that knowledge of Indigenous communities via pre-existing relationships is an essential foundation for primary health delivery during crises, and is worthy of future research and government investment.

This study provides a compelling case for further research to describe emerging innovations within Indigenous PHC contexts in response to public health crises and disasters. This knowledge has the potential to inform and support ACCHO health systems to be more resilient to future crises, such as public health emergencies and disasters, and also to meet the challenges faced by Indigenous populations. For this to occur, governments must reinforce financial commitments and responsibilities toward equitable PHC service infrastructure for Indigenous communities, particularly during public health crises or emergencies.¹⁶

AUTHOR CONTRIBUTIONS

Rebecca Woodland: Conceptualization; formal analysis; investigation; methodology; writing – original draft; writing – review and editing; data curation; project administration. **Paula Morgan:** Conceptualization; validation; writing – review and editing. **Sarah MacLean:** Writing – review and editing; conceptualization; supervision. **Heather Downey:** Writing – review and editing; conceptualization; supervision.

ACKNOWLEDGEMENTS

Lakes Entrance Aboriginal Health Association, Lake Tyers Health and Children's Centre, their staff and management, the research participants and the local Aboriginal community. Open access publishing facilitated by La Trobe University, as part of the Wiley - La Trobe University agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

ETHICS STATEMENT

The La Trobe University Human Research Ethics Committee (HEC20390) approved this project.

ORCID

Rebecca Woodland  <https://orcid.org/0009-0005-1868-3238>

Heather Downey  <https://orcid.org/0000-0002-4957-7033>

REFERENCES

1. CTG Australian Government. Closing the gap Prime Minister's report – 2016. 2016. Available from: <https://www.dpmc.gov.au/resource-centre/indigenous-affairs/closing-gap-prime-ministers-report-2016>. Accessed 21 Dec 2017.
2. Canuto K, Wittert G, Harfield S, Brown A. "I feel more comfortable speaking to a male": Aboriginal and Torres Strait Islander men's discourse on utilizing primary health care services. *Int J Equity Health* [Internet]. 2018;17(1):185.
3. Nolan-Isles D, Macniven R, Hunter K, Gwynn J, Lincoln M, Moir R, et al. Enablers and barriers to accessing health-care Services for Aboriginal People in New South Wales, Australia. *Intl J Environ Res Public Health* [Internet]. 2021;18(6):3014.
4. Australian Institute of Health and Welfare. Access to health services for Aboriginal and Torres Strait Islander people. 2011. Available from: <https://www.aihw.gov.au/getmedia/196cb4a7-969b-45cc-8b87-0f75ac837342/12263.pdf.aspx?inline=true>
5. Australian Institute of Health and Welfare. Australia's health 2022: in brief. Canberra: Australian Government; 2022. Available from: <https://www.aihw.gov.au/getmedia/c6c5dda9-4020-43b0-8ed6-a567cd660eaa/aihw-aus-421.pdf.aspx>
6. Davy C, Harfield S, McArthur A, Munn Z, Brown A. Access to primary health care services for indigenous peoples: a framework synthesis. *Int J Equity Health*. 2016;15(1):163. <https://doi.org/10.1186/s12939-016-0450-5>
7. 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. <https://doi.org/10.1186/s12992-018-0332-2>
8. Aspin C, Brown N, Jowsey T, Yen L, Leeder S. Strategic approaches to enhanced health service delivery for Aboriginal and Torres Strait Islander people with chronic illness: a qualitative study. *BMC Health Serv Res*. 2012;12(1):143.
9. McBain-Rigg KE, Veitch C. Cultural barriers to health care for Aboriginal and Torres Strait Islanders in Mount Isa. *Aust J Rural Health*. 2011;19:70–4.
10. Grad FP. The preamble of the constitution of the World Health Organization. *Bull World Health Organ*. 2002;80:981–4.
11. World Health Organization. The world health report 2008: primary health care now more than ever. Geneva: WHO; 2008.
12. Fitzpatrick K, Sehgal A, Montesanti S, Pianarosa E, Barnabe C, Heyd A, et al. Examining the role of indigenous primary healthcare across the globe in supporting populations during public health crises. *Glob Public Health*. 2022;18:1–29. <https://doi.org/10.1080/17441692.2022.2049845>
13. Gwynne K, Jeffries T Jr, Lincoln M. Improving the efficacy of healthcare services for Aboriginal Australians. *Aust Health Rev*. 2019;43(3):314–22.
14. State Government of Victoria. 2019–20 Eastern Victorian bushfires. 2022. Available from: www.vic.gov.au. 2019–20 Eastern Victorian bushfires | Victorian Government (www.vic.gov.au).
15. World Health Organization. Declaration of Alma-Ata. 1978 [cited 2021 1 Jan]. Available from: http://www.who.int/publications/almaata_declaration_en.pdf
16. Williamson B. Aboriginal community governance on the frontlines and faultlines in the black summer bushfires (Discussion Paper No. 300/2022). Canberra: Centre for Aboriginal Economic Policy Research, Australian National University; 2022. <https://doi.org/10.25911/V482-AE70>
17. Lansbury Hall N, Crosby L. Climate change impacts on health in remote indigenous communities in Australia. *Int J Environ Health Res*. 2022;32(3):487–502. <https://doi.org/10.1080/09603123.2020.1777948>
18. United Nations. Climate action – water at the centre of the climate crisis. Available from: [https://www.un.org/en/climatechange/science/climate-issues/water#:~:text=Climate%20change%20has%20made%20extreme,and%20more%20severe%20\(IPCC\).&text=Drought%20and%20flood%20risks%2C%20and,of%20global%20warming%20\(IPCC\)](https://www.un.org/en/climatechange/science/climate-issues/water#:~:text=Climate%20change%20has%20made%20extreme,and%20more%20severe%20(IPCC).&text=Drought%20and%20flood%20risks%2C%20and,of%20global%20warming%20(IPCC))
19. National Research Council (US), Institute of Medicine (US). In: Woolf SH, Aron L, editors. U.S. health in international perspective: shorter lives, poorer health. Washington, DC: National Academies Press, US; 2013.
20. Beks H, Mitchell F, Charles JA, McNamara KP, Versace VL. An aboriginal community-controlled health organization model of service delivery: qualitative process evaluation of the tuku wan Wininn mobile clinic. *Int J Equity Health*. 2022;21(1):163. <https://doi.org/10.1186/s12939-022-01768-4>
21. McCalman J, Longbottom M, Fagan S, Fagan R, Andrews S, Miller A. Leading with local solutions to keep Yarrabah safe: a grounded theory study of an aboriginal community-controlled

- health organisation's response to COVID-19. *BMC Health Serv Res.* 2021;21:732. <https://doi.org/10.1186/s12913-021-06761-1>
22. ID. East Gippsland Shire community profile. 2022. Available from: <https://profile.id.com.au/east-gippsland>
 23. Australian Bureau of Statistics. 2021 East Gippsland, Census Aboriginal and/or Torres Strait Islander people QuickStats. 2021. Available from: <https://abs.gov.au/census/find-census-data/quickstats/2021/IQSLGA22110>
 24. Stake RE. *The art of case study research*. Thousand Oaks: Sage; 1995.
 25. Miles MB, Huberman AM. *Qualitative data analysis: an expanded sourcebook*. Thousand Oaks: Sage; 1994.
 26. Lincoln YS, Guba EG. *Naturalistic inquiry*. Beverly Hills, California: Sage; 1985.
 27. Corden A, Sainsbury R. Exploring 'quality': research participants' perspectives on verbatim quotations. *Int J Soc Res Methodol.* 2006;9(2):97–110. <https://doi.org/10.1080/13645570600595264>
 28. NHMRC. *Ethical conduct in research with Aboriginal and Torres Strait Islander peoples and communities: guidelines for researchers and stakeholders*. Canberra: Commonwealth of Australia; 2018.
 29. Wenitong M, Adams M, Holden CA. Engaging Aboriginal and Torres Strait Islander men in primary care settings. *Med J Austr.* 2014;200(11):632–3. <https://doi.org/10.5694/mja14.00160>
 30. Fogarty W, Lovell M, Langenberg J, Heron M-J.. *Deficit discourse and strengths-based approaches: changing the narrative of Aboriginal and Torres Strait Islander health and wellbeing*. Carlton South, Vic: Lowitja Institute; 2018. <https://doi.org/10.3316/informit.9781921889554>
 31. Jeyakumar R, Patel B, Coombes J, Madden T, Joshi R. "We're on the ground, we know what needs to be done": exploring the role of aboriginal health workers in primary health care. *Front Public Health.* 2023;10:1010301. <https://doi.org/10.3389/fpubh.2022.1010301>
 32. Reeve C, Humphreys J, Wakerman J, Carter M, Carroll V, Reeve D. Strengthening primary health care: achieving health gains in a remote region of Australia. *Med J Aust.* 2015;202(9):483–7.
 33. 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;42:218–26. <https://doi.org/10.1071/AH16149>
 34. Munns A, Toye C, Hegney D, Kickett M, Marriott R, Walker R. Aboriginal parent support: a partnership2 approach. *J Clin Nurs.* 2018;27(3–4):e437–501.
 35. Panaretto KS. Aboriginal community controlled health services: leading the way in primary care (vol 200, pp 649, 2014). *M J Aust.* 2014;201(2):91.
 36. Colbran R. Primary health care in disaster planning. Partyline [Internet]. 2021;74. <https://www.ruralhealth.org.au/partyline/article/primary-health-care-disaster-planning>

How to cite this article: Woodland R, Morgan P, MacLean S, Downey H. The experiences of a regional Aboriginal community accessing primary health care during times of crisis. *Aust J Rural Health.* 2024;32:80–89. <https://doi.org/10.1111/ajr.13064>