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Next Steps in Decolonising Aboriginal and Torres Strait Islander Primary Health Care Policy in Australia: An Analysis of Key Stakeholder Views

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Résumé de l'article

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Abstract

Following a failed 2023 referendum on constitutional recognition of Aboriginal and Torres Strait Islander people, Australian governments must work with Indigenous leaders to chart a new way forward in policy to support Indigenous health and wellbeing. Here we report on key stakeholder views on what is required to decolonise Indigenous primary health care (PHC) policy. This article reports on qualitative research conducting yarns with 20 senior staff working in key government and non-government organisations comprising the Indigenous PHC sector ('stakeholders'). Stakeholders see the sector as exemplifying decolonisation, motivated through Indigenous leadership. However, further changes are needed in mainstream health services, workforce development, intersectoral policy, and determinants of health. We discuss how the Indigenous PHC sector can inform decolonising policy in other sectors and reflect on the international implications of our findings. We conclude that the sector provides important lessons for decolonising Australian public policy.

Keywords

Decolonisation, First Nations, Aboriginal,Torres Strait Islander, Primary Health Care, Policy

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Next Steps in Decolonising Aboriginal and Torres Strait Islander Primary Health Care Policy in Australia: An Analysis of Key Stakeholder Views

The failed 2023 referendum in Australia to recognise First Nations Peoples in the Constitution and establish a Voice to parliament caused shock and grief to many (First Nations leaders et al., 2023) and is a watershed moment for public administration of Aboriginal and Torres Strait Islander affairs. Existing policy prescriptions are not working (Productivity Commission, 2024), and the opportunity presented by the referendum for better health outcomes (Anderson et al., 2023) has been forfeited. Governments must now partner with First Nations leaders to define a clear path forward to substantially improve Indigenous health, wellbeing, and self-determination. In this paper we examine this challenge as one of *decolonising* public policy and programs.

First Nations Australians have occupied the Australian continent for well over 65,000 years. Prior to British invasion and ongoing colonisation, they maintained 'flourishing sovereign societies' with their own laws, knowledge systems, economies, and trade relationships (Rigney et al., 2022, p. 17). Since the West's colonial tenure began, Aboriginal and Torres Strait Islander peoples have worked hard to maintain their rich and diverse cultures, but also been undermined through successive, targeted colonial policies. Colonisation has brought profound disruption through impacts of racism, attempted genocide, disease, armed conflict, dispossession, and removal of children (Rigney et al., 2022). Colonisation continues today manifesting in structural inequalities in power, systemic racism, health inequities, paternalism, and high rates of incarceration and child removal (Paradies, 2016; Sherwood, 2013).

The First Nations' *Uluru Statement from the Heart* which called for the Voice referendum also reasserted longstanding calls for national treaty making and truth telling processes (National Constitutional Convention, 2017). Unlike most other Western colonised countries, hitherto Australian governments have not agreed any treaties with First Nations Peoples (Hobbs & Williams, 2019). However, while the failed referendum has derailed national discussion, several regional State governments are working with First Nations within their jurisdictions to establish representative bodies, and initiate Treaty making and/or Truth-telling processes, with Victoria currently the most advanced (Government of Victoria & First People's Assembly of Victoria, 2024). Such moves are significant but also vulnerable to changes in political climate.

National 'native title' land rights legislation was established in 1993, resulting to date in around 240 successful or partially successful claims. Alongside these processes, Australian Health policy and services have been a venue for decolonising leadership over decades in policymaking (Fisher et al., 2018) and establishment of First Nations-led (and publicly funded) community-controlled services, workforce development and representative organisations (Sherwood & Edwards, 2006). This article draws on the experience and knowledge of senior-level staff working in key stakeholder organisations within and outside government comprising the Indigenous PHC sector (see Figure 1) to assess the current state of decolonisation in Indigenous PHC policy and how that process can be further advanced.

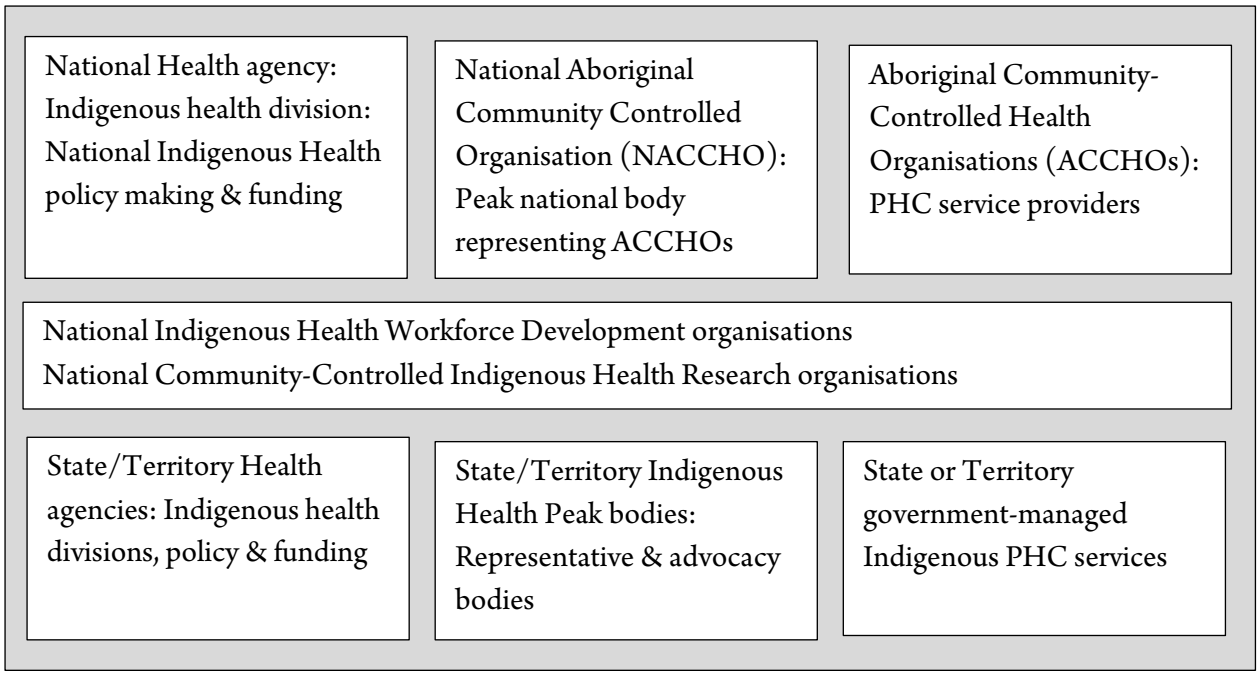

Figure 1. **Key stakeholder organisations in the Australian Indigenous PHC sector**

The concept of *decolonisation* originally described the processes of countries claiming independence from colonial rule (Wesseling, 1987). An Indigenous-led standpoint centres Indigenous Peoples' movements within their respective countries to challenge and reverse the harms of colonisation and assert rights to prior sovereignty, restorative justice, political voice, and self-determination (O'Dowd & Heckenberg, 2020; United Nations, 2008). Decolonisation is a complex concept, encompassing imperatives for political, cultural, socioeconomic, and psychological change in neocolonial societies. Tuhiwai-Smith argues that decolonisation requires a "bureaucratic, cultural, linguistic and psychological divesting of colonial power" (Tuhiwai-Smith, 2021, p. 98). Politically, decolonisation must include processes related to sovereignty, reparations, treaty-making and so on, as alluded to above (Tuck & Yang, 2012; Hobbs & Williams, 2019). Socially and culturally, it is concerned with changes not only in material conditions of living but also in colonising beliefs and practices. In the health sector, decolonisation can be applied to challenge policies or practices manifesting colonialist features such as power inequalities, racism, whiteness, bureaucratic control, or narrow biomedical views of health (Sherwood, 2013; Mackean et al., 2019).

In an extension of evidence on social determinants of health (SDH), literature now commonly recognises *social, cultural, and political determinants of Indigenous health* (SCPDIH) (Carson et al., 2007; Rigney et al., 2022). SCPDIH in Australia include protective factors such as self-governance and empowerment (Rigney et al., 2022), and strong connection with culture (Dockery, 2010), and harmful factors such as exposure to racism (Paradies, 2016). Colonisation is recognised as a critical underlying determinant of health inequities affecting First Nations people in Australia (Australian Institute of Health and Welfare, 2015; Carson et al., 2007; Paradies, 2016; Sherwood, 2013) and in other colonised societies (Anderson et al., 2016; Czyzewski, 2011). Decolonisation in the health sector requires recognition of SCPDIH leading to positive, transformative actions (Mackean et al., 2019; Ramsden, 2002).

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Our research was conducted as part of a larger project on *Decolonising Practice in Aboriginal and Torres Strait Primary Health Care* (PHC). Here we report on findings from aspects of our research focused on what is required to decolonise Aboriginal and Torres Strait Islander PHC *policy* in Australia, which involves both national and State/Territory governments. The Indigenous health division of the Federal Department of Health and Ageing has a primary role in development of national policies (Australian Government et al., 2021) and funding the community-controlled PHC sector, encompassing the National Aboriginal Community Controlled Health Organisation (NACCHO), State/Territory peak bodies, and Aboriginal Community-Controlled Health Organisations (ACCHOs). Federal government also funds four national Indigenous health workforce development non-government organisations (NGOs). State/Territory Health departments fund and manage public Indigenous PHC services within their respective jurisdictions and may also fund ACCHOs for specific programs. We report original, qualitative research examining stakeholder views on decolonising this policy environment, including areas of progress, current barriers, and prospective next steps. We discuss the current situation for decolonising Indigenous PHC policy and consider implications for policy change and decolonised practice within PHC services.

Hereafter, we use 'Aboriginal and Torres Strait Islander' or 'Indigenous' interchangeably to refer to the First Nations people/s of Australia.

Methods

The broader *Decolonising Practice* project has sought to implement decolonising research methods within a collaborative enquiry research methodology (Freeman et al., 2023), working in partnership with five Aboriginal and Torres Strait Islander PHC services. The overall project has examined decolonising practice at partner services (not reported here) and assessed decolonisation in the national PHC policy environment. The project has involved data collection in four States and Territories, and ethics approvals were received from appropriate bodies in each jurisdiction, including the Aboriginal Health Research Ethics Committee in our home State of South Australia. Aboriginal research team members have led processes to embed decolonising methodology, informed by a relational worldview, Indigenous ways of knowing, being, and doing, and a holistic view of health. Such processes included Aboriginal researchers meeting separately to discuss the research and feedback key points to the wider team. Non-Indigenous researchers also met separately to discuss ways of working respectfully at the interface of knowledge (Durie, 2005). We have worked to build an evidence base that privileged Aboriginal voices, experiences, and interpretations.

Here we report findings from our research gathering views of key stakeholders on the challenges and prospects for decolonisation in Indigenous PHC policy nationally and how this policy environment enables or hinders decolonising service practices. We sought to recruit participants working in senior roles actively engaged in Indigenous PHC policy from across key stakeholder organisations operating in the sector (see Figure 1), being Indigenous health divisions of Federal and State/Territory health agencies, Indigenous PHC sector peak bodies and ACCHOs, national Indigenous workforce NGOs, and Indigenous health research organisations, with preferential selection of Indigenous participants where possible. Prospective participants were contacted by email and provided with information on the research. We recruited 13 Indigenous and 7 non-Indigenous participants covering all target stakeholder organisations.

We used a qualitative method of yarning (Bessarab & Ng'Andu, 2010; Vance et al., 2024) to conduct a semi-structured yarn with each participant, using a one-page yarning guide developed by the research team to capture key topics relevant to decolonising practice, based on findings from the broader project (see Figure 2). We found this enabled participants to gain an overview of the research and focus on aspects relevant to their experience. Researchers initially introduced our yarning approach and encouraged participants to freely voice their views. Researchers also had a set of questions available to use if needed, seeking participant's views about progress on or barriers to decolonisation in the current policy environment, next steps needed to decolonise PHC policy, and how the policy environment affects decolonising service practices. All yarns were conducted by Author 1 or Author 2, either online via Zoom or face-to-face. They generally lasted around 45-60 minutes and were recorded, transcribed into text and deidentified.

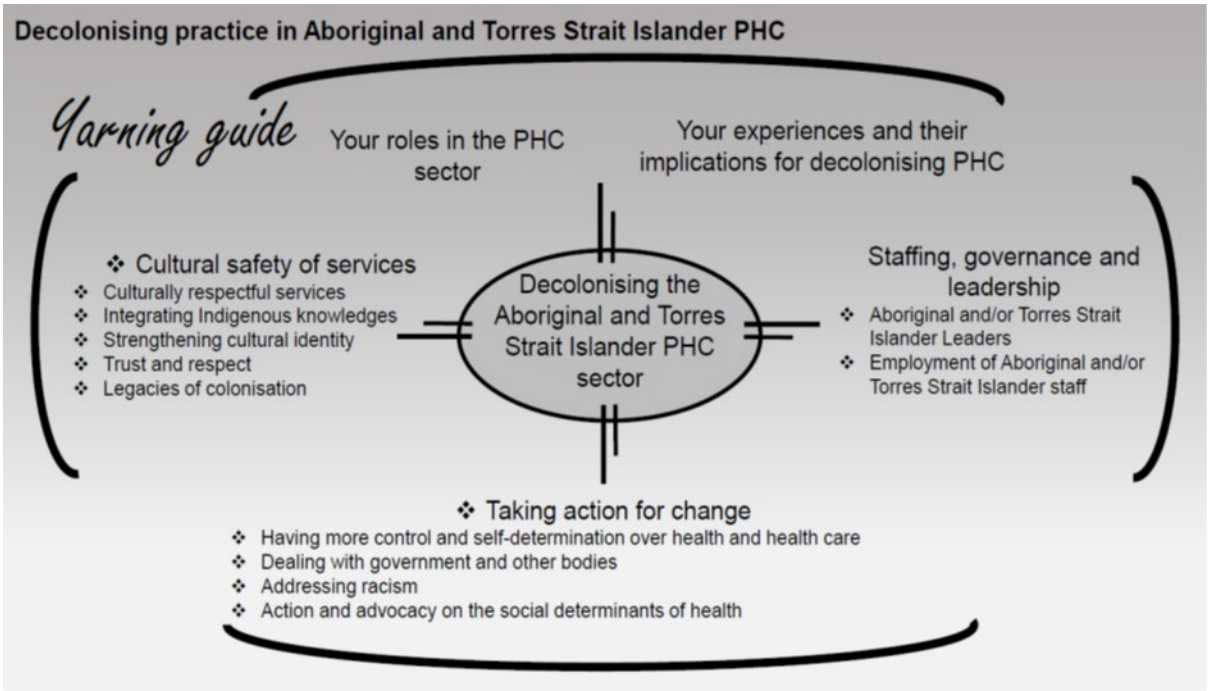

Figure 2. **Yarning guide for data gathering**

We developed a collaborative, team approach to data analysis, prioritising the contribution of Aboriginal researchers. Our approach emphasised both participants' narratives and emerging themes in the data. To analyse data, we first undertook thematic analysis (Clark & Braun, 2017) using NVivo software and a thematic code book reflecting shared team insights on aspects of de/colonisation under main themes of Context & power, Health and wellbeing, Policy facilitators and barriers, Indigenous leadership, and Organisational practices In addition, we read through transcripts as whole narratives, and used deep listening (Bobongie-Harris et al., 2021; Vance et al., 2024) of selected yarn recordings as a team to further understand participants' narratives and context (Durie, 2004). Noting that the code book was designed for use across the whole *Decolonising Practice* project, we then undertook secondary analysis – guided by the data and drawing particularly on coding under 'Policy facilitators and barriers' and 'Indigenous leadership'— to specify themes directly related to the challenge of decolonising Indigenous health policy. These themes form the sub-headings of the Results section to follow.

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Results

Conceptions of decolonisation in health policy

Stakeholder views on decolonising Indigenous PHC policy were consistent with theoretical concepts of decolonisation as a multi-faceted process of political change, standing in critical relation to status quo arrangements. Key elements identified included: strengthening Indigenous leadership; advancing self-determination through the ACCHO sector; recognition of culture as central to Indigenous peoples' health; acknowledgement of and action on SCPDIH; and addressing racism in mainstream health systems:

> Self-determination is decolonisation. (Aboriginal participant, research)

> I think the focus that the health policy nationally – that it's going down that cultural determinants approach … that's how we're going to decolonise these systems. (Aboriginal participant, national workforce NGO)

> We decolonise not because it's a catchphrase of the decade but it's actually about getting the best … outcomes for our people … we know that culture has always been a determinant [of Indigenous health] and we're using our own sense of franchise to say that culture as a determinant is important and has been around and is still with us and hasn't gone. (Aboriginal participant, State/Territory govt)

> I suppose where I've probably seen decolonisation work the most … is in the Aboriginal Community-Controlled Health sector … true decolonisation happens when we have alternative systems, systems that aren't created by non-Indigenous people. (Aboriginal participant, research)

Stakeholders emphasised how decolonisation demands change in racist beliefs and behaviours of non-Indigenous policy actors and health service staff, including ignorance or denial of ongoing colonisation, lack of understanding of SCPDIH, and deficit-based views of Aboriginal and Torres Strait Islander people.

> When you start talking about the effects of colonisation and some of the past policies … people tend to go, "Oh, but that was so long ago and it's not really an issue anymore …" (Non-Indigenous participant, State/Territory health dept.)

> …many of the clinicians, especially in the acute care, have no understanding about the social determinants of health; and without that understanding, I don't think decolonisation process will occur. (Non-Indigenous participant, State-managed PHC service)

> You need to get the [non-Indigenous] people in the room who all work from a deficit point of view, who all think, whether they admit it or not, that Aboriginal families are useless. (Aboriginal participant, ACCHO)

Some participants described the potential psychological effects of colonisation, through undermining Indigenous people's confidence in asserting their own capabilities grounded in culture,

both within community and in organisational settings. Thus, decolonisation includes work to recognise and remediate these effects, which may be intergenerational.

> Probably the most important thing that colonisation does is undermine people's sense of capacity. Right from zero you're told you're not good enough, and that's an ongoing message for Aboriginal and Torres Strait Islander people. (Aboriginal participant, research)

> Sometimes when you're working in the bureaucracy of a large organisation the dominant culture can actually make you … really suppress the skills and attributes that you have as an Aboriginal person to bring to the table. (Aboriginal participant, State/Territory health dept.)

Not all participants applied the concept of 'decolonisation' in their work. Other key terms used included 'self-determination', 'institutional racism', and 'community control'. 'Cultural safety' was seen by some as important for health policy advocacy because it has been adopted by the Australian Health Practitioner Regulation Agency (AHPRA) (Australian Health Practitioner Regulation Agency, 2020) and has currency with policy agencies.

> I don't use that word 'decolonising'; I use the term 'cultural safety' … because the Government has signed off on cultural safety … [it] makes my work a lot easier to talk to people around cultural safety and making services culturally safe. (Aboriginal participant, national workforce NGO)

These various conceptions of decolonisation in Indigenous PHC policy are reflected in sub-sections to follow.

The national health policy environment

Nationally, stakeholders described a policy-making environment that has undergone significant, recent changes favourable to decolonisation, including strengthening Indigenous leadership and a partnership approach in policy development, stronger recognition of culture as central to health, and commitments to preferentially funding and growing the ACCHO sector. Health sector policies were seen as closely aligned with current, national 'Closing the Gap' (CTG) policy settings (The Coalition of Aboriginal and Torres Strait Islander Peak Organisations & Australian Governments, 2019).

> …what's happened with those [policy] plans is there's been a really strong, positive shift. There is a lot stronger recognition of culture and the cultural determinants of health … [that] culture keeps people well. (Non-Indigenous participant, national workforce NGO)

> I've seen more shift at the Commonwealth level of how agencies are starting to think and operate at this in the last probably 18 months than I reckon I have in probably 15 years. (Non-Indigenous participant, national health dept.)

> …there's good language that's come out of the Closing the Gap priority reforms… if there is funding for program areas, it needs to go to an Aboriginal community-controlled organisation. (Aboriginal participant, State/Territory peak body)

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In the States/Territories, the picture for decolonising changes in health policy was more varied, but one decolonising aspect identified was support for development of new ACCHOs, including by transitioning existing State-managed Indigenous PHC services. Community consultation and participation in these processes were seen to be essential:

> And that was an exciting process … because in the Aboriginal Health community development initiative was that [ACCHO] got established in [town] and [ACCHO] in [town], and that process of community development was established. (Aboriginal participant, State/Territory health dept.)

> [We've had] four services go over to community-controlled. We're just about to commence transferring three in [region] and we've got three more to do in [region]. It's working well. (Non-Indigenous participant, State/Territory health dept.)

However, while stakeholders welcomed decolonising changes in policy development, they also identified persistent problems in national and State/Territory *policy implementation*; especially in relation to conventional structures and practices of funding and regulating Indigenous PHC services (Fisher et al., 2021; O'Donnell, 2015) including overly prescriptive or insecure funding, excessive reporting demands, and one-size-fits-all programs not meeting local needs:

> …what I've seen happen to the sector…you say yes to opportunities…and you end up being able to take money from government so you can employ Aboriginal people but it's actually not you as a service needing that particular [program]. (Aboriginal participant, research)

> …government might say, "Oh, okay. We have this much money for Aboriginal programs and Aboriginal affairs," but actually it's money which is coming to us with all these strict restrictions to it and we then have to do so much reporting on that money that it becomes a real burden. (Aboriginal participant, State/Territory peak body)

> … something that government departments miss completely is that impact in having to have short-term funding; a revolving door of staff potentially, and not investing in things that work. (Aboriginal participant, ACCHO)

This problematic 'space' between decolonised policy development and not-so-decolonised implementation was also mentioned in relation to action on SCPDIH:

> Certainly, the social determinants of health are well reflected in [national policy], although, I think that's still an area that doesn't translate well into action. (Non-Indigenous participant, national workforce NGO)

On the funding issues, while one might suppose that State-managed services – being part of mainstream health systems—would enjoy relatively secure funding streams, in fact participants from such services described significant problems with insecure funding, and restrictions of operating under a biomedical model:

> …unfortunately, our resources are periodic and insecure … 80% of our staff, including the Aboriginal Health Practitioners, are actually on contracts … we lose the experience and the

> knowledge of staff who feel very threatened by it and leave. (Non-Indigenous participant, State-managed PHC service)

> So, we are in a bind all the time … Because the model of care we sit under … is very much a mainstream service. So, the model doesn't fit the people's need. (Non-Indigenous participant, State-managed PHC service)

These characteristics of funding and regulation were not only seen as operationally difficult, but also as colonising: positioning government agencies as 'having' to prescriptively control 'untrustworthy' services, or constituting a form of institutional ignorance about the on-the-ground effects of policy decisions or the nature of an Aboriginal approach to PHC (O'Donnell, 2015):

> Actually, the research is there, we know what we're doing … But then there's all that level of institutional racism about ACCHOs, about how useless we all are, and how we need so much capacity building. (Aboriginal participant, ACCHO)

> [The next step in decolonising is] probably block funding where the sector can really truly self-determine what programs they want to run, when they become truly sovereign over their data and for their planning. (Aboriginal participant, research)

> …in terms of this whole project around decolonising practices … what was seen as unorthodox stuff in Aboriginal programs and services is now seen as best practice … but the system, the dominant culture, would never give credit to Aboriginal people and Aboriginal ways of doing stuff. (Aboriginal participant, State/Territory health dept.)

However, data from a national health agency participant indicated some attempts to respond to criticisms of ACCHO funding and regulatory practices:

> …what we're trying to do is increase the amount of core funding that goes into [ACCHO] organisations now, which is pretty flexible … [and] trying to give them more longer-term certainty around the funding …[with] rolling four-year funding agreements. (Non-Indigenous participant, national health dept.)

This person also noted that NACCHO has now been assigned responsibility to allocate some lines of national funding directed toward ACCHOs. However, in general, responses from government participants still indicated attachment to a policy logic of top-down performance management rather than alternative (and potentially more decolonising) approaches such as devolved governance, co-design, and block funding (Fisher et al., 2021; Hill & Hupe, 2009). For example:

> …it is taxpayers' [money], so you need some sense of transparency, accountability for it because otherwise you do run the risks of people doing things, and they do, but you also want some clarity about what actually is the purpose of it and what gets done. (Non-Indigenous participant, national health dept.)

Finally, one senior national health agency participant argued that the growing momentum of Indigenous leadership in national policymaking might lead over time to establishment of a new Indigenous-led health funding body. As he asked:

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> …if you think of it from a decolonisation point of view …what's the ultimate synthesis of this [expanding Indigenous leadership]and what does it look like? (Non-Indigenous participant, national health dept.)

Whether or not this occurs, Indigenous policy leadership nationally will continue to face the tensions between central control of funding and regulation, versus the autonomy and localised flexibility demanded by services.

Indigenous and non-Indigenous leadership in policy and practice

Stakeholders identified assertive Indigenous leadership as a key factor driving decolonising change in Indigenous health and CTG policies, as discussed above.

> I think what is really different is the Aboriginal leaders coming around the government with a different layer of expectation … [which] has dragged government in a very different direction (non-Indigenous participant, national health dept.)

> [We] refreshed the National Aboriginal and Torres Strait Health Plan … [and] the Workforce Plan …. both of those were Aboriginal and Torres Strait Islander led … So, I actually think that's kind of revolutionary. (Non-Indigenous participant, national health dept.)

> …the [CTG] priority reform areas … they were developed … by Aboriginal people for Aboriginal people. So, it wasn't really the Government; we got their support with it, but it wasn't developed by Government. (Aboriginal participant, national workforce NGO)

Indigenous-led, publicly funded health sector NGOs, were seen by both Indigenous and non-Indigenous participants to provide an important 'infrastructure' for the decolonising role of Indigenous leadership:

> All of us workforce peaks have runs on the board, they're looking at another four years [funding]. So, they're seeing return on their investment … the bureaucrats, they've twigged on to that. (Aboriginal participant, national workforce NGO)

> NACCHO who do a lot of work in that advocacy space nationally … so that's a really effective model. And we have … a good policy network which extends to every jurisdiction across the country. (Aboriginal participant, State/Territory peak body)

Stakeholders also emphasised the potential importance of Indigenous or non-Indigenous leaders to 'champion' decolonising approaches within mainstream services and lead change in staff attitudes and practices:

> Some of the things that I've seen happen really well … is when there is a leader in place that really does want to make a difference and is real brave and courageous and steps out and understands what racism is and they have the zero tolerance towards it. (Aboriginal participant, research)

Indigenous leadership, including in governance and management, was also seen as a key component of decolonising practice in Indigenous PHC:

> Decolonising practices in primary health care for Aboriginal and Torres Strait Islander health … is actually about having Aboriginal governance, Aboriginal leadership and Aboriginal management in place, the philosophies but also the product itself. (Aboriginal participant, State/Territory health dept.)

Several senior and experienced Aboriginal participants also described an ongoing necessity to lead by disrupting and challenging individual or institutional attitudes and assumptions within government agencies about what is happening, what is possible, funding constraints, and what communities need:

> We're a frontline service, we see around 130 clients a day … we've got strong connections. And I'm a fighter, and I won't sell us out … I guess there's a lot of respect for what I do. And I'm saying what a lot of other people can't. (Aboriginal participant, ACCHO)

> I was never shy of rebutting a lot of things in government, and I believe that's because I was mentored by some deadly fellas who were never shy of being frank and fearless … leading with Aboriginal identity, in everything that they did, unashamedly. (Aboriginal participant, State/Territory health dept.)

> So, pushing back on that [funding constraint] all the time too … So [program name] a really good example, I think, of decolonising practice. And even now … Aboriginal people in the Department, and non-Aboriginal people [are] saying, 'Oh yeah, but you'll only get 12 months of funding.' … 'Bullshit,' I said, 'There's no way we're going to stand for that.' (Aboriginal participant, ACCHO)

Finally, despite positive aspects of leadership noted above, one participant described a lack of Indigenous leadership at higher levels within health departments:

> There are certain levels… where the majority of Aboriginal and Torres Strait Islander staff members tend to be recorded, and then the numbers drop off … we talk a lot about Aboriginal health being core business. But more often than not, at a certain level, the conversations don't include Aboriginal people. (Aboriginal participant, national health dept.)

The growing influence of Indigenous leadership and NGOs in PHC policy is a positive example of decolonising practice which could be emulated in other policy sectors.

Decolonisation in health services

Stakeholders consistently described the growth of the ACCHO sector over decades as decolonisation in action, highlighting Indigenous leadership, provision of holistic, culturally safe, and accessible care, and acting as a political response to racism, biomedicalism, status hierarchies and other access barriers in mainstream health systems:

> I always think about how the [community-controlled] sector got started. It was from the self-determination of the people that come before us … looking at how the mainstream health services weren't meeting the needs of Aboriginal and Torres Strait Islander people, but also how it was ingrained in racism. (Aboriginal participant, State/Territory peak body)

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> …the concept of decolonisation itself … is intrinsically political … [and] frames history in a certain way, and it frames all the work and the struggle and the resistance that is … part of creating the community controlled primary healthcare services and movements. (Aboriginal participant, national health dept.)

> …we see whole people; we don't do body parts. And so, it is that social, emotional, spiritual, cultural, and physical wellbeing. So, it's not just about doctors and nurses. (Aboriginal participant, ACCHO)

However, as an extension of these views, several participants argued that, as Indigenous PHC services necessarily interact with mainstream services, further progress on decolonisation demands change in mainstream health systems:

> [The ACCCHO sector] might be really good at those decolonising practices, however, we need to think about it when we're working with our [mainstream] partners … because they're the ones that don't understand these factors. (Aboriginal participant, State/Territory peak body)

> … we can privilege Aboriginal and Torres Strait Islander ways of knowing, being and doing in how we work. But we are also obviously operating within mainstream settings and systems … That's where I think the decolonising approach is really, really important. (Non-Indigenous participant, national workforce NGO)

Consistent with other literature (Kelaher et al., 2014), the challenge of decolonisation in the mainstream health system was primarily seen as one of addressing on-going racism and increasing cultural safety in interpersonal behaviours, service practices and system structures.

> We had a document launched …[recently] that looked at the public health system and rated us on our institutional racism level, and all our sites got really low [scores]. (Aboriginal participant, State/Territory health dept.)

> Bottom line: along with a cultural safety approach, we have to get rid of racism in health. That's just got to be abolished. (Aboriginal participant, research)

Participants also offered insights into how racism manifests in mainstream services, highlighting deficit-based, racist and/or 'blaming' and stigmatising views of Indigenous service users, and rigid biomedical systems blind to context and an equity perspective:

> Most surgeons …[have] been educated on a very core level of, "… Aboriginal people have contributed to their own health issues and so they don't deserve my service." (Aboriginal participant, research)

> And that's what happens with a biomedical model. They come in, "Oh, you're at risk because you're an Aboriginal person" … So, straightaway … they enter with that deficit discourse. (Aboriginal participant, research)

> … when they enter a unit, they're already judged by their colour, by their Aboriginality. … So, the prejudice is there. (Non-Indigenous participant, State-managed service)

> So, equity and equality are really not understood … we still have [Indigenous] clients that if they did not attend [a service] three times, are actually deleted from the list … we will still get the answer, well this is a rule for everyone. (Non-Indigenous participant, State-managed service)

> I think there needs to be more focus on the systems, the institutions that allow racism to happen. (Aboriginal participant, national workforce NGO)

However, some participants described modest progress in increased willingness of health system leaders and professionals to name and tackle racism explicitly as a problem. Notwithstanding the responsibilities of health system leaders in this regard, several participants also highlighted potential for decolonising practice through development of relationships between ACCHOs and mainstream services at a local or regional level:

> What I know is happening at [ACCHO name] is that they are connecting with the other sectors … That's where our people die in those health settings … they're showing this is about building a relationship. (Aboriginal participant, research)

> There was some interesting work done in [place name] about having the local ACCHO involved more with the mainstream public health services … That was about a different kind of relationship. (Non-Indigenous participant, research)

However, funding structures may not support such engagement as a recognised and valued part of ACCHO activity. There may also be significant scope for skill sharing between ACCHOs in this area of practice.

Decolonising the Aboriginal and Torres Strait Islander PHC workforce

Participants described growth and development of the Indigenous PHC workforce, including doctors, nurses, allied health providers, Aboriginal Health Practitioners (AHPs), Aboriginal Health Workers (AHWs), and Ngangkari (traditional healers) as crucial to further decolonising policy and service practice, both in mainstream and Indigenous-specific services:

> No matter who we talk to or what we talk about, workforce is the biggest thing that needs to be focused on right now. (Aboriginal participant, national health dept.)

> Seeing an Aboriginal and Torres Strait Islander health worker or practitioner as your first point of clinical call within the service really does go a long way to decolonising practices. (Aboriginal participant, national workforce NGO)

> …[we're] trying to build the Aboriginal and Torres Strait Islander allied health workforce. I think we see that as being a real underpinning to decolonisation. (Non-Indigenous participant, national workforce NGO)

Indigenous leadership in development of national Indigenous health workforce policy, AHPRA's recognition of AHPs as a designated health profession, and wider system recognition of the role of AHPs and AHWs were seen as significant gains in decolonising PHC workforce policy:

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> Aboriginal and Torres Strait Islander health workers and … health practitioners. So, … they're a profession in their own right; they're not doctors, nurses, allied health. (Aboriginal participant, national workforce NGO)

> Aboriginal and Torres Strait Islander workforce peaks along with NACCHO were heavily involved in the development of this [workforce] plan. (Aboriginal participant, national workforce NGO)

However, participants also described failures by health systems and services, and models of care, to understand or properly value the role of Indigenous staff, including AHPs and AHWs. While Indigenous PHC services and communities see Indigenous staff as central, this is not always reflected in mainstream structures:

> Aboriginal staff here are the backbone of the service … doctors and nurses … [they] get big funding. But our mob tend to get left behind in that because no one really values Aboriginality. … Because of the low rates of pay, [AHWs are] the working poor, and the work that they do is invaluable. (Aboriginal participant, ACCHO)

> …in a lot of mainstream health environments, they don't understand the role of … Aboriginal and Torres Strait Islander health workers and practitioners. (Aboriginal participant, national workforce NGO)

> … we have a lot more work to do around retention and supporting [Indigenous] staff … particularly our Health Practitioners to feel that they are valued as a clinical team member and able to then practice to the full scope of their training. (Non-Indigenous participant, State/Territory health dept.)

Participants described the value that Indigenous staff bring to health services and communities in terms of outreach, connection to community, healing practices, addressing social determinants, and cultural understanding, and failure of government agencies or mainstream services to appreciate these practices:

> Our profession … we go into the homes; we take the services out. … a lot of our mob don't have a vehicle; they might have three kids at home; they can't afford to come into a GP practice. (Aboriginal participant, national workforce NGO)

> If you're Aboriginal, you're connected to the community, then I want you. Everything else can come after that, your cert four or whatever. (Aboriginal participant, ACCHO)

> We need staff at all levels. … We're using culture. We're using language and culture for part of that healing. And social and emotional wellbeing is a big part. It's hard to explain that to government. (Aboriginal participant, State/Territory peak body)

> When we think about our mobs that are needing healing, we need to go back to some of the things that are just fundamentally … who we are as Aboriginal people. Those traditional practices are very relevant today. (Aboriginal participant, State/Territory health dept.)

Participants working in the ACCHO sector described having to rely on non-Indigenous staff, sometimes over relatively short periods of employment, due to a lack of trained Indigenous staff, especially doctors and nurses. While non-Indigenous staff can contribute effectively to a decolonised service, they can also bring colonising attitudes into services such as a biomedical and hierarchical view of health care, ignorance about colonial history, or a lack of understanding of culturally safe practice:

> …it's a bit frustrating because we do have to employ non-Aboriginal people. A lot of them have got no understanding of the history of this country. (Aboriginal participant, ACCHO)

> …how that translates from strategic policy into an operational setting where people are like, 'I'm busy saving lives, and this [addressing racism, cultural safety] is important but it's not so important, because I'm following clinical guidelines and saving people's lives. (Aboriginal participant, national health dept.)

> We've got staff who haven't been there for very long and therefore also have no relationship with the community … that seems to be a really big factor in whether you have a culturally safe service. (Non-Indigenous participant, State/Territory health dept.)

> … nurses have got to get over thinking they're the answer … And that's what the biomedical model says, "Oh no, you're number 1". They say that about nurses, they say that about surgeons, they say that about GPs, and that's where we have a problem. (Aboriginal participant, research)

Stakeholders raised the role of the Vocational and Educational Training (VET) and university health courses in workforce development. One participant noted a basic lack of parity in the numbers of Indigenous graduates:

> …if you put a target for 4 percent to get [Indigenous] people at that qualification, we have to be pushing out of universities, 4 percent [of all graduates being Aboriginal or Torres Strait Islander]. Our universities don't even put out 1 percent across all the fields of health services. (Aboriginal participant, State/Territory health dept.)

To improve this situation, participants noted requirements on provider institutions to include cultural safety in health course curricula. However, our findings indicated that Indigenous students face barriers to completion along the whole training and placement pathway. For example:

> And for clinical placements, especially if you talk about doctors, nurses, Allied Health, they're mainstream clinical placements. So, if you get put in a space that's [culturally] unsafe from a worker point of view … You just don't succeed. (Aboriginal participant, State/Territory health dept.)

Examples of successes included cohorts of Indigenous students studying together and Indigenous student-only training courses, with supports in place:

> … where you see cohorts of Aboriginal and Torres Strait Islander people going into the profession or into university that's where you will find retention as well. (Aboriginal participant, research)

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> … our academy program, I think mainstream education could learn a lot from that. We do a lot to support people to have access to transport … or meals if they need it … We see students that will have perfect attendance. (Non-Indigenous participant, national workforce NGO)

However, another participant described the gradual loss of Indigenous Registered Training Organisations (RTOs) due to a funding model requiring students to be charged fees:

> Our Aboriginal Community-Controlled RTOs are becoming less and less because they're not funded [appropriately]. We don't charge our students for the training they do, so it's really hard for us to keep the doors open. (Aboriginal participant, research)

While there has been significant growth in the numbers of Indigenous Australians employed in health-sector roles over the last 10 years, further, long-term growth is seen as essential (Australian Institute of Health and Welfare, 2024). Decolonising policies and practices in workforce development pathways may help to achieve that goal.

Holistic care and action across policy sectors

Participants consistently described the way Indigenous PHC services work to deliver a holistic, cultural, and person-centred comprehensive model of PHC (CPHC), using teams with multiple skills and attributes to give attention not only to medical needs (under the Medicare funding model) but to service users' wider health needs and life circumstances.

> …it's a comprehensive model of primary healthcare, so it's … not just having a GP there to address an immediate need … you can look at social and emotional wellbeing. You can look at other factors – family life … employment, housing. (Aboriginal participant, State/Territory peak body)

> … when people go to a medical service … particularly when we're talking about mental health, it is something that could be related to finances, or … a legal issue … this holistic approach that we're talking about involves all of that. (Aboriginal participant, national health dept.)

However, commitment to this CPHC approach also means services inevitably confront and attempt to offer their service users support for life issues affected by policy in other policy sectors. Justice and Corrections, Child Protection, and Housing were most commonly mentioned (and all are the subject of targets in the current CTG agreement) (Coalition of Peaks & Australian Governments, 2023). Participants described several ways PHC services attempt to deal with these issues; by seeking additional funding, using unfunded strategies delivered by volunteers or service staff, or through referrals to other services:

> …when we do holistic health … [which] also brings child protection, probation, and parole. … this week, parole's coming to [our service]. So, the mob can come in. And there's a criminal lawyer here … so if they've breached their parole, they can get that [addressed]. (Aboriginal participant, ACCHO)

> … whatever might bring [a person] into that [PHC] service, doesn't mean that we just turn them away … because it's not a health thing. They will try and have those wraparound services or know where those wraparound services are to make sure that they're getting the assistance that they need. (Aboriginal participant, national health dept.)

Several participants made clear that the often inequitable and harmful effects of policies in 'non-health' sectors on Indigenous people are understood as contemporary features of on-going colonisation. For example:

> …have a look at Child Protection, that system was not established for white people, it was established for black people and our children being taken away, that's inherent in that system and you see the outcomes of it. (Aboriginal participant, research)

We will consider what this means for future policy in the next section and in our Discussion.

Social and cultural determinants of Indigenous peoples' health

All participants recognised a need for action on SCPDIH, and most interpreted this in terms of decolonising action across policy sectors as discussed above:

> … decolonisation from an ACCHO perspective means more than just providing education to the broader determinants of health, so it's not just the health sector; it's housing, it's corrections, it's the justice mob who steal our kids. (Aboriginal participant, research)

> I know every service wants to do more …[on] social determinants … You've got all the work in those other areas around education, justice, housing, employment … These are the things which actually shape your health. (Aboriginal participant, State/Territory peak body)

However, participants working within State/Territory governments (which control key policy areas such as Justice and Corrections, Child Protection, and Social Housing) noted several challenges to motivating intersectoral action on SCPDIH in practice between government agencies:

> … when we have more equal representation around the table when it comes to leadership and decision-makers, I think that that may potentially be when we get more traction around … the social and cultural determinants of health. (Aboriginal participant, State/Territory health dept.)

> … more often than not when we talk about social determinants all the agencies automatically assume that's a Health portfolio issue. (Aboriginal participant, State/Territory health dept.)

> We definitely do need to get more mature [with intersectoral policy], similar to what South Australia have done with their Health in All Policies Program. (Non-Indigenous participant, State/Territory health dept.)

Others spoke more about ways to address determinants within communities through a CPHC approach to care and recognition of culture as a determinant of positive health and wellbeing:

> While we need systemic changes … in policy … there are just some things at an individual, family and community level that is about connecting with the traditional values, the

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> traditional philosophies, the traditional practices that are absolutely relevant today. (Aboriginal participant, State/Territory health dept.)

Others spoke of a need for greater control of data within the community-controlled sector, to identify determinants affecting communities at a local or regional scale, and the need for action on SCPDIH within workforce training:

> … we can't tell community social determinants of health, based on the data that we collect. … if we had a mechanism … where we can have a community dashboard around social determinants … then we can advocate to Government and say, 'We have the data here'. (Aboriginal participant, State/Territory peak body)

> I think what has always worked well … are scholarships, as in disabling barriers that are part of the social determinants, so housing scholarships, [or] employment during a traineeship … if you address those social determinants absolutely someone's more likely to enter into study and enter the workforce. But then the other bit is retaining them and that absolutely has to do with those cultural determinants … [when] the system's not culturally safe. (Aboriginal participant, research)

Ultimately, addressing SCPDIH will be difficult to achieve without decolonisation in the broader Australian policy environment, beyond the Health sector.

Discussion

This research has sought to understand key stakeholder's perspectives on decolonising policy, in a sector where policy and practice has already been decolonised to some extent. Our research shows that decolonisation is a valuable concept and approach to bring about policy change because it defines an agenda consistent with key stakeholders' perspectives on the social, cultural, and political nature of problems to be addressed and solutions needed. It places responsibility on non-Indigenous policy systems, services, and actors to undergo change in their own assumptions and practices.

Our findings indicate that national governance of Indigenous PHC policy demonstrates decolonising practice by partnering with Indigenous leadership in policy and workforce development and funding the ACCHO sector (Fisher et al., 2018; Panaretto et al., 2014). State & Territory health agencies contribute to decolonisation when their policies support State-managed, Indigenous PHC services providing culturally safe care (Hayman et al., 2009), growth in the ACCHO sector and the Indigenous health workforce, and reduced racism in mainstream services (Durey et al., 2012).

However, there is considerable scope and need for further improvement. Priorities for further decolonisation include further reform in national structures of funding and regulating the ACCHO sector, to move away from a model of top-down 'performance management' (Germov, 2005; Hill & Hupe, 2009), fragmented funding and excessively prescriptive regulation, toward structures allowing for funding certainty and greater localised control in how funds are applied to meet local needs (Fisher et al., 2021). A principle of reciprocal or mutual accountability (Dwyer et al., 2011; O'Donnell, 2015) could be applied as a means to build trust and strengthen partnerships between government and ACCHOs. To achieve this change, policy actors would benefit from more direct contact with services to better understand the CPHC model of care in Indigenous health and the

additional roles it requires, including to act as representative organisations of the oldest surviving culture in the world (O'Donnell, 2015).

Our research affirms the crucial leadership role Indigenous health sector NGOs have played in driving decolonising changes in health and CTG policies (Fisher et al., 2018; Fisher et al., 2021). However, there is still a need for increased Indigenous leadership at higher levels within health agency bureaucracies with license to challenge norms and drive innovation. Equally, leaders working within Indigenous PHC services have a crucial role to *push back* where necessary against policy decisions or practices that are onerous on services or fail to meet community needs.

Decolonisation in Indigenous PHC demands concomitant action in mainstream services, with a particular focus on disrupting the multifaceted ways that racism shapes practices and policies. Our research supports the existing evidence that multiple strategies will be required, extending well beyond cultural awareness training. These include: building on AHPRA's endorsement of cultural safety (Australian Health Practitioner Regulation Agency, 2020); increasing leaders' and staff understanding of SCPDIH and the way these affect service access; strengthening recognition of AHPs and AHWs; and local-level engagement with ACCHOs or other Indigenous PHC services and community members (Durey et al., 2016). However, while cultural safety has value as a tool to address power inequalities and racism in healthcare services (Browne, 2023), we see decolonisation in Indigenous PHC policy as a broader concept extending into policy and governance changes within and beyond the health sector.

Building the Indigenous health workforce is essential to decolonisation and needs far more than a focus on recruitment. Rather, Indigenous workforce peak bodies should lead strategies to address SCPDIH affecting Indigenous students along the whole training pathway, and to improve cultural safety of mainstream placements. Indigenous-led RTOs should be funded to provide free services.

Decolonising Indigenous PHC policy and practice, and improving health and wellbeing outcomes, cannot be achieved without systemic changes in SCPDIH affected by policy in other sectors. The accumulated knowledge and achievements of the Indigenous PHC sector suggest that, while immediate measures are urgently needed, longer-term decolonisation in sectors such as Justice and Corrections, Child Protection, Education and Social Housing will require Indigenous representation, policy leadership and workforce development, coupled with an increased role for community-controlled services or programs. State and Territory Cabinets need to provide leadership and an authorising environment for this work. In this way, the Indigenous PHC sector should be seen as a model of decolonised practice for long-term change in other sectors.

International relevance

PHC has been a venue for theory and action to decolonise Indigenous health care and address health inequities between Indigenous and non-Indigenous peoples in a number of colonised countries (Anderson et al., 2016; Came et al., 2021; Ramsden, 2002). While the context and challenges of decolonisation in health policy differ between countries (Sium et al., 2012), findings from this research may offer shared learnings on the key role community-controlled PHC services working collectively can play in this process, and the contemporary challenges they may nevertheless face in a wealthy settler-colonial society such as Australia. In particular, the Australian experience speaks to a potential for structures and processes of Indigenous leadership in decolonising PHC policy to

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provide a model for change in other policy sectors. A process such as Australia's Closing the Gap framework can be a vehicle for driving such multi-sectoral action, provided Indigenous leadership is to the fore (Coalition of Aboriginal and Torres Strait Islander Peak Organisations & Council of Australian Governments, 2019).

Conclusion

The unsuccessful referendum on constitutional recognition of Australia's First Nations peoples is now also part of the Australian context. It may speak to similar experiences in other jurisdictions where effective work to decolonise specific areas of policy is nevertheless held back by inertia (and resistance) in basic colonialist structures—including federalism in Australia's case—and their inbuilt inequalities in power (Sanders, 2021). These structures embody basic Indigenous rights 'issues' of sovereignty, self-determination and land for which decolonisation demands a reckoning (Maddison, 2022; United Nations, 2008). This was very much the understanding underpinning the Uluru Statement from the Heart (National Constitutional Convention, 2017), on which the Australian referendum was based. Current State-level treaty-making processes may address these structural issues to some extent. However, in the face of institutional inertia, more 'bottom-up' processes of decolonisation (George et al., 2019) such as described in this paper can nevertheless drive important forms of decolonised health policy to address Indigenous health inequities and contribute to aims of self-determination and nation-building (Eni et al., 2021; Rigney et al., 2022).

This paper suggests some ways to develop a new approach to public administration of First Nations affairs in the post-referendum period. As is widely recognised, working in partnership with Indigenous leaders, organisations, and communities is the essential foundation. However, genuine partnerships are still the exception rather than the rule (Productivity Commission, 2024). Our research indicates that decolonisation is an important concept for defining the necessary pathway, and that the Indigenous PHC sector offers a model of decolonising practice, which can be further improved and extended in public policy and programs.

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