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Leading the way: the contribution of Aboriginal community controlled health organisations to community health in Australia

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ABSTRACT

Background. The Aboriginal community controlled health sector has been a leader in community health in Australia. We sought to understand the influence this sector has had on the non-Indigenous community health movement in Australia since the 1970s. **Methods.** We interviewed 87 key informants on the history of community health in Australia, including policy makers, researchers, medical doctors, allied health, social workers, nurses and politicians. Five were Aboriginal, and 11 had particular experience in Aboriginal community health. A team approach was taken to qualitative analysis using a codebook. We interrogated data to seek evidence for the influence of Aboriginal community health on non-Indigenous community health, and the relationship between the two sectors. This was complemented by construction of a policy timeline. **Results.** Aboriginal community health services were regarded as best practice community health, and informed and influenced practice in non-Indigenous community health services. Non-Indigenous community health was sometimes more of a competitor than an ally. The respect for the Aboriginal community health sector, particularly community controlled, was seen to have grown over time, acknowledging the strengths of the model. Although establishing Aboriginal community health services was a struggle, the resulting model has better resisted managerialist control compared with non-Indigenous community health. **Conclusions.** The Aboriginal health sector developed a vision and practice of community health that went on to inform generalist non-Indigenous community health sector in Australia. The sector continues to remain strong today as an example model of community health that is relevant to all Australians.

Keywords: Aboriginal health, community control, community health, community participation, health policy, Indigenous health, primary health care, social determinants of Indigenous health.

Introduction

The Aboriginal community controlled health organisation (ACCHO) sector grew out of Aboriginal and Torres Strait Islander social movements for sovereign rights and self-determination, inspired by the Black Panther movement in the US (Foley 2009). Services were established to strengthen Aboriginal control of their health and health care, and in response to the racist treatment Aboriginal and Torres Strait Islander peoples received in mainstream health settings, resulting in poor access and healthcare outcomes.

The first ACCHO was in Redfern, New South Wales, in 1971 (Foley 1991). Initially staffed on a volunteer basis, after much lobbying, the Redfern Aboriginal Medical Service succeeded in receiving 'minimal financial support' through a government grant to hire a doctor, a nurse and a field worker (Foley 1991, p. 6). In coming years, other ACCHOs were established around Australia, including Central Australian Aboriginal Congress in Alice Springs in 1973, and Pika Wiya in South Australia in the early 1970s, born out of grassroots community activism for self-determined community controlled health care (Bartlett and Boffa 2001).

Collection: Models of Community Health in Action

Research has shown that the ACCHO model is a world leading example of comprehensive primary health care, based on community control, a social view of health, multidisciplinary care, and an emphasis on accessibility and equity (Freeman *et al.* 2016). The development of ACCHOs predated the 1973 Whitlam Community Health Program, which accelerated the development of generalist community health services in Australia, and the 1978 Declaration of Alma Ata that promoted primary health care as a means of achieving health for all (World Health Organization 1978).

As part of a broader project looking at the history of community health in Australia, we sought to examine the contribution of the ACCHO movement to the community health sector. There are similarities between the general community health model and the ACCHO model, including prioritising equity and accessibility, multidisciplinary teamwork, community participation, and taking a social view of health, including addressing social determinants of health (Lawless *et al.* 2014), yet little has been written on the interactions between these two sectors, and the extent of influence and collaboration between them.

ACCHOs have remained a strong and enduring presence in the Australian health system, with 145 ACCHOs across the country (NACCHO 2024), and have maintained their community health principles. The Whitlam government's Community Health Program (CHP) established >700 community health centres, services, and initiatives in all states and territories from 1973 to 1976. Its implementation varied within and between states, but funding cuts from 1976 and the end of federal support from 1981, and state policy and funding changes have curtailed their extent and scope (Owen and Lennie 1992; Baum and Freeman 2022). At present, the best expression of CHP ideals and this once vibrant community health movement is found in ACCHOs, and the Victorian community health sector and some community health activity in NSW (Baum and Freeman 2022).

Our research question was:

> How did the ACCHO movement influence the wider community health sector in Australia, and what was the relationship between the sectors?

We sought to answer this question to understand better the strengths of community health models, and barriers to the promotion of comprehensive primary healthcare models in Australia.

Methods

This research was part of a project funded by an Australian Research Council Special Initiative grant that sought to extract lessons from the history of community health services in Australia for the contemporary health system. This paper draws on a policy timeline for the history of ACCHOs in Australia, and analysis of interviews conducted with 87 key informants (see Table 1) covering ACCHOs, women's community health services and generalist community health services (i.e. services not directed at a specific population group, but serving the local community). Outside of ACCHOs, for which the research took a nationwide focus, the research particularly examined South Australia, Victoria and New South Wales, where the generalist community health sector flourished the most.

Policy timeline

Policies and details of seminal events were collected via web, library and archive searches. To be considered a relevant

Table 1. Interview and focus group participant characteristics and experiences.

Participant experience/characteristic	*N*	%
Gender		
Male	38	44%
Female	49	56%
Aboriginal	5	6%
State/national/international experience[A]		
South Australia	27	31%
Victoria	41	47%
New South Wales	20	23%
Other state/territory	4	5%
National	12	14%
International	20	23%
Community health experience[A]		
Generalist community health	61	70%
Aboriginal community health	11	13%
Women's community health	19	22%
Workers' community health	3	3%
Community mental health	5	6%
Professional background[A]		
Medical doctor	20	23%
Social worker	15	17%
Psychologist/psychiatrist	3	3%
Allied health[B]	17	20%
Nurse	10	11%
Academic/researcher	22	25%
Government bureaucrat/advisor/policymaker	30	34%
Federal/state politician	6	7%
Other	2	2%
Total	87	100%

[A]Categories are not mutually exclusive, totals >87.

[B]Allied health includes: nutritionist, health/health promotion education, teacher, physiotherapist, speech pathologist, and Aboriginal and Torres Strait Islander Health workers and practitioners.

strategic policy, documents needed to include goals, objectives and strategies relevant to community health. We included policy documents related to general community health, including primary health care, and to Aboriginal health and women's health, as these are all underpinned by a comprehensive vision of primary health care. Policy documents included formal government policies, and discussion papers and reports that influenced government decisions and action. The research team included investigators with long-term experience and knowledge of ACCHOs and community health in Australia, who reviewed draft policy timelines for comprehensiveness.

Interviews

To recruit interviewees, contact details were retrieved from web searches and professional networks. In many cases, a member of the research team had a pre-existing professional relationship with the interviewee. We used a purposeful sample (Patton 2007) to include information-rich representation from generalist, Aboriginal, women's and workers' community health services, participants with policy or academic expertise, and to ensure data on South Australian, Victorian and New South Wales community health services, and Aboriginal community controlled health services nationwide. Snowball sampling (Parker *et al.* 2019) was also used where participants recommended other potential interviewees. Members of the research team emailed invitations to participate to potential participants. Interviewees provided informed consent prior to the interview, with most waiving their right to anonymity. The semi-structured interview guide was developed by the research team to reflect the project research questions, and covered the interviewee's role over time in the community health sector, and their perspective on community health, equity, community development, multidisciplinary teams, governance, funding and political support, and changes in these over time. Interviews were conducted face to face or by videoconference and lasted approximately 1 h. In addition to 68 interviews, four focus groups were conducted (three in South Australia and one in Victoria) with a total of 11 participants. Focus groups were semi-structured, and included experts in community health in that state who could provide a group account of the history of the sector in their particular state. Each focus group was made up of members with a shared historical experience. This was particularly useful for prompting each other's memories, as well as clarifying with colleagues about historical, institutional and political facts. For example, one of the focus groups was with women who worked in women's health centres in SA over the 1980s to early 2000s. It also captured the collaborative nature of the community health movement during this period, and complimented the more traditional one on one oral history interviews. An additional eight interviews conducted previously by Victorian research team members on the history of community health in that state prior to the research project were included in the analysis to yield further information on community health in Victoria. Interviewees quoted in the paper gave their permission for their names to appear.

As indicated in Table 1, five interviewees were Aboriginal, and 11 interviewees primarily had experience in Aboriginal community health, although more had spent part of their careers in Aboriginal community health. Most participants' experiences of ACCHOs and community health spanned decades, including beginning from the 1970s and 1980s, and into the 2000s.

Analysis

A team approach was taken to thematic analysis. Policy documents and interview transcripts were imported into QSR NVivo. We developed a coding framework for the interviews that included a mix of *a priori* themes based on community health principles and our project research questions, and content identified as analysis progressed, developed and refined through team discussions. Preliminary analyses were presented at a series of team analysis workshops, a public webinar with 82 registrants, with a breakout session that discussed the ACCHO findings, and at a NACCHO annual general meeting session, to review and reflect on the ideas and findings. This paper focuses on analysing themes from the interviews relevant to the role and contribution of ACCHOs in community health in Australia, and the relationships between ACCHOs and generalist community health. First author TM, a Waljen public health physician and researcher, contributed to planning, debate and interpretation of findings, and the webinar and NACCHO sessions, and identification of themes for this paper. Analysis for this paper was guided by the framework developed by Baum *et al.* (2017) to describe comprehensive primary health care that emphasises principles including a holistic, social view of health, multidisciplinary teamwork, community participation, action on social determinants of health, and equity. Given the topic of Aboriginal health, the analysis was also guided by the key principles prevalent in Indigenous theories of wellbeing, as summarised in Mackean *et al.* (2022), such as collective wellbeing, culture, and Indigenous self-determination, sovereignty and rights, as central to Indigenous wellbeing, and wellbeing as collective and based on interrelationships rather than as an individual attribute.

Ethics approval

Ethics approval was received from the Flinders University Human Research Committee (Project No: 4168), Aboriginal Health Research Ethics Committee (AHREC Protocol: 04-22-974) and the Central Australian Human Research Ethics Committee (HREC Reference Number: CA-22-4379).

Results

Fig. 1 presents a timeline of key events and policies relevant to ACCHOs in Australia.

Although the ACCHO sector has grown over time and is now funded by government, interviewees emphasised that the establishment of ACCHOs was a struggle, and that nothing was gifted. This is evidenced by the fact that early ACCHOs began as volunteer staffed services, only later securing government funding. The national CHP that funded many community health services around Australia was not a significant source of funding for Aboriginal services:

> It [the CHP] was a bit exclusive really that club. They only ever funded 10 [Aboriginal services]. I think there was 10 . . . then I think they ended back up on the Aboriginal Affairs funding list (Pat Turner, Aboriginal, national Aboriginal health)

This pattern was mostly due to the Department of Aboriginal Affairs rather than the federal Department of Health (which administered the CHP) having responsibility for Aboriginal health.

Interviewees noted that ACCHOs continued to struggle for recognition:

> The everyday work of trying to get the Aboriginal community controlled health service to be seen as legitimate and a really important part of the health system. And that still happens every day. (de-identified, non-Indigenous, GP)

The ACCHO model of community health

Admiration for the ACCHO model was universal among interviewees, even when they acknowledged implementation challenges. ACCHOs were commended for their comprehensive model of primary health care: 'they were more comprehensive. They weren't just a medical service.' (Ben Bartlett, non-Indigenous, GP in Aboriginal health). ACCHOs were seen to excel at accessibility, pursuing multiple strategies to ensure they reached, and were welcoming for, Aboriginal and Torres Strait Islander peoples:

> they could contact people out of hours, they got transport, that they felt the people were on their side, that it wasn't racist. But it's all these little things that make it up to be an acceptable service. (Fran Baum, non-Indigenous, SA community health)

> They did a lot more things that we didn't do in community health, and they still do. Like transport, you know, come pick up someone and bring them to the appointment. So, very different model, a bit more hands on, model. (Kristine Olaris, non-Indigenous, Vic community health)

ACCHOs' commitment to a social view of health and health promotion that sought to empower individuals and the community was also acknowledged as a nation-leading strength:

> I think for me the main difference was that socioenvironmental model, grass roots partnership, empowerment,

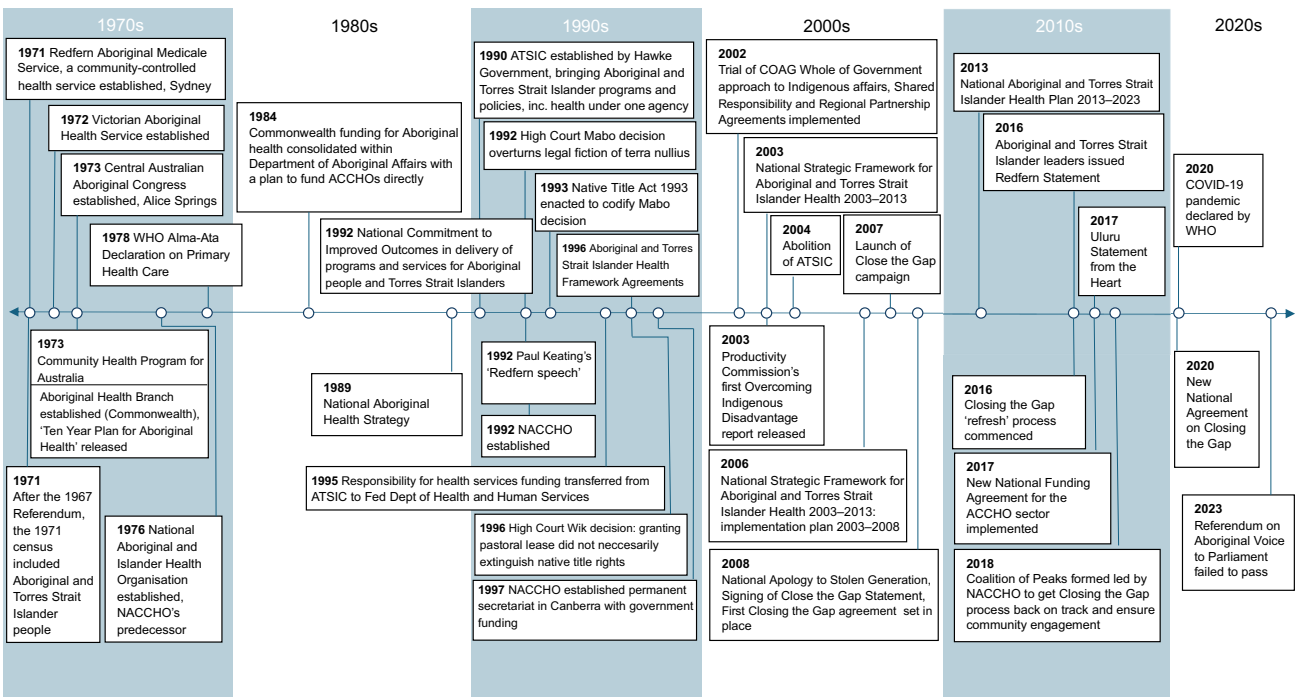

Fig. 1. Timeline of key events and policies relevant to ACCHOs in Australia 1970–present.

> you know, that much more of the embodiment of Ottawa Charter in community health compared to any other health service that I knew about. (Kaye Mehta, non-Indigenous, SA community health)

This included placing an 'emphasis on culture', which 'was really powerful' (Elizabeth Becker, non-Indigenous, SA community health). Attending to cultural and spiritual determinants of health was seen as a strength of the ACCHO model:

> With Aboriginal Health, you know, the spiritual is present. That's not present in other models, and I think that's very, very important as a cultural determinant of health. ... there is the central element that goes to land, community and connection, and country and people ... which I know is entirely embedded in that model, and I would wager is key to its efficacy too. (Lyn Morgain, non-Indigenous, Vic community health)

The attention paid by ACCHOs to living conditions and environments demonstrated innovative ways of improving health to the generalist community health sector. The Nganampa Health Council, established in 1984 by the Pitjantjatjara people in the far north of South Australia, conducted a detailed survey of living conditions and environments in its geographic area, which included housing, food and essential services, such as water, power and waste removal. The survey produced a list of nine prioritised healthy living practices and described the infrastructure needed for these practices to be conducted (Torzillo *et al.* 1992). A detailed 'survey and fix' methodology evolved and has been applied across Aboriginal communities in regional and remote Australia. These efforts have illustrated the complexities of advocating for and implementing 'housing for health' programs in Indigenous public policy (Lea and Pholeros 2010; Pholeros *et al.* 2013). This work initiated by Nganampa Health Council demonstrated the need for a multi-sectoral approach in health, and the value of a social and environmental perspective to the generalist community health sector. One interviewee described the power of ACCHOs consulting with community elders:

> the sense of the importance of elders in the community, importance of consulting with elders in the work that community health centres do, and that incredible respect that people have. (Kristine Olaris, non-Indigenous, Vic community health)

Several interviewees pointed out that ACCHOs employing Aboriginal health professionals was an important strength:

> Another important reason to fund health services is the employment and training provided to people in the Aboriginal community, and the role modelling of career options. As a result of having Aboriginal Health Services, there are now more Aboriginal doctors, nurses and health practitioners. ... without an Aboriginal Health Service, those Aboriginal workers and community members wouldn't have got to see in the same way that medicine and nursing, and most health disciplines, are possibilities for them. (de-identified, non-Indigenous, GP)

These characteristics of the ACCHO model reflect the commitment to self-determination and community control that underpins the sector:

> In Aboriginal community control, the community appoint the board. That is a form of self-determination. (de-identified, Aboriginal, ACCHO manager)

A strong theme was that the ACCHO model was a good model for all Australians:

> Aboriginal models of community controlled organizations have come to be accepted as almost benchmarks of how things perhaps could be in wider society ... the Federal and State governments need to realise that these are very good models with a lot of potential benefits for the wider community and, yeah, they've got quite a bit to learn from this model, I think. (de-identified, non-Indigenous, Aboriginal health)

> They all want to adopt our model and you know everyone wants to adopt our model. Even Greg Hunt (former Coalition Health Minister 2017–20) said ... rural health should be based same as NACCH ... It's a great, the best model, he said. I said well, you know it's not just rural communities, Minister, you should have it right throughout Australia for every Australian. (Pat Turner, Aboriginal, national Aboriginal health)

Interactions between ACCHOs and the generalist community health sector

Some interviewees reported the two sectors had extensive interaction, including interviewees, and other workers and key actors moving between Aboriginal, women's community health and generalist community health, or working across all. There were 'lots of networking connections' (Judith Dwyer, non-Indigenous, SA, women's health and Aboriginal health) between ACCHOs and the rest of the community health sector. For example:

> There was a lot of exchange between doctors who worked in community health and went to work in Aboriginal Health Services. That happened quite frequently. I did notice that an enormous number of our registrars who came to work at the health centre also did rural rotations to remote Aboriginal community health services. (Lyn McKenzie, non-Indigenous, Vic women's health and Aboriginal community health)

The two sectors were described as 'real fellow travellers' (de-identified, non-Indigenous, SA community health), and that 'they co-evolved' (Ian Anderson, Aboriginal, national Aboriginal health). The Public Health Association was cited as a venue for collaboration, as a 'hook into the mainstream' (Judith Dwyer, non-Indigenous, SA, women's health and Aboriginal health) for the ACCHOs.

Alukura is a long-term project by an ACCHO in Alice Springs, Central Australian Aboriginal Congress to offer women-only care related to birthing matters, pregnancy, childbirth, and the care of women and their infants in ways that preserve and recognise Aboriginal identity, culture, law and languages, and is guided by the Grandmothers' Law (Ah Chee *et al.* 2001). Concerns in the mid-1980s from the Commonwealth Department of Health that services delivered by Alukura would result in lower standards of care compared with existing services were dissipated following a review of Alukura services based on Community Health Accreditation and Standards Program (Carter *et al.* 2004). The Community Health Accreditation and Standards Program program, an activity of the Australian Community Health Association, the national advocacy body for the community health sector, developed a set of standards based on community health principles and values, and a review process to assess the extent to which a centre or service achieved the standards (Fry 1990). This example illustrates productive collaboration between the ACCHO and the generalist community health sectors.

Some interviewees described close collaboration; for example, one community health service in Victoria collaborated with the local ACCHO on:

> various committees, on joint projects, joint publications, all sorts of stuff. Our staff worked a lot with [ACCHO] staff around homelessness issues, injecting drug use issues etc. When we appointed Aboriginal Liaison workers, we invited [ACCHO] to sit on interview panels, we got them to deliver training of various kinds, so we worked reasonably closely together. (Vera Boston, non-Indigenous, Vic community health)

Not all interviewees shared this viewpoint, with one interviewee reflecting 'They always felt a bit separate to me' (de-identified, non-Indigenous, GP). Another reported that for their community health service, connections with the local ACCHO were 'pretty limited' (de-identified, non-Indigenous, SA community health). Although there were examples of collaboration, community health was sometimes more of a competitor than an ally, as this example shows:

> whereas you would think, wouldn't you, that community health services – with the philosophical base and the objectives that we've talked about here... would be able to get on perfectly well with the AMS [Aboriginal Medical Service]. And we didn't... So when I got there in 1985, I discovered that there was this team of about four or five people who were based in Redfern ... who were doing community health-type work, early childhood work ... this seemed to me to be completely bizarre, they're about one block away from the AMS, and we had our own little Aboriginal health unit. It was – seemed extraordinarily strange to me, because why not rely on the community-based organization to do it? And the answer to that, is an answer around bureaucracies and hierarchies. (Greg Stewart, non-Indigenous, NSW community health)

This was exacerbated by competition over resources:

> There was a lot of competition, because the states believed that they were entitled to a bunch of money to provide services for Aboriginal people, and do things to and for Aboriginal people... there was quite a lot of resistance and competition between independent services and state based services. Because there was money involved and people had their careers in the state sector (de-identified, non-Indigenous, Aboriginal health)

One interviewee noted how women's health and Aboriginal health were driven by different ideas:

> It's similarities and differences in community health between Women's health and Aboriginal community... The vision, the alternative models are pretty much the same, but the emphasis is perhaps a little different. Gender and patriarchy more essential to the analysis in Women's health, race and post-colonialism with Aboriginal Health. (Brian Stagoll, non-Indigenous, Vic community health)

The contributions of the ACCHO movement to community health

Interviewees discussed the contributions the ACCHO movement had made to community health, and how they had inspired generalist community health models:

> The whole [ACCHO] sector has transformed the health system in really quite profound ways. It changed from that very local, voluntary-led notion of control and care to almost a part of a system and part of the sector. (Ian Anderson, Aboriginal, national Aboriginal health)

The following account is from a key actor in the South Australian health and community health system from the 1970s to 2010s:

> I went to Whyalla and had quite a lot to do with [Aboriginal] services on the peninsula and upper north, so I got hugely influenced by what you saw and what you experienced, and some great people that I worked with who were trying to make a difference in Aboriginal

health. (Jim Birch, senior health service executive and Former CE SA Health, non-Indigenous)

Another interviewee reflected:

It was just an inspiration for me to arrive [at the ACCHO] and find myself working in quite a different situation than I had experienced before. In that it was a vibrant community organisation providing primary health care in a different way to what I'd previously experienced. So that was my first exposure to community health. I learned a lot about what community was and what it meant, very quickly, just by being in that environment. (de-identified, non-Indigenous, Aboriginal health)

One particular contribution of the ACCHO sector was as a model of community control of health services. Aboriginal models of community control inspired community inclusion and governance in generalist community health services, as these examples show:

Well, community control, we were reaching towards at [community health centre name], but I don't think any of us had a good idea of what community meant. Whereas, I think in Aboriginal health ... there's a much better idea about what community means. (de-identified, non-Indigenous, Vic community health)

We knew that we had to respond to the community, and we had to be in touch with the community, ... probably an idea that's particularly come from Aboriginal services. So, the best example is Aboriginal health services. Nobody, but Indigenous people, can run Aboriginal health services ... So, I think it's, we had an inkling, as I mentioned before, with the Women's Health Centre and the women's health services, that that was important. (Rick Mohr, non-Indigenous, NSW community health)

During the COVID-19 pandemic, ACCHOs played a critical role in supporting the health of their community, serving as a trusted source of health promotion information, enabling on the ground contract tracing, and to act as a collective voice for communities (Finlay and Wenitong 2020; Schultz 2020). The ACCHOs' ability to respond to the pandemic and promote the health and needs of their local communities was cited as a demonstration of the strength of the model:

I think that the COVID pandemic experiences have made it very, very clear that had we had a platform of community health centres across Australia that had been there for years, and had developed trusted relationships with their local communities and subgroups within those communities, how easy, relatively easy it would have been to mobilise action ... The Aboriginal community health-controlled health centres have shown that. (de-identified, non-Indigenous, national community health)

ACCHOs' retention of a strong model of community health

There were powerful shared forces that challenged the ACCHO and generalist community health services, including managerialism (the introduction of private sector management techniques into the public service, typically focusing on financial management and quantitative performance targets; Baum 1996):

I think managerialism that's crept into the whole health sector has really borne down on Aboriginal organisations in the form of reporting requirements and endless assessments of activities (de-identified, non-Indigenous, Aboriginal health)

The issue of multiple funding streams with consequent high level of reporting requirements has long been reported as a challenge for ACCHOs, with 'multiple sources of funding right across all governments. What comes with it is multiple reporting requirements, let alone the accreditation burden, the standards' (de-identified, Aboriginal, Aboriginal health). Funding models were reported to be a challenge, particularly fee for service models fostering a more individualised primary medical care model:

There's been increasing pressure on Aboriginal health services over the last few years to focus more and more on clinical services work. There's been more and more pressure to generate funding through Medicare/Medical Benefits Schedule rather than being able to rely on the block funding. And that tends to be working with individuals rather than families or groups. (de-identified, non-Indigenous, GP)

Crucially, interviewees within and outside the ACCHO sector agreed that the ACCHO sector resisted these forces better, and having kept the integrity of their model to a greater degree than generalist community health. Some interviewees attributed this to ACCHOs being part of the movement for self-determination:

I think it's the, I suppose the self-determination, the tenacity of Aboriginal people that said, 'We deserve this. We need this. This is for our future generations. (de-identified, Aboriginal, Aboriginal health)

One interviewee noted that ACCHOs appeared to be well organisation, including through highly regarded jurisdictional peak bodies, whereas the generalist community health movement was by comparison 'very disparate' (de-identified, non-Indigenous, SA community health). Outside of ACCHOs, one interviewee described 'what has been retained of community health services' as 'hanging on by their fingernails, really' (de-identified, non-Indigenous, Aboriginal health).

Key Aboriginal senior actors and bureaucrats, Ian Anderson and Pat Turner, both noted a shift over the decades from sidelining to valuing the ACCHO sector, and respecting the model they had developed:

> In the Northern Territory, there was a high degree of reluctance to have the AMSANT [Aboriginal Medical Services Alliance Northern Territory] as a signatory … In 2017, this is a passage of about 20 years, and the first thing the Northern Territory government said to me is, 'Don't bugger up our relationship with the community controlled sector'. Which is telling in terms of how much that relationship had evolved and come in that period of time. (Ian Anderson, Aboriginal, national Aboriginal health)

This respect was seen as one of the reasons for ACCHOs' longevity:

> I think Aboriginal community health services are now very much an accepted part of the health system. I think it is probably going to be hard to actually get rid of them. I think that they will continue… that particular kind of approach to community health, comprehensive primary health care, multidisciplinary teams, providing health care where the priorities are determined by the local community. That kind of approach to health care has traditionally been very much the strength of the Aboriginal community controlled health service movement. (de-identified, non-Indigenous, Aboriginal health)

One interviewee also felt there were strong spokespeople for the ACCHO model:

> I'm just thrilled to see the voice of Indigenous Australia or First Nations people just being stronger and stronger. … we never had that strong spokespeople, I don't think. I think in some ways we might have been complacent. We just never saw the urgency of it or something until it was too late. (Kaye Mehta, non-Indigenous, SA community health)

Another reason put forward for ACCHOs' longevity was the strengthening effect of cooperation between sectors for Aboriginal affairs, particularly in Victoria:

> the power of the Aboriginal Medical Service in remote communities was actually assisted greatly by the prior arrival of Aboriginal Legal Services. So, these things actually work cooperatively, hugely cooperatively. And enabled health. (Brian Stagoll, non-Indigenous, Vic community health)

Discussion

ACCHOs are a leading model of community health in Australia, and there is evidence from the interviews of extensive interaction between the ACCHO sector and the generalist community health sector. ACCHOs were reported to have informed the development of generalist community health service models. Some of the lessons learned from attributes of ACCHOs that were reported to inspire other models of community health are summarised in Box 1.

The strengths interviewees identified in ACCHOs concords with the extensive literature on the model (Panaretto *et al.* 2014; Freeman *et al.* 2016; Campbell *et al.* 2018). In particular, the holistic approach of ACCHOs reflects an understanding that health issues need to be addressed through consideration and action on social and cultural determinants of health (Pearson *et al.* 2020). That the National Aboriginal and Torres Strait Islander Health Plan raised determinants, such as culture and racism, speaks to the complexity of addressing Aboriginal health, and the value of such a holistic approach has been shown again and again for Aboriginal people (Fisher *et al.* 2019).

ACCHOs' model of community governance strongly influenced the structures of community health services. There are parallels in other spheres, such as land management, where Aboriginal ways of knowing, being and doing, particularly cultural burning practices, have proved valuable to addressing vital environmental issues (Freeman *et al.* 2021). Although it was clear that ACCHOs had inspired ways of working in generalist community health services, it was also apparent that the unique experience of being colonised created different drivers for the ACCHO sector; for example, the need to push back against white supremacy in health and non-health structures, policies, and practices. The value of community governance in the ACCHO model for Aboriginal and Torres Strait Islander peoples is evident in the context of ongoing colonisation. The project findings point to the community control movement creating its own space, not just for health, wellbeing and access, but to foster self-determination and as an expression of sovereignty. The ACCHO movement was, and is, a vehicle for resistance within the health system that Aboriginal people have driven to improve Aboriginal health through social justice. After data collection for this project, the

Box 1. Attributes of ACCHOs offering lessons for community health.

- Demonstration of effective community governance and community control, and its importance for self-determination
- The importance of grass roots community engagement – arising from and being a part of the community
- A model of primary health care based on a social view of health that addresses social and cultural determinants of health
- An emphasis on accessibility, including provision of transport
- Effective use of Aboriginal Health Workers to link community with the health service
- Maintaining an advocacy program on social health issues

referendum for an Aboriginal Voice to Parliament was held, and did not succeed in attaining a 'yes' result. This speaks to the extent of work still to be done for truth telling and establishing space for Aboriginal and Torres Strait Islander self-determination.

Aboriginal and Torres Strait Islander peoples' inherent collective way of working, seeing communities before seeing individuals, creates an overarching connectivity that acts as a significant driver of solidarity, even with diversity of geography and clan group. It is this underpinning collective solidarity, along with intergenerational thinking, that emphasises responsibility for legacy and future generations, that has kept progress and resistance continuing for >200 years. It has contributed to the organisational sustainability and tenaciousness of the ACCHO sector.

In contrast, the holistic model of community health has been undermined by more short-term, managerialist approaches to health care that have failed to take responsibility for health of the community in the same way. Once vibrant community health services were subject to funding cuts, short term funding cycles, unsupportive policy environments that emphasised individual responsibility and market approaches to health care (Baum and Freeman 2022). Thus, the Australian health system would benefit from learning from the role ACCHOs play in communities, not just as an on the ground model of health care, but as an approach to health policy that is sustainable and equitable.

Strengths and limitations

Although we could not provide a comprehensive account of the history of ACCHOs within the bounds of this project, we could focus on seeking to understand the contribution they made to generalist community health. Given the time that has passed, and the limit on the number of people we were able to interview, there is likely to be interactions between the ACCHO sector and generalist community health sector that we have not captured here. However, the interviewees included very senior key actors in the ACCHO and community health sectors in Australia over the period of study, ensuring an accurate overview of the history of these models of community health. In addition to community controlled services, state government managed Aboriginal and Torres Strait Islander primary healthcare systems have been established to support access to culturally safe primary health care, such as Inala Indigenous Health Service (Hayman *et al*. 2009). Such services have made a valuable contribution to access to culturally safe health care for Aboriginal and Torres Strait Islander peoples in Australia, but were not the focus of this research.

Conclusion

The ACCHO model is a leading model of community health in Australia, and endures where many generalist community health services have not. They largely maintain the strong community health principles on which they were established. This achievement reflects the social movement for Aboriginal and Torres Strait Islander self-determination in Australia, and the strength of vision and organisation of the sector. It continues to provide models for community health today, particularly in terms of accessibility, community governance and a social view of health, that could be of benefit to the whole Australian community. The ACCHO model and movement remains vital for Aboriginal and Torres Strait Islander health in the face of the ongoing struggle against colonisation.

References

Ah Chee D, Alley S, Milera S (2001) Congress Alukura-Women's Business. In '4th Australian Women's Health Conference', 19–21 February 2001, Adelaide, SA. (Central Australian Aboriginal Congress Aboriginal Corporation) Available at https://caac.org.au/wp-content/uploads/pdfs/Conference-Congress-Alukura-Womens-Business-2001.pdf

Bartlett B, Boffa J (2001) Aboriginal community controlled comprehensive primary health care: the Central Australian Aboriginal Congress. *Australian Journal of Primary Health* **7**(3), 74–82. doi:10.1071/PY01050

Baum F (1996) Community health services and managerialism. *Australian Journal of Primary Health* **2**(4), 31–41. doi:10.1071/PY96053

Baum F, Freeman T (2022) Why community health systems have not flourished in high income countries: what the Australian experience tells us. *International Journal of Health Policy and Management* **11**(1), 49–58. doi:10.34172/ijhpm.2021.42

Baum F, Freeman T, Lawless A, Labonte R, Sanders D (2017) What is the difference between comprehensive and selective primary health care? Evidence from a five-year longitudinal realist case study in South Australia. *BMJ open* **7**(4), e015271. doi:10.1136/bmjopen-2016-015271

Campbell MA, Hunt J, Scrimgeour DJ, Davey M, Jones V (2018) Contribution of Aboriginal community-controlled health services to improving Aboriginal health: an evidence review. *Australian Health Review* **42**(2), 218–226. doi:10.1071/AH16149

Carter E, Lumley J, Wilson G, Bell S (2004) 'Alukura . . . for my daughters and their daughters and their daughters'. A review of Congress Alukura. *Australian and New Zealand Journal of Public Health* **28**(3), 229–234. doi:10.1111/j.1467-842x.2004.tb00701.x

Finlay S, Wenitong M (2020) Aboriginal community controlled health organisations are taking a leading role in COVID-19 health communication. *Australian and New Zealand Journal of Public Health* **44**, 251–252. doi:10.1111/1753-6405.13010

Fisher M, Battams S, Mcdermott D, Baum F, Macdougall C (2019) How the social determinants of Indigenous health became policy reality for Australia's National Aboriginal and Torres Strait Islander Health Plan. *Journal of Social Policy* **48**(1), 169–189. doi:10.1017/S0047279418000338

Foley G (1991) Redfern Aboriginal Medical Service 1971–1991: twenty years of community service. Aboriginal Medical Service Co-operative, Redfern, NSW, Australia.

Foley G (2009) Black power in Redfern 1968–1972. In 'There goes the neighbourhood: redfern and the politics of urban space'. (Eds Z Begg, K De Souza) pp. 12–21. (Performance Space: Sydney, NSW, Australia)

Freeman T, Baum F, Lawless A, Labonté R, Sanders D, Boffa J, Edwards T, Javanparast S (2016) Case study of an Aboriginal community-controlled health service in Australia: universal, rights-based, publicly funded comprehensive primary health care in action. *Health and Human Rights* **18**(2), 93–108.

Freeman D, Williamson B, Weir J (2021) Cultural burning and public sector practice in the Australian Capital Territory. *Australian Geographer* **52**(2), 111–129. doi:10.1080/00049182.2021.1917133

Fry D (1990) Systems of standards for community health services in Australia. *International Journal for Quality in Health Care* **2**(1), 59–67.

Hayman NE, White NE, Spurling GK (2009) Improving Indigenous patients' access to mainstream health services: the Inala experience. *Medical Journal of Australia* **190**(10), 604–606. doi:10.5694/j.1326-5377.2009.tb02581.x

Lawless A, Freeman T, Bentley M, Baum F, Jolley G (2014) Developing a good practice model to evaluate the effectiveness of comprehensive primary health care in local communities. *BMC Family Practice* **15**(1), 99. doi:10.1186/1471-2296-15-99

Lea T, Pholeros P (2010) This is not a pipe: the treacheries of indigenous housing. *Public Culture* **22**(1), 187–209. doi:10.1215/08992363-2009-021

Mackean T, Shakespeare M, Fisher M (2022) Indigenous and non-Indigenous theories of wellbeing and their suitability for wellbeing policy. *International Journal of Environmental Research and Public Health* **19**(18), 11693. doi:10.3390/ijerph191811693

NACCHO (2024) Who we are. Available at https://www.naccho.org.au/about-us/

Owen A, Lennie I (1992) Health for all and community health. In 'Community health policy and practice in Australia'. (Eds F Baum, D Fry, I Lennie) pp. 6–27. (Pluto Press: Sydney)

Panaretto KS, Wenitong M, Button S, Ring IT (2014) Aboriginal community controlled health services: leading the way in primary care. *Medical Journal of Australia* **200**(11), 649–652. doi:10.5694/mja13.00005

Parker C, Scott S, Geddes A (2019) Snowball sampling. SAGE research methods foundations. Available at http://eprints.glos.ac.uk/6781/1/6781%20Parker%20and%20Scott%20%282019%29%20Snowball%20Sampling_Peer%20reviewed%20pre-copy%20edited%20version.pdf

Patton MQ (2007) Sampling, qualitative (purposeful). In 'The Blackwell encyclopedia of sociology'. (Ed. G Ritzer) (John Wiley & Sons, Ltd)

Pearson O, Schwartzkopff K, Dawson A, Hagger C, Karagi A, Davy C, Brown A, Braunack-Mayer A (2020) 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* **20**, 1859. doi:10.1186/s12889-020-09943-4

Pholeros P, Lea T, Rainow S, Sowerbutts T, Torzillo PJ (2013) Improving the state of health hardware in Australian Indigenous housing: building more houses is not the only answer. *International Journal of Circumpolar Health* **72**(1), 21181. doi:10.3402/ijch.v72i0.21181

Schultz R (2020) Australian Aboriginal community response to the COVID-19 pandemic. *Social Innovations Journal* **3**.

Torzillo P, Rainow S, Pholeros P, Tunkin W, Vartto K (1992) Extending community health services. In 'Community health policy and practice in Australia'. (Eds F Baum, D Fry, I Lennie) pp. 199–210. (Pluto Press: Sydney, NSW, Australia)

World Health Organization (1978) Declaration of Alma-Ata. World Health Organization. Regional Office for Europe.

Data availability. The data that support this study will be shared upon reasonable request to the corresponding author.

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