Critical Indigenist Examination of the Impact on the Efficiency and Sustainability of Quality Management Systems in Aboriginal Primary Health Care

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Statement on the Contribution of Others

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Declaration on Ethics

The research presented and reported in this thesis was conducted from a First Nations worldview within the principles and parameters of our Indigenist ways of knowing, being and doing, wherein our cultural currency is relationality, respect, and reciprocity. The research was further supported within the academy guidelines for research ethics outlined in the AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research (2020). James Cook University, as of 1 January 2024, applies the National Statement on Ethical Conduct of Human Research 2023.

The proposed research methodology received clearance from the James Cook University Ethics Review Committee with the assigned ethics approval number H 7865. Every reasonable attempt has been made to gain permission from and to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

13/06/2024

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Ms Jenifer Olive Darr Date

Abstract

Research title. Critical Indigenist Examination of the Impact on Efficiency and Sustainability of Quality Management Systems in Aboriginal Primary Health Care.

Background. Two streams of business are primarily responsible for providing primary health care (PHC) at the first tier of the Australian health industry. These are general practice health services and Aboriginal community-controlled organisations (ACCOs). In 2008, the Australian federal government legislated a national framework for the Australian healthcare industry. In 2010, the Aboriginal community-controlled health sector (ACCHS) was mandated to apply a second certification standard known as ISO 9001:2015 to their business. Over the ensuing decade, our research explored the types of quality frameworks in practice and learned that general practice health services apply one accreditation standard: the Royal Australian College of General Practice (RACGP) Standard. Conversely, the ACCHS applies up to 11 mandated, multiple, yet different accreditation standards. There is an underlying assumption that quality management system (QMS) improves ACCO service performance, and this research tests this assumption.

Aims and objectives. This study explores the impact of implementing QMS on efficiency and sustainability for the ACCOs. The objectives were to:

- Define what the terms efficiency and sustainability mean in the PHC context, specifically for ACCOs.
- Explore the experiences of one remote ACCO undergoing its first accreditation and the problems encountered in the process.
- Examine the experiences of staff working in the ACCO accreditation space—including ACCO staff, accreditation experts and accreditation industry staff.
- Create recommendations for industry changes to address needs unique to the ACCO sector.

Method. This study takes a critical Indigenist approach to a qualitative analysis of the phenomenon of accreditation in ACCO services. Using Brayboy's (2006) TribalCrit theory, the study utilised yarning circles and storytelling alongside literature reviews, interviews and personal professional reflections to weave a story about the current state of accreditation experiences in ACCO spaces.

Results. There are three overarching concepts in the data: Knowledge, Power and Ownership. Within the yarning circles [focus groups and interviews] represented were five major themes exploring the environment of participant experiences with accreditation processes, exposing the pain points participants laboured over. The investigation of

Knowledge, Power, Ownership, as they pertain to the contract between the ACCOs and the certification body and their assessors, raises questions on the validity, purpose and benefit of Australian industry-designed accreditation standards.

Conclusion. Currently, Australian accreditation standards are not holistic in design, as represented by their critical cultural deafness, disproportionately affecting ACCO service providers. The prescriptive nature of these standard indicators/criteria inhibits continuous quality-improvement measures inherent in an iterative 'plan, do, study, act' cycle. Additionally, these prescriptive standards disable a system development in the company or program area of a business. This research labels Australian accreditation standards as colonial constructs. Colonial constructs are identified as measures of quality and safety designed by external entities without the expressed consideration of Aboriginal and Torres Strait Islander history, heritage and being in our Country and how holistic health and wellbeing are viewed and practised. This definition is premised on First Nations sovereignty.

For over 14 years, the ACCO sector has carried this heavy burden without complaint or cogent evidence. Quality improvement is one pillar of clinical governance, a framework ACCOs have operated for over half a century, informing their innovative client models of care and a dynamic contribution to the Australian primary healthcare tier. The efficiency and sustainability in applying multiple, disparate, and mandated accreditation standards for ACCOs is not viable and is not fit-for-purpose. The accreditation standard owners' enforced practice of multiple frameworks towards ACCOs can only be viewed as discriminatory, with racism as the root cause.

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Abbreviations

Acronym	Name
ABCD	Audit for best practice chronic disease clinical audit tool
ABCDE	Audit and best practice for chronic disease expansion project clinical audit tool
ACCHSs	Aboriginal Community-Controlled Health Services
ACCOs	Aboriginal Community-Controlled Organisations
ACCREDIT	Accreditation Collaborative for the Conduct of Research, Evaluation and Designated Investigations through Teamwork project
ACSPRI	Australian Consortium for Social and Political Research Incorporated
ADF	Australian Defence Force
AHS	Aboriginal Health Service
AGPAL	Australian General Practice Limited
AMS	Aboriginal Medical Service
BIRC	Building Indigenous Research Capacity
CB	Certification Body
CBPR	Community-Based Participatory Research
CEO	Chief Executive Officer
Chellie's	Grandmothers
COVID 19	Coronavirus 19
CQI	Continuous Quality Improvement
CRT	Critical Race Theory
DNA	DeoxyriboNucleic Acid
GPA+	General Practice Accreditation plus
GP	General Practice[s]
HREC	Human Research Ethics Committee
HSQF	Human Services Quality Framework
ISO	International Organization for Standardization
JASANZ	Joint Accreditation System of Australia and New Zealand
JCU	James Cook University
KASC	Kowanyama Aboriginal Shire Council
KPIs	Key Performance Indicator[s]
NACCHO	National Aboriginal Community-Controlled Health Organisation
NSQHS	National Safety and Quality Health Standard
NATSIFAC	National Aboriginal and Torres Strait Islander Flexible Aged Care standard

NDIS	National Disability Insurance Scheme
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand
PAR	Participatory Action Research
PDSA	Plan, Do, Study, Act cycle
PIP	Practice incentive payments
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analysis
PHC	Primary Health Care
QI	Quality Improvement
QIC	Quality Improvement Council
QLD	Queensland
QMS	Quality Management System
RACGP	Royal Australian College of General Practice standard
SA	South Australia
SIP	Service incentive payments
TribalCrit	Tribal Critical Race Theory
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
VIC	Victoria

Dedication

Author unknown. Stock images, Microsoft.

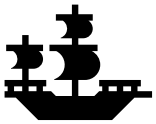
All honour and Glory to Elohim for His being in my life.

This thesis is dedicated to my parents—I thank God for you, your faithfulness and love.

I honour all my elders who went before me.

Listen as Wisdom calls out! Hear as understanding raises her voice! Proverbs 8: 1. Wisdom is Sapience. Sagacity is the ability to think and act using knowledge, experience, understanding, common sense and insight. To produce, unbiased judgement, compassion, experiential self-knowledge. Through non-attachment, ethics and generosity. [Credit: TD Jakes Entrepreneur]

Our Story of Change



Preamble

Standpoint

My spirituality and religious beliefs are core to who I am as a Yuwi Vanuatu woman. My spirituality and religious beliefs, as expressed in this thesis, are my basic human rights—both of which are considered an evolving expression of the dynamism of our culture and history as a First Nation family in this academic milieu. I am because of all who went before me, and I am their representative.

My spirituality and religious beliefs as a human right cannot be called into question or elaborated upon—they purely are! These affirmations speak to who I am in this story of change and becoming from my Christian faith and my heritage. 'My distinction is the key to my success, significance and prosperity. I am an epic creation of God Almighty, and no one else can do what I am ordained to do. My distinction will work for me, not against me. I was born to stand out and shine bright, and I will not shrink to fit in; I am unapologetic! My uniqueness is significant and vital to the world around me and the Kingdom'.[1]

Dedication

This thesis is committed to Elohim, who is the centre of my life, for without Him, I am nothing. I am grateful for the guidance, love and nurturing of my devoted parents—Percival Vincent Darr and Olive Eva Darr—who generously sowed goodness and Christian values into me during my formative years to establish me in my latter years. It is upon their shoulders and all who went before them I stand. My parents are and remain trailblazers and pioneers in the faith who left a lasting legacy for the community they raised us in: Ayr, Queensland, Australia. I honour and thank my parents and other family in the Burdekin for their moral and social justice compass. Their Christian beliefs and prevailing social justice positions established the largest real estate company in the Burdekin to meet a housing crisis for the Aboriginal and Torres Strait Islander community. Their legacy is Bur-Del Cooperative Advancement Society; 49 years after they established it, this legacy still operates today. Their ceiling is the floor on

[1] Source: Author Toure' Roberts (2014) from the book *Purpose Awakening*.

which we build. To God be the Glory for serendipitously orchestrating the processes of this philosophical doctorate.

In identifying this, my heart posture in this PhD carries the essence, fortitude and presence of my ancestors on both sides of our rich, vibrant, ancient and enduring heritages. I am the culmination of all who went before me. Their intertwined histories are me. I honour each of them for their selfless sacrifice in making and nurturing me into all of who I am—Jenifer Olive Darr. Your lives are acknowledged and the memories of you are precious, forever held in the memory bank of my heart. I acknowledge and thank the great crowd of elders who continuously keep watch over me. In unveiling my ancestry, I declare my genealogy, where everything is connected. This homeland is where I write from as an author, researcher and entrepreneur.

Prelude

First Nations people are 3.8% of the Australian population. We are the longest continuing culture on earth and have the longest economic participation in the world (Keen 2010).

First Nations peoples' ancient culture, knowledge and being on Country is the deep rich historical vein, scaffolding contemporary Australian First Nations purview in how we operate and engage in our daily lives and business. Our history informs our future. Now, some 250 plus years after colonisation, all persuasions of government have never wholeheartedly understood, considered, or embraced the genuine inclusion of First Nations people, the original custodians of Country in Australia. So, for centuries there has been a denial of 'us' in the nationhood building of Australia, where truth telling of our Country's recent blood-stained history remains veiled, muted, and dismissed. The driver - xenophobic racial intolerance.

As history reports, in 1770 the British colonised our nations Country claiming (the Latin expression) Terra nullius – land belonging to no one.

Eddie Koiki Mabo's challenge to this notion established, in Australian law, recognition of us, our Country and place in Australia. The Keating government response to the Mabo high court case rejecting the notion of Terra nullius initiated the Native Title Act 1993 as the legal framework. The Mabo High Court decision was founded on human rights. Justice Brennan in his judgement made this statement:

Whatever the justification advanced in earlier days for refusing to recognise the rights and interests in land of the indigenous inhabitants of settled colonies, an unjust and discriminatory doctrine of that kind can no longer be accepted. [Justice Brennan]

Professor Mick Dodson, a First Nation Yawuru man appointed as the first Social Justice Commissioner shortly after the Mabo decision gave this explanation on Native Title:

We] have been here for a long, long time. The British came along, took our country without our consent, decimated the population, and ignored any rights we may have had. They asserted in fact that we had no rights. That was wrong of course. And that remained unaddressed for two centuries or more. That's what Mabo *meant [for Aboriginal and Torres Strait Islander peoples]* – Mabo *addressed that wrong*. [Professor Mick Dodson]

An international treaty securing our place in Australian society, is the United Nations Declaration on the Rights of Indigenous People (UNDRIP), to which Australia is a signatory. This document enshrines the equal rights of Aboriginal and Torres Strait Islander people to attain the highest standard of health wellbeing (Luke, 2020). The UNDIRP treaty and Native Title Act underpin the definition of First Nations Peoples health. Health, as embodied in a First Nations perspective is broader than an individual's physical wellbeing. The National Aboriginal Community Controlled Health Organisation (NACCHO) describes First Nations Peoples health as:

"Aboriginal health" refers to the social, emotional, and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.

It has been established within international and national contexts that colonisation is a determinant of the health of First Nations people all over the world. Czyzewski (2011) introduces and discusses (Canadian) colonialism as a broader social determinant of health. In exploring the Canadian context, Czyzewski links colonialism to a distal determinant of Indigenous health with an emphasis on intergenerational trauma. Highlighting real health effects of social, political, and economic marginalisation expressed in individuals having a collective influence on entire communities (Czyzewski, 2011). Australian First Nations Peoples, post the unlawful land claim made in 1770, have also suffered the impactful and harmful influences of colonisation. In recent studies published by the Lancet (Anderson et al. 2016), it was determined that Indigenous people across the globe have suffered poorer health than benchmark (coloniser) populations.

The international treaty and national instruments mentioned above establish the prism through which this research is presented. Whereby the social, emotional, and cultural wellbeing of Australia's First Nations people are the origins of holistic health care delivery for the Aboriginal Community Controlled Organisation (ACCO) national network of businesses. In addition, the research is premised in the adopted philosophical TribCrit framework of Brayboy (Brayboy, 2006). These international and national frameworks create the foundation for our inclusion and recognition of 'us' as First Nations Peoples, guiding the reader through the holistic prism framing our research.

Nationally, the universal denial of us, with our rights ignored, and our populations decimated across time, through successive discriminatory government policy, exhibits our resilience. Our endurance of strength, evolution, and resilience presents in the thesis through the methodological choices. A methodological mixture of qualitative data, yarning circles, narrative case study enquiry with in-depth analysis to present a contemporary oral and written story of our research.

The wholistic NACCHO definition of Aboriginal health's cyclical concept includes social, emotional, and cultural well-being. This whole of life continuum is represented in the holistic boutique businesses of ACCOs nationally as their comprehensive service to mob and community.

Many ACCO clients require a range of service types, such as health, housing, family and justice services to support complex needs. Delivering appropriate services requires implementation of client-centred, highly coordinated, integrated models of care. Whereby some ACCOs are multifunction organisations supplying a suite of services and/or collaborate with other organisations to ensure clients obtain the required services (Silburn K., 2016).

The product of ACCOs unique businesses is providing health wellbeing care (in the fullness and vastness of the meaning of holistic health wellbeing care) to Aboriginal and Torres Strait Islander people – 3.8 % of the Australian population.

Silburn (2016) et al reports - the ACCO business model generates revenue in three main ways:

1. Historical arrangements – negotiated amount is provided through service and funding agreements with both State and Federal governments annually or 3 yearly for specified delivery of PHC services;

2. Fee for service arrangements from payment for medical services through Medicare (Bulk Billing model).

3. Competitive processes through request for tenders or application to funding rounds (Silburn K., 2016).

A First Nation researcher, I am a staunch advocate for the ACCO business model of holistic health wellbeing services, and my experience knows this sector punches above its weight to deliver good services for mob and community. The ACCO existence since 1972 and continued innovation over time is evidence their holistic health care model is a sound business model where others are failing.

In April 2024, a report from Dilin Duwa Centre for Indigenous Business Leadership, Indigenous Economic Power Project provided a snapshot of Aboriginal Businesses contribution to the Australian economy. This infographic report shows Indigenous businesses contribute more than $16 billion to the Australian economy, employ 116,795 people and pay $4.2 billion in wages, from less than 3% of the Australian population. An astounding contribution. The fourth biggest industry contributor to the revenue is Health Services in Australia to which the ACCO sector holds a considerable position with a network of around 145 member organisations nationally. Health Services is outranked by three industries: 1) Professional Services; 2) Consumer Goods/Retailing and 3) National and Regional Commercial banks.

Gordon (2022) et al reported health spending represented 10% of Australian gross domestic product (Gordon J, 2022).

I have always pondered why ACCOs have never advertised or showcased themselves as businesses but rather, applied the label and station of health service delivery to describing who ACCOs are. As someone who has managed ACCOs I always viewed my role through a business paradigm simply because the holistic extent of our business and service delivery supports the health needs of our clients.

Secondly, I could never fully understand why there is this notion to compare ACCOs with the other counterpart operating at the primary health care tier – General Practices. Their contrasting business models as it relates to comprehensive holistic PHC, are situated at opposite ends of the PHC model of service delivery. Both operate as fee-for-service with GPs setting their fees for their services. Whereas, ACCOs operate as a Medicare bulk bill service commensurate with their client's need, however, my personal experience is proof this model has a propensity to generate considerable revenue if organised right.

Gordon et al (2022) reports: COVID-19 has changed the way general practice services are conducted in Australia. The availability and use of telehealth services represents a dramatic shift to the way general practice services are provided to the public with little data available to

show how COVID-19 has impacted the clinical activity undertaken by GPs and the quality of care provided through telehealth. Changes to the GP workforce resulting from COVID-19 and the future intentions of the GP workforce may have been impacted by the pandemic, but with little data available it is impossible to quantify these (direct quote Gordon J, 2022).

ACCOs since their inception developed a robust reporting culture as a result of the multiple state and federal government funding agreements. Now, this 52 year reporting culture developed within each ACCO a robust reliable system (albeit disparate) to capture and monitor their reporting requirements on a monthly, quarterly, annual and triennial basis. This consistent level of reporting culture contingent on the key performance indicators in each funding agreement created depth to an interlinked systems approach to monitoring and collating data and a sound clinical governance framework. Robust clinical governance frameworks that ushered in evidenced based innovative models of care. In contrast, General Practices are not bound to a reporting culture based on their direct fee-for-service business model with limitations to their levels of business data.

This research explores the application of frameworks between the years of 2010 – 2024 as it pertains to the primary health tier in the Australian health system. Therefore, the history of the movement of accreditation has not been discussed in this body of work. The concept of quality assurance is an antiquated term replaced by continuous quality improvement and this body of work examines the application of frameworks in the context of efficiency and sustainability. Meaning the accreditation standards are used as the examples to identify the efficiency and sustainability of these applied frameworks within a business environment – particularly Aboriginal Community Controlled Organisations. The framework examples of RACGP and ISO, a result of this research identified their corresponding traits in table 4.1 and 4.2 in chapter 4. The purpose is to introduce the readers to the traits of prescriptive (Australian designed accreditation standards) and open (international accreditation standards). These traits provide evidence of the traits of both frameworks as a comparison for the audience to understand the quality, value, return on investment and benefit these frameworks give in determining efficiency and sustainability for a business environment.

Before 2010, RACGP Standard was the only standard in operation at the PHC tier. It entered the market in 1996 designed for general practices only and in 2000 the RACGP standard was mandated for ACCOs. In 2010, I was fortunate to have been invited to a meeting hosted by DoHA - Office of Aboriginal and Torres Strait Islander Health Services (OATSIHS)

convened in Brisbane with ACCO CEOs and management, about the introduction of a second accreditation framework for the ACCO sector. I recall advocating strongly for the implementation of this second accreditation framework of ISO 9001:2008 at this meeting with a few male CEOs. Prior to attending I examined ISO 9001:2008 certification standard and could easily see where the benefits lay for the ACCO sector [personal correspondence]. Based on my knowledge and perspective ISO 9001:2008 (in operation then) offered to the ACCO sector the following: 1. It is a superior framework to RACGP as it is applied to every area of the ACCO business environment; 2. The ISO clauses allow the ACCO business to determine how they meet each clause based on their maturity and location; 3. ISO 9001:2015 is an international framework supported by other standards and it meant ACCOs would be applying a gold-standard framework, receiving certification to an international standard. OATSIHS initially offered funding to ACCOs to apply this second standard but ceased this funding in 2012. My opinion, ISO 9001:2008 (and its updated version ISO 9001:2015) is designed in a way that suits the ACCO holistic model of care and business. It is the one framework that shows accountability to funders seeking this level of scrutiny through an independent third party auditing of ACCOs applying ISO 9001:2015 certification.

The catalyst to the national accreditation framework implemented by the Rudd / Gillard governments in Australia were the Dr Death case (2005) in Bundaberg hospital resulting in a Royal Commission (Davies 2005). The previous year (2004) there were multiple recorded and reported deaths of babies in a Victorian maternity hospital. The author of the health and hospital reform commission report (2008) in point 8 - promoting improved safety and quality of health care notes: between 15-20% of hospital overnight episodes have an adverse event estimated to cost $2 billion dollars annually (Bennett, 2008). Since 2010 we have witnessed multiple accreditation frameworks come to market. The table below shows the growth in accreditation frameworks to the market at the Australian primary care tier for ACCOs.

Table 1. Growth in accreditation frameworks at the Australian Primary Care tier for ACCOs

Year and State	Frameworks	Standard type	Source
2010 [National]	2	RACGP and ISO 9001:2008	Darr et al (2021);10:e001091. doi:10.1136/bmjoq-2020-001091

2016 [Victoria]	5	ISO 9001:2015; QIC Health & Community Service Standard; RACGP Standard (for ACCOs with medical clinics); Home Care Standards; Department of Human Services (DHS) Human Services Standards	Silburn et al (2016)
2024 [National]	11	ISO 9001:2015; QIC Health & Community Service Standard; RACGP Standard (for ACCOs with medical clinics); Mental health standard; Australian Service Excellence standard; National Disability Insurance standard; Aged Care standard; National Quality and Safety Health Service framework; National Quality Framework for Drug and Alcohol standard; Spirometry standard; Rainbow tick standard and other state equivalent standards.	Thesis Jenifer Darr

The growth in accreditation frameworks for ACCOs across 14 years indicates the flooding of frameworks into the market. The table shows standards went from 2 in 2010 and increased by 9 in six years to now 11 mandated frameworks operating at the primary care tier of the Australian health system in 2024.

Most of these frameworks are mandated for the ACCO sector with many ACCOs applying on average seven accreditation frameworks. The mandated status is a result of their funding agreements linked to the types of service provision to First Nations community and clients with funders owning the standards. The design of the standard indicators is designed from the owner's perspective for surveillance. To mandate accreditation standards on ACCOs and not hold any level of consultation or consider First Nation cultural practices, history and political status in Australia is myopic.

I never understood why ACCOs were mandated to apply the RACGP standard. When a second certification framework in ISO 9001:2008 (now 2015) entered the market for ACCOs I welcomed and embraced this wholistic standard. In managing a remote ACCO I realised why we had to apply the RACGP standard. The application of this standard is linked to the ACCO access to Service incentive payments (SIP) and Practice incentive payments (PIP) as Medicare income. I later learned for GP services, applying the RACGP standard is an option (MP, 2021).

My experience in applying the RACGP standard into an ACCO business was a framework that was never designed for the ACCO holistic model of care or business and a stance I maintain and will always advocate. This notion that the prescriptive RACGP standard provides homogeneity to businesses with medical clinics, without consideration of the unique models of care like ACCOs provide, was vexing. The RACGP standards (prescriptive design) dismiss the holistic, organised, systematic model of health care services provided by ACCOs unique business model. ACCOs possess a 50+ year history of a systems approach to health wellbeing care for clients and community evident in their clinical governance (Phillips, 2010).

The misalignment in design of accreditation frameworks mandated upon ACCO businesses is what led me to embark on this PhD. I am grateful I did with the fortitude, perseverance, researched evidence and hope for change!

The frameworks grounding this research were born out of the Building Indigenous Research Capacity program (BIRC) and movement established by Professor Jacinta Elston. The purpose of the BIRC program was to grow a body of Indigenous scholars who could be influencers in the research domain. By creating an environment for the BIRC scholars to thrive in, transitioning who we are as Indigenous scholars to our respective areas of research. To be sown into, empowered and nurtured by other Indigenous academics and allies. Growing a thriving movement of First Nations scholars who would test and question the mainstream academic teachings and knowledge and bring First Nations nuanced history, knowledge and critical analysis to bear. To be influencers of change in a mainstream environment that lives and holds onto, tightly, the residue of colonialism. The principles of BIRC laid the foundation for me as a researcher, led into adopting the nine concepts found in Brayboys TribalCrit framework outlined in the thesis (Brayboy, 2006).

Knowledge Translation. The three results chapters of the thesis (Knowledge, Power, and Ownership) use the principles of BIRC and Brayboy's TribalCrit framework to unpack these key concepts. The BIRC Indigenous knowledge definition and Brayboy's TribCrit framework definition of knowledge links to this work as it pertains to the development of Australian accreditation standards for use within ACCOs. The BIRC 'Indigenous knowledge' concept elaborates on Indigenous knowledge systems and Indigenous research methodologies privileging Indigenous ways of knowing, being and doing within research (Martin Mirraboopa 2003; Rigney 2001). Indigenous knowledge refers to traditional knowledge and the growing body of scholarship seeking to develop more culturally relevant respectful methods and adherence to cultural protocols. Brayboy identified the importance of making connections

between knowledge in different types and forms to meet larger community goals of self-education and sovereignty in academia, by linking the inherent disconnect between community stories, personal narrative, and 'theory' (Brayboy, 2006).

The result chapter of Power draws on both the BIRC identity and cultural interface principles and definition to inform how power can be disassembled, reasserting a neutral position whilst exercising elements of Brayboy's TribalCrit framework, as it pertains to the assessment of re-designed Australian accreditation frameworks for the ACCO industry. BIRC principles of Identity: refers to the way both the First Nations and the non-First Nations participants expressed notions of their cultural/spiritual origins and places of belonging, such as Country, family and community.

BIRC principle of Cultural interface: acknowledging the cultural-difference challenges experienced in personal, professional and research relationship occurring between First Nations and non-First Nations participants, including sensitivities to, as well as respect for Indigenous and non-Indigenous differences in histories, worldviews and understandings. Brayboy asserts, community stories, passed down through generations, are theories of sovereignty, reflecting self-determination, and self-education to serve as the basis for how our communities work. Stories, or oral history Brayboy claims, explain the overarching structures of society and communities as nuanced roadmaps, reminding us of our individual responsibilities to the longevity of our communities.

Brayboy states; at the heart of this conflict are different epistemologies and ontologies and Brayboy explores this identified difference to make connections between different forms of knowledge and their application through a community-oriented theoretical lens (Brayboy, 2006).

The 3rd core results concept of Ownership adopts the BIRC principle of Ownership, Indigenous leadership and respect to annunciate the core elements advocated for by the Indigenous researcher[s] within an Indigenous research agenda. Further emphasising Indigenous leadership, ownership and respect for Indigenous peoples, histories and traditions in research practice including notions of empowerment and reciprocity. All of these elements combined are explored in the results using of TribalCrit theory in the thesis. Brayboy in constructing the TribalCrit theoretical framework addresses and discusses the complicated relationship between American Indians and the United States federal government. The term Brayboy uses is liminality to raise the tension experienced in racial and legal/political groups and individuals. In describing race, Brayboy states, that 'racial' references the embodiment of

American Indians as racialised beings. The TribalCrit nine concepts outlined in the framework emphasises the position of liminality [Latin meaning is liminality is rooted in this idea of a threshold – limen] and tensions experienced over time between American Indians and the federal government (legally/politically and socially) (Brayboy, 2006). A threshold position occupied and experienced by First Nation Australians legally, politically, and socially with the Australian federal government and the Australian society since colonisation: we, as First Nation Australians have never moved to a position with the Australian federal government of mutual understanding in the value of Indigenous leadership, respect, notions of empowerment in self-determination and genuine reciprocity.

The narrative case study seated in chapter 4 and these results are being presented to the CEO of Kowanyama Shire Council and the community on 28 – 30 October 2024. We are excited to be sharing this knowledge and findings of their story.

In closing, to socialise the reader to the thesis content, below is a table outlining: the chapters, title, content and applied qualitative methods and publication status. And an overview of what to expect in each chapter. The PhD is a thesis by publication with each chapter written as a standalone piece for publication lovingly stitched together in the thesis.

Thesis Chapter	Title and Content [in italics]	Applied qualitative methods & Journal status
Chapter 1	Our Story of Change Introduction: Objectives and Aims and Overview of Thesis	Thesis only
Chapter 2	The gap and the guide – a work in progress Literature Review 1: To identify the gap and situate our research Literature Review 2: To unpack quality through analysing efficiency and sustainability as traits of quality via Leximancer analysis	 # 1 Published in BMJ Open Quality [PRISMA] # 2 Peer review in BMC Health Services Research [PRISMA and Leximancer content analysis]
Chapter 3	The Viewing Platform Methodology	Participant selection & data collection, analysis & synthesis – Indigenist lens * Thematic analysis through

		Transformational grounded theory To be published
Chapter 4	Strength in our collective voice Narrative case studies and ethnography	Narrative Case Studies * Ethnographic paper 4 years of observational field work [2019, 2020, 2021, 2022], Community Based Participatory Research (CBPR), Participatory Action Research (PAR) & Plan, Do, Stud, Act (PDSA). # 3 Peer review in AlterNative
Chapter 5	Leading for sustained change Results 5 themes and 3 papers: Knowledge, Power, Ownership	YARNING ^ circles, Transcription of data, Thematic analysis through Transformational Grounded Theory * To be published
Chapter 6	ACCO gift to government Discussion, Integration of results & Recommendations	Discussion from three result papers & recommendations * To be published
Chapter 7	Reciprocity in action - The gift that keeps on giving Conclusion	Research findings and Knowledge Translation Plans To be published
Chapter 8	Appendices	Thesis only

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1 The Outline for Our Story
(Aims, Objectives and Overview)

Map of First Nations Country known as Australia

[Online picture. Author unknown.]

'If we are to survive, let alone feel at home, we must begin to understand our Country. If we succeed, one day we might become Australian.' Henry Reynolds

[Quote from the foreword in *Biggest Estate on Earth: How Aborigines Made Australia,* page xxiii, Bill Gammage]

My cornerstone is my heritage and positionality. Our heritage is steeped in an ancient history that is so deep, rich and vibrant, with over 65,000 years of an evolving culture and knowledge to draw upon from both our Yuwi and our Vanuatu ancestors. This beautiful mixed heritage is our deep, limitless historical tapestry from where my life is woven to hold me and it reaches into the next and coming generations. I am blessed. I am the daughter of trailblazing parents and second-generation Christians who chose to raise us in a small country town. My personal experiences are informed by and overlaid with the principles my generous parents instilled in my siblings and me in our formative years of growing up in Ayr, North Queensland, Australia. My hope is for my ceiling to be the floor for the coming generation—a stage for all who journey after me. May there be many!

My Vanuatu Australian lineage is a result of the odious Australian Government policy in the mid-1800s to the early 1900s (known as Blackbirding—Australia's slave trade),[2] which assigned and dispatched ships to the Pacific Islands, seeking out young men, boys and young women as slaves to start the Australian sugar and cotton industry. My father is Yuwi and Vanuatu (Ambrym Island), and my mother is Vanuatu (Epi and Tongoa Islands). My mother is a first generation born Vanuatu–Australian. My father, his parents and his family lived on Bakers Creek, Yuwi Country, historically known as the largest Aboriginal reserve in Queensland. For

[2] https://www.sea.museum/2017/08/25/australias-slave-trade, accessed 5 July 2023.

both sides of my ancestry, cultural genocide, forced removal from their ancestral lands and the loss of their mother tongue or language are the heinous common threads uniting them—human depravity and subjugation perpetrated on people groups who remain steadfastly resilient (Behrendt et al. 2015; Martin Mirraboopa 2003; McIvor et al. 2009; Reid et al. 2022). Fast forward to 25 February 2020, the day the Yuwi Nation was acknowledged as Yuwi Country custodians.[3]

I was a key negotiator in our native title claim, where we contested the myth of terra nullius for our ancestral Country in the Federal Court of Australia versus the local, state and federal governments[4] (Australian Human Rights Commission 2015, Australian Human Rights Commission 2020; Young 2021). The court case lasted seven years, resulting in the handover of 313,000 hectares of land and sea Country to 10 nautical miles or 18.52 kilometres—the start of our Indigenous Estate (Dillon 2017, 2018; Gammage 2012). The Yuwi claim footprint can be viewed in the footnote link below: a massive win for a proud Yuwi Nation. This Federal Court case commenced at the same time I enrolled in this PhD (albeit on a part-time basis while working full-time). I found myself simultaneously managing and navigating two large-scale projects unfolding in my voyage of life.

Professionally, nursing is my substratum, requiring of me a sound knowledge and understanding of the human body and its systems. This skillset is the knowledge transfer to systems thinking needed to understand accreditation standards, their clauses, indicators or criteria and the process for how these are implemented successfully into a business's environment. Companies are living, evolving organisms. My passion for improving the development of an organisation's systems, policies, processes and tools for compliance as a change management strategy led me to embark on a PhD. I enrolled in the PhD in 2013 with 13 expansive years of technical knowledge and refined project management in the application of multiple accreditation standards in several small, medium and large companies, positioning me as a well-established and accomplished candidate for this chosen study area. From 2010 to 2013, the Queensland Aboriginal community-controlled organisation (ACCO) sector was the first to roll out a second accreditation standard, situating this state on the cutting edge of change in the accreditation industry nationally. Nationally, this change introduced ISO 9001:2008 QMS certification as the second standard in Aboriginal primary health care (PHC). During this time, I became a trained ISO auditor. I served on the NACCHO working group for the design of an interpretive guide for the ISO 9001:2008 Quality Management System (QMS)

[3] http://www.nntt.gov.au/searchRegApps/NativeTitleClaims/Pages/Determination_details.aspx?NNTT_Fileno=QCD2020/001 accessed 19/4/ 2024.

[4] https://lnkd.in/ehy6J72i accessed 12/4/2024.

certification standard for the ACCO sector nationally. In the latter years, I circled in multiple boutique services of Aboriginal community-controlled organisations in a variety of roles, including management. Now, my experience is an expansive 20-plus years of issues encountered and questions raised in the application of multiple accreditation standards in ACCOs, the Australian Defence Force and my own business, Jadee Consulting. This knowledge bank of vast technical experience lends weight to this doctorate, and it is from this foundation that my research questions were generated. The PhD sets the stage to explore and find answers, to raise issues at the national and international level in the accreditation industry.

The title of this research is 'Critical Indigenist Examination of the Impact of Efficiency and Sustainability of Quality Management Systems in Aboriginal Primary Health Care'.

The research question is: What is the impact of implementing a QMS on efficiency and sustainability for the ACCO?

The assumption is that QMS improves service performance for ACCOs. This presumption is what sparked my passion, ignited a growing social justice lens for my research and prompted me to find answers to my questions through a solution-oriented process.

1.1 Our Indigenist Research Agenda

As a First Nations, Yuwi–Vanuatu researcher my goal is to accomplish this research within the orbit of an Indigenist Research Agenda. To understand and comprehend the Indigenist Research Agenda, we must first understand Indigenous research methodology as an academic and scholarly method of viewing, knowing and experiencing our tacit involvement as First Nation researchers (Saunders et al. 2010). The very first step in understanding is acknowledging. To acknowledge is to honour. We honour and see all First Nations scholarly academic giants, at home and globally, whose resolute tenacity carved out the Indigenist Research Agenda milieus for us as new and early First Nations researchers. We see you; we thank you and we honour you!

Henry et al. (2002) describe the Indigenist Research Reform Agenda as an evolving movement in the identification and promotion of research methodologies compatible with the community targets of the emerging agenda for research reform. For each of us First Nations researchers, it is important to have knowledge of an Indigenous methodology, in how we perform the processes of research with the integrity and validity from First Nations worldview (Henry et al. 2002). Wilson's (2001) research explores how peoples' epistemologies (how people think and how this affects things in their world) affect how they do what they do, for example, to be a successful Indigenous researcher and yet maintain strong links to their culture, relationship and Indigenous identity. How is it possible for First Nations peoples to live in both worlds and the thinking behind this milieu to bring success (Wilson 2001)? The thought

process, Wilson (2001) asserts, is indicative of an Indigenous epistemology and methodology. Research reform is underpinned by an overriding resolute commitment to decolonise existing Western research traditions expressed in mainstream institutions (Henry et al. 2002).

Proposals for the reform of Indigenous social science and health-related research claimed by Henry et al. (2004) refer to the importance of developing an institutional research culture that does not support the marginalisation of individual and collective Indigenous community interests. This positioning is framed as a response to the historical links between research and the processes of deconstructing colonisation examined in the scholarly detailed works of noteworthy academics such as Māori researcher Linda Tuhiwai Smith and First Nations academics Humphrey, Dodson and Irabinna-Rigney (Henry et al. 2004; Rigney 2001; Tuhiwai Smith 2021).

Wilson (2001) contends that research methodologies in their simplest form create the process for how First Nations researchers are going to use ways of thinking (your epistemology) to gain more knowledge about your reality. Professor Rigney (2001) outlines Indigenous research principles. Rigney's work responds to the need for First Nations researchers to historicise, politicise, strategise and actualise our being and our future. Wilson's (2001) research espouses that an Indigenist research paradigm is the combination of ontology, epistemology, methodology, axiology and beliefs about the world—and about gaining knowledge that, when combined, guides the researchers' actions as to how to undertake research. An Indigenous paradigm is derived from a fundamental belief that knowledge is relational, and everything is connected (Wilson 2001).

The Cooperative Research Centre for Aboriginal and Tropical Health Report notes that at the heart of the Indigenous Research Reform Agenda (initiated in the early 1980s) is the formalisation of Indigenist research philosophies, principles and practices (Henry et al. 2002). Henry et al. (2004 p 72) claims that ['in particular, First Nations] researchers are the key agents of change, to reform the way research is initiated, conducted and the findings disseminated. There is the unresolved question of how to engage individual researchers in these processes'. The missing component, in the Australian context, is the systematic engagement of First Nations researchers and academics to bring about a system-wide solution. In 2021, The Lowitja Institute became Australia's only Aboriginal and Torres Strait Islander community-controlled health research institute, filling the gap of the missing component (Lowitja Institute 2017). In 2021, our research was fortunate to have secured a grant from the Lowitja Institute. It garnered support and input from community mob as a prominent agency in the unfolding of our research. These two principal practices ensured that our research was conducted in a manner that upholds, is accountable, is relational and disseminates our findings within the

context of an Indigenist research paradigm. This PhD is the social justice instrument giving voice to the voiceless in the accreditation industry nationally and internationally.

In 2008, a national accreditation framework was the vital policy reform legislated by the Australian Government to install quality and safety in the Australian healthcare system (Bennett 2008; Darr et al. 2021). Now, 16 years on, in 2024, for many primary healthcare providers, the national accreditation framework has triggered the application of multiple and different accreditation standards. The increased release to the market of industry-designed accreditation standards initiated a supply-and-demand-driven market, directly affecting the increased numbers of certification bodies operating in the Southern Hemisphere. The Australian accreditation industry at the primary healthcare level has 12 prominent accreditation standards. The Australian accreditation market is heavily populated with varying frameworks or accreditation standards and numerous certification bodies. There is no synchronicity between the 11 different accreditation standards.

Darr et al. (2021) detailed, as described by Buetow and Wellingham (2003), the definitions for practice accreditation and certification. Buetow and Wellingham (2003 p 7) established definitions of *practice accreditation* as 'peer assessment against explicit standards and an outcome of accreditation of practice and development of systems necessary for quality improvement for medical care of clients'. This is in contrast to receiving *organisation certification*, which is defined as:

> The auditing (by ISO specialist, not peers) against generic international standards of quality systems and management processes (within a business can be) strengthened and standardised to achieve efficiencies. The outcome being a certificate of compliance with standards for whole-of-organisation development. (Buetow and Wellingham 2003 p 7)

The language used for accreditation and certification is different. Companies, as clients applying accreditation and certification standards, must and should be acutely aware of their purchase and value for money in the engagement to applying standards, be it accreditation or certification. The names assigned to the outcome processes (of practice accreditation and organisation certification is contingent on the standard) of quality and safety speak to the type, gravitas and product weighting a business receives. It is a case of buyer beware—be very aware!

1.2 The Difference Between Accreditation Standards and Certification Standards

In identifying the differences in the design of accreditation and certification standards, it is important to highlight the language used with these different processes of acquiring a

certificate of compliance, albeit for accreditation or certification. This unpacking allows companies who provide businesses in health wellbeing care to appreciate and acknowledge the traits (of standards) to evaluate each standard for the value it brings to a company's business. With Australian industry-designed accreditation standards, their name and nature by design are for specific industries that are the owners of their specific standards. Our study found that they are prescriptive in design and closed in scope for interpretation, with disabling limitations in their translation across the company's business environment. By design (with no synchronicity across the 11 standards), they segment the accreditation industry and silo the health wellbeing care for ACCO businesses. Our results section in this thesis outlines these traits in detail for the Australian industry-designed prescriptive standards and the internationally designed certification standard of ISO 9001:2015 QMS. Our caveat: Every accreditation standard is not the same in design, purpose, quality or value!

1.3 Auditing to the Standards

Our research determined that the language used to identify the assessment of standards is couched in the value of the end product the company receives from their engagement in and application of the standard. For practice accreditation or application of industry-based standards, the language used for individuals assigned to assess conformity (to the standard) is 'assessor' or 'surveyor'. The language used for certification of a company's business systems (to the certification standard) is 'auditor', someone who is ISO trained and certified. The outcome of the audit for companies applying the International ISO suite of standards is always to test the maturity of the company's business systems to the open clauses. The outcomes for compliance with Australian industry-based standards and the International ISO suite of standards are vastly different, and their test for conformity is for very different aspects of the company's business as dictated by the standard. Testing for conformity across distinct aspects of the business gives rise to wide variances in the individual tasked with assessing, surveying and auditing using the standards for compliance. Our results section in the thesis provides further clarity and nuance.

1.4 Gaps in Understanding of the Impact of Standards on ACCOs

There are two businesses assigned to provide PHC in the Australian context—GP practices and Aboriginal community-controlled health organisations (ACCOs). Our research gives validation to the fact that GP practice businesses and ACCO companies are not the same when it comes to providing PHC premised on their business model and the application of accreditation standards. Their scopes of service provision are worlds apart. There is a serious and genuine inequity flagged between these businesses as it pertains to applying accreditation standards—1 versus 11. While we refrain from creating homogeneity by doing a baseless

comparison between these companies, our research identified a grave injustice being experienced by the ACCO companies who, by design, provide boutique, holistic, client-centred wellbeing care to the Aboriginal and Torres Strait Islander people group. When the ratio of 1 to 11 is weighed against the cost of applying 11 accreditation standards across 145 ACCOs nationally, this practice is morally unethical.

Darr et al. (2021), in their first literature review, raised valid questions:

1. Is there value in the application of dual (now multiple accreditation) systems at the primary care level?
2. How much do they cost?
3. Are double (now multiple and different) accreditation/certification standards sustainable?
4. How are these standards affecting the health and community outcomes of First Nations people?

We invite you to read the proceeding chapters as we reveal the truth about a disingenuous Australian accreditation industry pertaining to a national network of over 145 Aboriginal community-controlled businesses. All Australian ACCOs (in this story for change) are the gifts that keep giving to the Australian federal and state governments. ACCOs, at the PHC tier, are innocently unaware that they hold (as a sector) the status of being the financial backers to the current multimillion-dollar Australian accreditation industry.

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2 The Gap and the Guide: A Work in Progress (Literature Review 1 and Literature Review 2)

[Potter's Wheel, Stock images Microsoft]

The Potter's hands mould and craft what we have seen spinning for some time to make shape out of it. This needed clarification process adds the beginning touches to our message.

[Credit: Nate Johnston]

Chapter 2 presents the findings of two literature reviews. The first identified the gap and knowledge deficit in the Australian accreditation industry to situate the research as a valid research project. The second was undertaken to understand efficiency and sustainability as traits of quality—to measure quality in the application of accreditation standards in the Australian context. In the second literature review, a Leximancer content analysis tool supported the results.

Note. This work is published: BMJ Open Quality 2021;10:e001091. doi:10.1136/bmjoq-2020-001091

2.1 Paper 1. Quality Management Systems in Aboriginal Community-Controlled Health Services: A Review of the Literature

Running Title

Reviewing QMS for Aboriginal Health Services

Authors

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Recognition—We pay honour to our First Nations ancestors and acknowledge the custodians of Country on whose land we live and work.

Qualification—First Nations peoples is the designated title for Australian Aboriginal and Torres Strait Islander people used by the first author. We declare there are no competing interests.

Contributorship Statement—The first author, Jenifer Darr, was responsible for the majority of the written piece, including the design of the search strategy, analysis and preparation of the manuscript.

The members of the authorship team, Richard Franklin, Kristin McBain-Rigg, Sarah Larkins, Yvette Roe, Kathryn Panaretto and Vicki Saunders, assisted in the development of the research design and editorial assistance in the preparation of the manuscript.

2.1.1 Abstract

Background. A national accreditation policy for the Australian PHC system was initiated in 2008. While certification standards are mandatory, little is known about their effects on the efficiency and sustainability of organisations, particularly in the Aboriginal community-controlled health service (ACCHS) sector.

Aim. The literature review aims to answer: To what extent does the implementation of the ISO 9001:2008 QMS facilitate efficiency and sustainability in the Aboriginal community-controlled health service sector?

Methods. Thematic analysis of peer-reviewed and grey literature was undertaken from the Australia and New Zealand PHC sectors with a focus on First Nations people. The databases searched included MEDLINE, Scopus and three Informit sites (AHB ATSIS, AEI ATSIS and AGIS ATSIS). The initial search strategy included quality improvement, continuous quality improvement, efficiency and sustainability.

Results. Sixteen included studies were assessed for quality using the McMaster criteria. The studies were ranked against credibility, transferability, dependability and confirmability criteria. Three central themes emerged: accreditation (n = 4), quality improvement (n = 9) and systems strengthening (n = 3). The accreditation theme included effects on health service expenditure and clinical outcomes, consistency and validity of accreditation standards, and linkages to clinical governance frameworks. The quality-improvement theme included audit effectiveness and value for specific population health. The theme of system strengthening included prerequisite systems and embedded clinical governance measures for innovative models of care.

Conclusion. The ACCHS sector warrants reliable evidence to understand the value of quality management systems and enhancement tools, particularly given ACCHS (client-centric) services and their specialist status. Limited evidence exists for the value of standards on health system sustainability and efficiency in Australia. Despite a mandatory second certification standard, no studies reported on the sustainability and efficiency of a QMS in PHC.

Key words. Aboriginal community-controlled health service, certification, primary health care, accreditation, quality assessment.

2.1.2 Introduction

The ACCHS sector operates in dynamic and innovative settings. These settings are rich, intuitive environments that have remained relevant and effective since the first ACCHS opened in Redfern in 1972. The sector has evolved to deliver comprehensive PHC to First Nations peoples (NACCHO, 2014b). Nationally, the ACCHS sector includes more than 145 health organisations, specialising in a variety of health areas, including population, environmental, tropical and public health (Alford, 2014a). ACCHSs can be considered 'boutique' marketplaces for speciality training (Larkin, 2009). ACCHSs deliver services which are ground-breaking, sustainable and effective in financially suppressed operating environments (Alford, 2014b). These are traits demonstrating the continued relevance of the sector's resilience and strength-based approach—a true testament and acknowledgement to the culture and tenacity of the ACCHS sector nationally.

Australia spends $154.6 billion on health care annually (AIHW Australian Government, 2015) and performs well by international health service standards (AIHW Australian Government, 2016). Three tiers of healthcare delivery comprise the Australian healthcare system: tertiary care (hospital specialist), secondary care (private specialists) and primary care (GP and client). There are areas of service delivery where Australia performs well below international standards for equitable levels of health care coverage and outcomes (Wenitong M et al., 2007). Most notable is the inequity among First Nations people, for whom chronic disease, psychosocial illness and the social determinants of health account for the majority of disparities in health outcomes between them and the rest of the Australian population (Streak Gomersall J et al., 2017).

To quantify the quality and safety of the Australian health system, a significant commissioned study in 1994 reviewed adverse events experienced in tertiary hospitals in New South Wales and South Australia (Wilson RM et al., 1995). The Quality in Australian Healthcare Study identified the quality of health care in Australia as problematic (Richardson, 2005): 16.6% of hospital admissions in South Australia and New South Wales resulted in adverse events (including client disability and longer hospital stay) and, of those adverse events, 51% were deemed preventable (Wilson RM et al., 1995). This evidence resulted in the establishment of the Quality in Australian Health Care taskforce (Wilson RM et al., 1995), and, subsequently, a national expert advisory group and the Australian Council for Safety and Quality in Healthcare (Rubin, 2005) (Smallwood, 2006) Part of the statutory authority's mission is to improve health care across the country (Rubin, 2005).

2.1.2.1 Standards and Quality Assessments in Primary Health Care

Internationally, by the mid-2000s, there was a growing body of evidence concerning the importance of a systems approach to enhancing the quality of care in PHC (Wise et al., 2013, Øvretveit J, 2003, Braithwaite et al., 2011). In 2008, the Australian Government introduced vital policy reforms to the Australian healthcare system, including a national accreditation framework (Bennett C, 2008). The Australian Government holds primary responsibility for financing the primary care sector(Bennett C, 2008, Segal, 2008). For many primary care providers, the national accreditation framework triggered the application of dual standards: the Royal Australian College of General Practice (RACGP) Standards and the ISO 9001:2008 QMS, an international, whole-of-organisation certification (Silburn K., 2016). The RACGP non-legislated accreditation standard focuses on clinical service delivery and clinical governance arrangements with a choice of two national accreditation bodies of Australian General Practice Limited (AGPAL) and General Practice Accreditation plus (GPA +)(Wise et al., 2013).

There are differences between accreditation and certification. The RACGP defines accreditation as peer-reviewed recognition of a health practice meeting the requirements of Australian general practice standards, known as practice accreditation (RACGP, 2010). Conversely, certification is a process whereby an authorised independent agency recognises individuals or healthcare organisations as meeting predetermined requirements beyond those set by licensure (Buetow, 2003). The other notable difference between accreditation and certification is the mandatory audit schedule as an inbuilt system of self-monitoring activities for the certification process. Audits routinely identify gaps for improvement and are integral components of clinical governance. Phillips describes clinical governance as a framework of strategies including clinical audits, clinical competence, client-directed interventions, risk management, education and training schedules and use of service information. Integration and a systematic approach to these strategies ensure that services deliver quality and accountable health care (Phillips, 2010). Illustrations of quality assessment models currently operating in Australia in the primary care context are presented in Table 2.1. The ACCHS sector applies a minimum of two or more standards to its business operations and service delivery (Silburn K., 2016).

Table 2.1

Australian Primary Health Care Quality Assessment Models

QA type	Aim	Rationale	Method	Outcome
Peer review of professional performance	Assess professional performance of individuals and practice team	Professionals can self-regulate to improve professional performance	Systematic site visit based on systems criteria and peer review	Assessment report only with no certificate of achievement
Practice accreditation	Assess organisation and delivery of specific practice services	Practices need to demonstrate public accountability	Peer assessment against explicit standards	Accreditation of practice and development of systems necessary for quality improvement for medical care of clients
International Organisation for Standardization (ISO) model	Implement international norms for quality systems	Quality systems and management processes can be strengthened and standardised to achieve efficiencies	Audit by ISO experts (not peers) against generic international standards	Certificate of compliance with standards for whole-of-organisation development

Note. Adapted from Buetow and Wellingham, 2003, p. 2.

In January 2013, the National Safety and Quality Health Standards (NSQHS) were introduced for all health-related facilities in Australia (Australian Commission Safety and Quality in Healthcare, 2014). The Queensland ACCHSs in 2010 to 2012, in compliance with the legislated national accreditation scheme, applied ISO 9001:2008 QMS together with the non-legislated RACGP Standard (RACGP, 2010).

2.1.2.2 Literature Review Question

Ultimately, standards aim to improve outcomes; thus, the underlying logic of applying a QMS is (a) to improve business performance and create systems which are process dependent, (b) to improve systems and microsystems via increased process dependency, (c) improved and interlinked microsystems providing enhanced service, and (d) enhanced service sustainability and efficiency (Braithwaite J et al., 2006, Braithwaite et al., 2011, Marley J V et al., 2012, Øvretveit J, 2003, Ralph et al., 2013, Silburn K et al., 2016, Wise et al., 2013). This literature review aims to answer: To what extent does the implementation of the ISO 9001:2008 QMS facilitate efficiency and sustainability in the ACCHS sector?

2.1.3 Methods

Systematic, iterative searches of five databases (discussed below) occurred from October 2016 to October 2018. Key studies were identified and reviewed for quality, study characteristics, data collection and analyses, overall rigour, conclusions and implications.

2.1.3.1 Data Sources and Study Selection

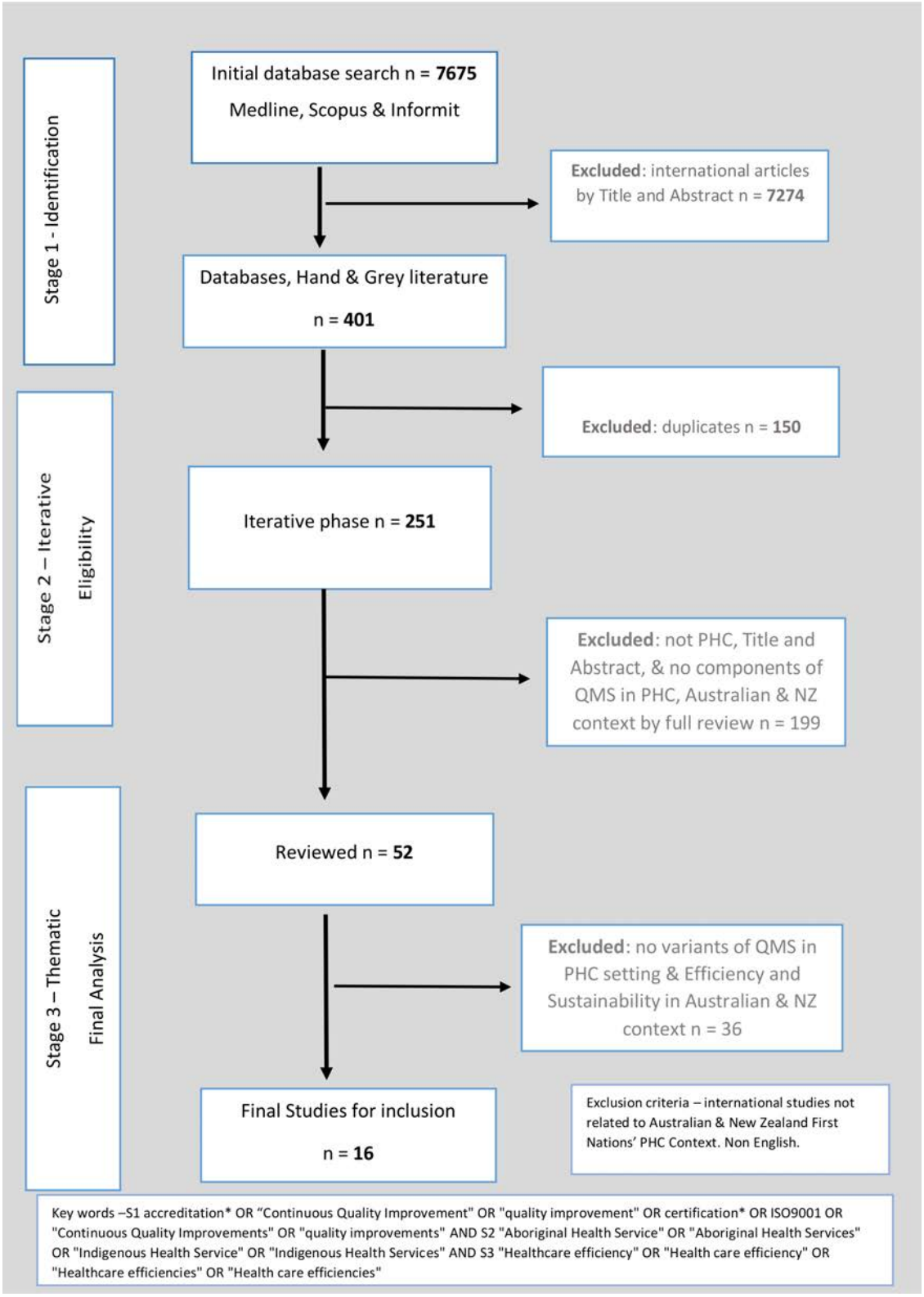
Searches were performed in MEDLINE, Scopus and three Informit databases (AHB ATSIS, AEI ATSIS and AGIS ATSIS). The literature searches were performed and conducted for the years 1995 to 2018. Exclusion criteria applied to studies (i) not related to the Australian and New Zealand First Nations' PHC context and (ii) not in English. Grey literature searches were picked up from reference lists of identified literature. Initial searches found limited studies using the search term 'quality management system'. Using the broader terms 'continuous quality improvement', 'quality improvement', and 'systems approach' identified 251 studies from a title and abstract review. In a second iterative phase, the terms 'accreditation' and 'systems strengthening' were included to narrow the search to the final 16 studies. In total, 7,675 studies were identified, and 401 were reviewed (Figure 2.1). The second phase identified 52 studies in the full-text review, with 16 studies selected for the final review. The initial search criteria were discussed with an academic librarian with search criteria adaptations and presented using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework (Figure 2.1) (Moher et al., 2009).

The eligibility criteria were:

1. PHC with a focus on Aboriginal and Torres Strait Islander or First Nations populations
2. Publications between 1 January 1995—October 2018
3. Publications in English
4. Human
5. Studies in the Australian and New Zealand PHC context
6. Application of quality improvement (and variants) and its impact on efficiency and sustainability.

Figure 2.1

PRISMA Diagram of Literature Review



Note. PRISMA diagram of literature review. ISO: International Organisation for Standardization; NZ: New Zealand; PHC: primary healthcare; QMS: quality management system.

2.1.3.2 Literature Quality

The McMaster framework was applied to explore indicators of quality in the 16 included studies (Letts, 2007). A quality assessment of the studies was performed using the representative criteria of credibility, transferability, dependability and confirmability, which were established to separate the 16 studies into four categories listed below (results displayed in Table 2.3) to quantify the quality.

- Category 1 includes studies of high quality with all the representative criteria confirmed.
- Category 2 represents studies with limited transferability.
- Category 3 has not confirmed means of dependability and confirmability.
- Category 4 studies have only one of the four representative criteria, confirmed from the synthesis of the study.

2.1.4 Results

A total of 16 studies met the eligibility criteria (as evidenced in Figure 2.1); of these, 15 were from Australia, with one from a New Zealand general practice context. Of the 16 studies, three were systematic reviews and nine were observational studies. Ten studies were participatory action research in design with the introduction of two conceptual models as improvement models for trial in primary care. Two studies were audits (desktop and chart). The desktop review of published literature was on health systems and structures throughout each state and territory in the Australian health care system. The inclusion of the systematic reviews was owing to the limited literature on a QMS. These reviews explain the systematic nature of quality management systems.

Table 2.2 shows how the 16 included articles were categorised by practice setting/context, the article's overarching theme and details on the type of study.

Table 2.2

Article Analysis By Category

Author and year	Context	Theme	Type of study
Dwyer, Judith M. 2004	Australian healthcare system	Health system strengthening	DESKTOP AUDIT Australian states & Territories
Phillips, Christine B. Pearce, Christopher M. Hall, Sally. et al. 2010	Australian general practice primary care	Health system strengthening (n = 25 databases & 19 high-quality studies)	System strengthening SYSTEMATIC review
Bailie, R. Matthews, V. Brands, J. Schierhout, G. 2013	Primary care Aboriginal health services	Health system strengthening (n = various concepts)	Promotion of systems strengthening for organisational performance through the application of stratified modelling OBSERVATIONAL STUDY Participatory action research (PAR) design
Bailie, R. Si, D. Connors, C. Weeramanthri, T. et al. 2008	Primary care Aboriginal health services	Quality improvement (n = 40–50 health centres across 4 Australian states/territories)	Promotion of ABCDE project as audit tools for chronic disease management OBSERVATIONAL STUDY PAR design
Bailie, R. Si, D. Shannon, C. et al. 2010	Primary care Aboriginal health services	Quality improvement (n = study protocols across 6 states/territories over 5 years)	Promotion of Audit tools for Indigenous health services OBSERVATIONAL STUDY PAR design

Author and year	Context	Theme	Type of study
Bailie, R. S, Si, D, O'Donoghue, L. Dowden, M. 2007	Primary care Aboriginal health services	Quality improvement (n = 12 community health centres)	Promotion of ABCD tools in a CQI approach for service delivery; effective & sustainable health programs. OBSERVATIONAL STUDY PAR design
Brennan, S. E. Bosch, M. Buchan, H. Green, S. E. 2012	Australian health care	Quality improvement (n = 41 instruments)	Instruments for CQI / Team Success factors SYSTEMATIC review
Ralph, A. P. Fittock, M. Schultz, R. et al. 2013	ACCHS—rheumatic heart disease & rheumatic fever	Quality improvement (n = 154 participants)	CQI for improvements in clinical outcomes OBSERVATIONAL STUDY PAR design
Gardner, K. L. Dowden, M. Togni, S. Bailie, R. 2010	ACCHS—Aboriginal health service enrolment in ABCD project	Quality improvement (n = 48 participants)	AUDIT TOOLS in Aboriginal Health OBSERVATIONAL STUDY PAR design
Marley, J. V. Nelson, C. O'Donnell, V. Atkinson, D. 2012	ACCHS—Aboriginal health service	Quality improvement (n = 254 participants)	Measurement of CQI & its relationship with clinical outcomes (i.e.: T2D MANAGEMENT IN DAHS—Derby AHS) CHART AUDIT
McDonald, E. L. Bailie, R. Michel, T. 2013	ACCHS—Aboriginal health service	Quality improvement (n = 8 participants)	AUDIT TOOLS in Indigenous HEALTH (HCAT) healthy community assessment tool & CQI OBSERVATIONAL STUDY PAR design

Author and year	Context	Theme	Type of study
Schierhout, G. Hains, J. Si, D. Kennedy, C. et al. 2013	ACCHS—Aboriginal health service	Quality improvement (n = 12 participants)	Barriers and Enablers for the update of CQI in NT, ABORIGINAL HEALTH SERVICES (ABCD project) OBSERVATIONAL STUDY PAR design
Buetow, S. A. Wellingham, J. 2003	Accreditation in general practice in NZ and Australia	Accreditation	AUST & NZ GP ACCREDITATION NON-SYSTEMATIC review
Elnour, A. A. Hernan, A. L. Ford, D. Clark, S. Fuller, J. Johnson, J. K. Dunbar, J. A. 2014	Accreditation in general practice, Australian healthcare system	Accreditation (n = 10 participants)	GP ACCREDITATION & Patient Safety OBSERVATIONAL STUDY
Braithwaite, J. Westbrook, J. Pawsey, M. Greenfield, D. Naylor, J. Ledema, R. Runciman, B. Redman, S. Jorm, C. Robinson, M. Nathan, S. Gibberd, R. 2006	Tertiary care and primary care	Accreditation (n = multi-level, multidiscipline, multi-method)	Hospital and primary care ACCREDITATION PAR design
Braithwaite, J. Westbrook, J. Johnston, B. et al. 2011	Australian general practice, aged care and acute setting	Accreditation (n = 12 interrelated studies)	12 interrelated studies of accreditation PAR design

Note. ABCD: Audit for Best-practice Chronic Disease Clinical Audit Tool; ABCDE: Audit and Best Practice for Chronic Disease Expansion Project Clinical Audit Tool; ACCHS: Aboriginal community-controlled health service; AHS: Aboriginal health service; CQI: continuous quality improvement; NT: Northern Territory; T2D: Type 2 Diabetes.

Iterative thematic analysis of the literature selected for review highlighted three themes that are also reflected in the broader PHC sector, as shown in Table 2.4 (see Appendix 2.1A) Theme 1, Systems Strengthening (n = 3), includes subcategories of systems thinking and system reform. Theme 2, Quality Improvement (n = 9), includes eight observational studies with subcategories of audits and continuous quality improvement. Theme 3, Accreditation (n = 4), includes two studies discussing the application of standards employed in Australian primary care and the validity of these across health care contexts, and a further two studies focused on RACGP practice accreditation. One is a pilot study of RACGP standards applied in a New Zealand GP context from general practitioners' perspectives. Another study focuses on the AGPAL surveyor perspective of the impact of RACGP accreditation on patient safety in Australian general practice environments.

2.1.4.1 Theme 1: System Strengthening

A key theme from three publications is system strengthening. The World Health Organisation defines it as:

> (i) a process identifying and implementing policy changes and practice in a country's health system to be responsive to its health and health system challenges; (ii) any array of initiatives and strategies improving health systems functions, leading to better access, coverage, quality or efficiency. (World Health Organisation, 2011, p 9)

Systems strengthening refers to the supporting instruments which enhance the effective delivery of health services such as continuous improvement, audits, staffing models, staff performance and review frameworks and communication pathways to promote systems thinking (Wilkinson R and Marmot M, 2003). R Bailie et al.'s (2013) 'Partnership Learning Model' (PLM) uses integrated concepts for the translation of knowledge to enhance health outcomes. The PLM is not dissimilar, to the current working business model used by ACCHSs. This ACCHS business model has evolved since ACCHS sector inception in 1972 and now aligns with a holistic ACCHS philosophy and responsive culture (NACCHO, 2014a). Panaretto (2014) reports that in recent times, ACCHSs have been building their capacity to use, collect and compile regional service data to monitor the health status of client cohorts, a process not dissimilar to the PLM concept described by R Bailie et al. (2013).

Dwyer argued the health systems reforms implemented by each state and territory towards centralisation would be counterproductive to stemming the burgeoning tide of chronic disease plaguing the primary and secondary care levels of the Australian health system (Dwyer, 2004). Dwyer flagged a need for better, innovative models of care (Dwyer, 2004). The

clinical governance models examined by Phillips describe clinical governance as a systematic, integrated approach to assuring safe, good, quality health care (Phillips, 2010). Phillips' endorsement of the ACCHS model as a systems approach at an organisational level may lead to effective PHC, a decrease in chronic disease, and an efficient business model (Phillips, 2010). Phillips describes the ACCHS sector as a leader in clinical governance in Australia, with valuable lessons for primary care more broadly. The knowledge gap in PHC Phillips reported was the fragmented evidence for the outcomes of clinical governance, with few models addressing safety, efficiency, sustainability, and the cost of primary care (Phillips, 2010).

There is a need to understand what quality systems are being used in the ACCHS sector (and how) to (i) drive and holistically measure the quality of care delivered by clinical teams and (ii) measure the quality of the organisation through corporate governance.

2.1.4.2 Theme 2 Quality Improvement

Quality improvement is one of the six building blocks defined by the WHO for health systems strengthening (Bailie R et al., 2013). Audits augment an organisation's risk management and clinical governance system (World Health Organisation, 2011). Seven observational studies authored by one research group describe the benefits and improvements of independent audit tools across a variety of health programs conducted within Aboriginal primary care settings (Bailie R et al., 2010, Gardner et al., 2010, Bailie et al., 2008, Bailie et al., 2007, McDonald et al., 2013, Ralph et al., 2013, Schierhout et al., 2013).

The common feature in these nine studies re-affirms that audits, when designed with specific indicators and under the right conditions, have the propensity to enhance and improve health service programs (Marley J V et al., 2012) (Ralph et al., 2013) (Brennan et al., 2012). From a systems perspective, the application of independent quality tools operates external to an organisation's compliance standard. Increasingly, health services implement (at a minimum) dual standards of quality enhancement systems. The result is a duplication of multiple audit processes through multiple quality enhancement tools coupled with the uptake of independent audit data into multiple legislated standard frameworks. The harmonisation of these quality tools for the ACCHS business raises questions of efficiency and sustainability. Under these conditions, the onus rests on the organisation to systematise the different standard processes into a QMS for national compliance. The responsibility to reduce duplication, optimise financial outlays, maximise human resource efficiencies and successfully operate health service delivery in a fiscally constrained environment is burdensome for ACCHS leadership (Silburn K., 2016).

Based on the evidence presented by these studies, there remain gaps in knowledge on: What added value are stand-alone audits offering to the existing QMS certification,

operating within the organisation? How efficient and sustainable are these stand-alone quality systems? Based on the synthesis and the questions raised, the overarching question being posed is: Have these quality systems driven efficiency in the ACCHS sector?

All authors in Themes 1 and 2 recognised vertical program funding between state and federal governments and the effectiveness of government policy, respectively, as the common limitations and disablers to harmonisation supported by Phillips (Phillips, 2010) and Dwyer (Dwyer, 2004).

2.1.4.3 Theme 3 Accreditation

Four studies were included in the accreditation theme. Two studies related to the RACGP standards (Buetow and Wellingham 2003; Elnour, 2014). The remaining two studies focused on the ACCREDIT project by Braithwaite (Braithwaite J et al., 2006; Braithwaite et al., 2011). Three of the four studies investigated the need for vendors and consumers through research to understand the value, impact and benefit of accreditation.

At a health service level, standards of compliance (such as RACGP accreditation (Australia) and QMS certification) provide a level of quality and safety for clients. Buetow and Wellingham (2003) discuss whether the non-legislated RACGP Standards provide consistency or validity, with a requisite for the RACGP standard to be an inclusion to the clinical governance framework in the NZ context. Braithwaite's 2006 and 2011 studies, performed in the Australian context, evaluate the validity, impact, and value of accreditation (Braithwaite J et al., 2006; Braithwaite et al., 2011). A knowledge gap highlighted by Braithwaite's research is reliable evidence on the efficiency and effectiveness of accreditation in achieving organisational improvements and the value of accreditation in cost-benefit terms (Braithwaite J et al., 2006; Braithwaite et al., 2011). The task of applying dual accreditation standards is a large assignment, resource intensive and an expensive process for any organisation, its leadership and staff to undertake. The stand-alone quality enhancement tools, such as audit tools and non-legislated standards, operate externally to the organisations' certification system. The conjecture is that these additional quality systems and non-legislated standards are extra cost imposts and compliance requirements, stretching existing resources and inhibiting a sustainable, systematic and efficient healthcare delivery. These discussions prompted the following questions: Is there value in the application of dual systems at the primary care level? How much do they cost, and are double accreditation/certification standards sustainable? How are these standards impacting the health and community outcomes of First Nations people?

2.1.4.4 Efficiency and Sustainability

Of the 16 studies, 10 studies refer to efficiency, effectiveness and sustainability. Phillips and Braithwaite were the only authors to contextualise efficiency and sustainability in primary care (Phillips CB et al., 2010, Braithwaite J et al., 2006). Braithwaite's 2006 study seeks to measure these quality criteria through a prospective research study across 12 countries (Braithwaite J et al., 2006). Eight studies discussed efficiency, effectiveness and sustainability as outcomes measures specific to the interventions being applied in these studies, but not in the context of a QMS as a standard used for the delivery of PHC services. The limitation evident in this review is an absence of studies exploring the application of a QMS certification standard in an Australian primary care context and its facilitation of efficiency and sustainability for health services.

2.1.4.5 Literature Quality

Table 2.3 presents the study themes and literature quality based on the criteria of credibility, transferability, dependability and confirmability. Six studies in Category 1 met all of the criteria for overall rigour (Letts, 2007). Five studies were graded as Category 2, two studies as Category 3 and three studies as Category 4 (Table 2.3).

Table 2.3

Study Quality Assessed Using the McMaster Framework

Theme	Studies	Credibility	Transferability	Dependability	Confirmability	Category
QI	1. Bailie, et al. 2007	•				4
QI	2. Bailie, et al. 2008	•		•	•	2
QI	3. Bailie, et al. 2010	•		•	•	2
SS	4. Bailie, et al. 2013	•	•			3
AC	5. Braithwaite, et al. 2006	•	•	•	•	1
AC	6. Braithwaite, et al. 2011	•	•	•	•	1
QI	7. Brennan, et al. 2012	•	•	•	•	1
AC	8. Buetow and Wellingham, 2003	•	•			3
SS	9. Dwyer, 2004	•		•	•	2
AC	10. Elnour, et al. 2014				•	4
QI	11. Gardner, et al. 2010	•		•	•	2
QI	12. Marley, et al. 2012	•	•	•	•	1
QI	13. Mc Donald, et al. 2013			•		4
SS	14. Phillips, 2010	•	•	•	•	1
QI	15. Ralph, et al. 2013	•	•	•	•	1
QI	16. Schierhout, et al. 2013	•		•	•	2

Note. SS = systems strengthening; QI = quality improvement; AC = accreditation.

2.1.5 Discussion

It is over a decade since the implementation of Australian health system standards, with limited evidence of the impact, sustainability and efficiency of these initiatives on health service delivery in the PHC sector (Bennett C, 2008). Nationally, the ACCHS sector has more than 145 health organisations that are specialists in their health care and a boutique market whereby holistic and rewarding training experiences in comprehensive PHC are sourced (Larkin, 2009).

Systematic searches of the literature found no studies currently addressing the efficiency and sustainability of implementing ISO 9001:2008 standard/QMS and quality enhancement tools in the ACCHS sector. The standards and quality enhancement tools presently used do not appear to promote efficiency and sustainability within the ACCHS business model. Since 2010, there has been a proliferation of accreditation standards introduced into the ACCHS sector (owing to the highly specialised set of care services provided in an ACCHS) and a massive increase in the number of certification bodies. There may be upward of nine different standards operating in ACCHS, maintaining a silo effect to certification and accreditation standards. The limited evidence suggests a duplication and lack of clarity on the appropriateness of the diversity of standards currently being used.

Additionally, anecdotal evidence indicates there are, on average, nine standards in operation for ACCHSs in Queensland and Victoria (Schmidt, 2018). These standards include the RACGP Standards (2015), ISO certification QMS 9001:2015, NSQHS Standards and NDIS Practice Standards, Human Services Quality Framework (for services that deliver child safety and disability services in Queensland) and the Victorian Human Service Standards. Current national aged care standards include the National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) standards, accreditation standards, Home Care Standards And Transition Care Standards. Since 1 July 2019, all aged care standards need to meet the one Aged Care Quality Standards (Schmidt, 2018).

If the standards' design is to improve the quality of business and client outcomes, the proliferation of certification/accreditation standards for PHC services raises the question: How can health services provide quality services while applying several standards with limited synergy? The application of dual standards increases staffing costs, is a financial burden and cost impost, removing the focus away from providing quality services, with flow-on effects for client health and wellbeing and community prosperity and inhibits a systematic approach to quality outcomes. The health disparity that First Nations peoples continue to experience is a result of centuries of uninformed, myopic and reactive policy, a stance supported by Pearson and Hunter (Pearson, 2011; Hunter, 2014).

The national accreditation policy was a catalyst for the emergence of a new workforce to support the application of standards across every level of the Australian healthcare system. At the regional level for the ACCHS sector, diverse new roles were established to support the application of multiple standards. New roles included quality coordinators, quality managers, auditors and an increase in certification bodies nationally. Their responsibility is for the application, assessment, monitoring and management of these standards. This research aims to contribute to the body of substantial evidence on the efficiency and sustainability of standards within the ACCHS sector.

The limited synergy of multiple standards is burdensome for ACCHSs in fiscally constrained environments. Furthermore, this burden reduces efforts to obtain sustained, holistic health and wellbeing outcomes for First Nations peoples (Australian Government, 2020). The missing component is the substantiated evidence that standards improve the efficiency and sustainability of ACCHS's business environment. The contemporary evidence supporting this statement is the number of standards any one ACCHS applies for compliance.

To comprehensively address health inequality at various levels, requires an explicit focus on issues of participation, governance and the politics of power, decision-making and empowerment (Barten F et al., 2007). The review findings and the status of onerous compliance standards for ACCHSs prompt questions of the accountability of state and federal governments in monitoring the synergy of certification and accreditation industry standards. The legislation is yet to be examined and assessed on how efficient and sustainable a national accreditation framework is for the Australian PHC sector.

2.1.6 Strengths and Limitations

This study identified, several independent quality enhancement tools in operation in the compliance and governance area for PHC services. The PHC sector, at a minimum, applies dual accreditation standards. The literature raised more questions to explore the value of the application of multiple standards in individual health services and how sustainable these are in terms of their business model. This study does not include the assessment of value, as this is the focus of a subsequent search and review as part of the overarching research project. A limitation identified in the literature was the lack of evidence for the efficiency and sustainability of stand-alone quality systems and stand-alone audit tools and their subsequent fit and synergy with applied certification standards by ACCHS. In this review, there was an absence of studies exploring the extent of a QMS in an Australian primary care context and its facilitation of efficiency and sustainability for health services. While search terms could be expanded to include concepts of efficiency and sustainability, this is the focus of further research questions in the field. What are the quality systems used in the ACCHS sector? How

do these quality systems drive and holistically measure the quality of care delivered? How are these standards impacting the health and community outcomes of First Nations peoples? The strengths of the gaps in the literature and the questions posed set the course and dialogue for the next level of research activity.

2.1.7 Conclusion

The application of multiple mandated certification standards, plus independent quality enhancement tools, is the current accreditation status for ACCHSs, creating a level of limited synergy between each 'quality system'. There is little evidence assessing the efficiency and sustainability of multiple standards and quality enhancement tools on ACCHS business model efficiencies. There are unanswered questions as to whether the implementation of quality systems has driven efficiency and sustainability in the ACCHS sector. The benefit of multiple standards for PHC services and their impact on the health and wellbeing outcomes of First Nations peoples (and their corresponding community benefits) has not been explored adequately to assert the value of the interventions.

The review findings and the status of onerous compliance standards for ACCHSs prompt questions of the accountability of state and federal governments to monitor the synergy of compliance standards in a systems approach to health care. It is crucial to ensure health services are not overburdened with compliance standards and extraneous operating expenses at the cost of delivering quality health services. The Australian Government funds PHC services to provide substantial, high-quality health outcomes for First Nations peoples, for whom chronic disease, psychosocial illness and the social determinants of health account for the majority of disparities in health outcomes. As the burden of chronic illness grows, pressure mounts on primary care to be efficient in its service delivery. Research in ACCHSs for dependable evidence on the efficiency and sustainability of compliance standards and the effectiveness of quality systems in achieving organisational improvements is vital (see Appendix 2.1A).

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2.1.9 Appendix 2.1A

Table 2.4

Data Synthesis of Eligible Papers in Describing the Application of QMS and Facilitation of Efficiency and Sustainability in Primary Care

Theme and doc ref #	Publisher	Author/year	Concept	Context/setting	Theme
System Strengthening 3 Studies 001	Medical Journal of Australia	Phillips Christine B, Pearce Christopher M, Hall Sally, Traveagkua Joanne, de Lusignan Simon, Love Tom and Kljakovic Marjan 2010	Review of the literature on models of clinical governance & exploring their relevance to the Australian PHC sector	Australian general practice primary care	QI—clinical governance & systems strengthening
002	Implementation Science	Bailie, R., Matthews V., Brands J., Schierhout G 2013	Promotion of an EB approaches to systems establishment and maintenance in PHC via a stratified model	Primary care: Aboriginal health services	SS—Promotion of Systems strengthening for organisational performance through the application of stratified modelling
003	Australian and New Zealand Health Policy	Dwyer, Judith M. 2004	(State by state) Examined the outcomes of the most recent official published reviews of systems and structures; identifies the common themes; and addresses two questions: what problems are being addressed? And how would we know if the changes were successful?	Australian Healthcare system	SR—Australian Health SYSTEMS REFORM

Theme and doc ref #	Publisher	Author/year	Concept	Context/setting	Theme
Quality Improvement 9 Studies 004	Implementation Science	Schierhout, G., Hains, J., Si, D., Kennedy, C., Cox, R., Kwedza, R., O'Donoghue, L., Fittock, M., Brands, J., Lonergan, K., Dowden, M., Bailie, R. 2013	Patterns of change in service delivery is achieved in a diverse range of health centres in a wide-scale program to achieve improvements in quality of care for Indigenous Australians	Aboriginal health services	QI—Barriers and Enablers for the update of CQI in NT, ABORIGINAL HEALTH SERVICES (ABCD project)
005	Medical Journal of Australia	Marley, J. V., Nelson, C., O'Donnell, V., Atkinson, D.2012	A decade of data to audit a health service in Derby (DAHS—1999–2009). Retrospective review of paper and electronic records	Aboriginal communities	QI—Measurement of CQI & its relationship with clinical outcomes (i.e.: T2D MANAGEMENT IN DAHS—Derby AHS)
006	Australian Journal of Primary Health	Gardner, K. L., Dowden, M., Togni, S., Bailie, R. 2010	Examines the practices and processes in policy and organisational context & aim to explore the ways in which they interact support or hinder service participation in Indigenous PHC CQI	Aboriginal health services enrolled in ABCD project	QI—AUDIT TOOLS in Aboriginal Health
007	BMC Health Services Research	Bailie, R., Si, D., Shannon, C., Semmens, J., Rowley, K., Scromgeour, D., Nagel, T., Anderson, I., Connors, C., Weeramanthri, T., Thompson, S.,	Study protocol: National research partnership to improve primary health care performance and outcomes for Indigenous peoples	Primary Care: Aboriginal health services	QI - Promotion of audit tools for Indigenous health services

Theme and doc ref #	Publisher	Author/year	Concept	Context/setting	Theme
		McDermott, R., Burke, H., Moore, E., Weston, R., Grogan, H., Stanley, A., Gardner, K. 2010			
008	International Journal for Equity in Health	McDonald, E. L., Bailie, R., Michel, T. 2013	Development and trialling of a tool to measure, monitor and evaluate key social determinants of health at community level.	Aboriginal communities	QI—AUDIT TOOLS in Indigenous HEALTH (HCAT) healthy community assessment tool & CQI
009	BMC Health Services Research	Ralph, A. P., Fittock, M., Schultz, R., Thompson, D., Dowden, M., Clemens, T., Parnaby, M. G., Clark, M., McDonald, M. I., Edwards, K. N., Carapetis, J. R., Bailie, R. S. 2013	CQI approach for improvements in rheumatic fever and rheumatic heart disease in an ACCHO	Rheumatic heart disease and rheumatic fever in ACCHO	QI—CQI for improvements in clinical outcomes
010	BMC Health Services Research	Bailie, R., Si, D., Connors, C., Weeramanthri, T., Clark, L., Dowden, M., O'Donohue, L., Condon, J., Thompson, S., Clelland, N., Nagel, T., Gardner, K., Brown, A. 2008	Pre-designed Audit tool for the specific management of chronic disease in an identified population and service setting	Primary care: Aboriginal health services	QI - Promotion of ABCDE project as Audit tools for chronic disease management

Theme and doc ref #	Publisher	Author/year	Concept	Context/setting	Theme
011	Medical Journal of Australia	Bailie, R. S., Si, D., O'Donoghue, L., Dowden, M. 2007	Promotion of ABCD tools as CQI in support of effective and sustainable health services	Primary care: Aboriginal health services	QI - Promotion of ABCD tools in a CQI approach for service delivery
012	Implementation Science	Brennan, S. E., Bosch, M., Buchan, H., Green, S. E. 2012	Systematic review of instruments to measure CQI	Australian health care	QI—Instruments for CQI / Team Success factors
Accreditation 4 Studies 013	BMC Health Service Research	Braithwaite, J., Westbrook, J, Pawsey, M., Greenfield, D., Naylor, J., Iedema, R., Runciman, B., Redman, S., Jorm, C., Robinson, M., Nathan, S., and Gibberd, R. 2006	A prospective, multi-method, multi-disciplinary, multi-level, collaborative, social–organisational design for researching health sector accreditation [LP0560737]	Australian health care services	ACCREDITATION - discussion on the research design as a framework for suitable application to future international research into accreditation
014	BMC Research notes	Braithwaite, J., Westbrook, J, Johnston, B., Clark, S., Brandon, M., Banks, M., Hughes, C., Greenfield, D., Pawsey, M., Corbett, A., Georgiou, A., Callen, J., Vretveit, J., Pope, C., Sũol, R., Shaw, C., Debono, D., Hinchcliff, Westbrook, M., Moldovan, M. 2011	Study in progress—Evaluate the effectiveness of Australian accreditation as it applies to health care across the spectrum with a variety of industry partners involved in this research	Australian general practice, aged care and acute setting	ACCREDITATION—Effectiveness of Australian accreditation for organisational performance

Theme and doc ref #	Publisher	Author/year	Concept	Context/setting	Theme
015	Quality and Safety in Health Care	Buetow, S. A., Wellingham, J. 2003	Non-systematic review of relevant research literature in English. Personal response to the posed four questions by the researcher	Accreditation in general practice in NZ, Australia and the UK	ACCREDITATION—AUST, UK & NZ GP ACCREDITATION
016	Medical Journal of Australia	Elnour, A. A., Hernan, A. L., Ford, D., Clark, S., Fuller, J., Johnson, J. K., Dunbar, J. A. 2014	Explored AGPAL surveyors perception of the impact of accreditation on patient safety	Accreditation in general practice, Australian healthcare system	ACCREDITATION—GP ACCREDITATION & Patient Safety

2.2 Paper 2. Sustainability and Efficiency with Aboriginal and Torres Strait Islander Community-Controlled Primary Healthcare Services—Disrupting the Status Quo: A Review of the Literature

NOTE: This work is submitted for publication to *BMC Health Services Research Journal*.

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2.2.1 Abstract

Background. Accreditation standards, in general, are linked to quality and safety. Accreditation of Aboriginal and Torres Strait Islander community-controlled organisations (ACCOs) is currently under review, questioning the premise of the notion that accreditation standards give a measure of quality and safety. This research delves deeper into exploring efficiency and sustainability as dimensions of quality to the application of accreditation standards in ACCOs. This paper aims to identify and understand the definitions, applications and constructs of PHC, efficiency and sustainability (as quality measures to accreditation standards) and how these concepts are applied within the ACCO sector.

Methods. Ten databases and grey literature were searched. The search strategy included 'Aboriginal and Torres Strait Islander primary health care' OR 'Aboriginal and Torres Strait Islander primary health care efficiency' OR 'Aboriginal and Torres Strait Islander primary health care sustainability'. The keywords were searched separately within each database. Peer-reviewed journal articles and reports within the scope of this review were appraised by the authors. The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) reporting standards were utilised for conducting the literature review to identify those articles with reference to the inclusion criteria. An additional content analysis was performed using Leximancer Version 5 to explore how the definitions, applications and constructs of efficiency and sustainability (as measures of quality) to the application of accreditation standards in the delivery of PHC is applied within the ACCOs context.

Results. Forty-one peer-reviewed journal articles and three reports were identified, and content analysis using Leximancer identified six significant concepts in published narratives of ACCO PHC: 'culturally', 'services', 'accessibility', 'health', 'community' and 'individual'. Analysis of the sustainability construct in these texts highlighted seven major concepts: 'service', 'leadership', 'sustainability', 'management', 'health', 'regional' and 'appropriate' and the efficiency construct is framed by five significant concepts, 'care', 'equity', 'health', 'resources', and 'process'.

Conclusions. Leximancer content analysis tool found four overarching concepts, namely 'health', 'service/s', 'community' and 'appropriate', which are all related to three major areas of this study: (a) PHC, (b) efficiency and (c) sustainability. The findings from reviewing the literature and using Leximancer to map constructs raise novel questions about the benefit of continuous quality improvement metrics, accreditation processes and how they are experienced, measured and valued.

Key words. Aboriginal and Torres Strait Islander peoples, health, wellbeing, Aboriginal community-controlled organisations, accreditation, standards, efficiency, primary health care, quality, sustainability.

2.2.2 Background

In Australia, Aboriginal and Torres Strait Islander community-controlled organisations (ACCOs) provide customised or tailored, comprehensive and holistic care,[1] focused on responding to the priorities of the Aboriginal and Torres Strait Islander communities they serve. The National Aboriginal Community Controlled Health Organisation (NACCHO) defines ACCO services as comprehensive and driven by a holistic Aboriginal worldview that incorporates body, mind, spirit, land, environment, custom and socio-economic status[2]. Aboriginal community-controlled health organisations (ACCHOs) are a network of more than 150 national businesses offering comprehensive, holistic health care to Aboriginal and Torres Strait Islander populations[2] (herein 'First Nations people'). ACCHOs are operated by, accountable to and provide holistic, culturally appropriate and accessible PHC to and for Indigenous people[3,4]. PHC, as it relates to this review, is defined as the 'socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most in need, maximises community and individual self-reliance and participation and involves collaboration with other sectors'[5]. However, ACCHOs transcend the general model of health care to include the social determinants of health[4].

The provision of this calibre of health service requires an intimate knowledge of the community, its land, environment, custom, socio-economic status and its health problems, with the community itself providing the most effective and appropriate way to address its main health problems, including promotive, preventative, curative and rehabilitative services, and economic development opportunities (Adapted from the World Health Organisation, Alma-Ata Declaration 1978)[6]. Fortuitously, ACCOs contend valiantly with a multiplicity of operating issues and with insufficient resources to service the health needs of the communities they serve. Since 2010, the Australian Government has mandated national accreditation legislation as an added measure of quality and safety for the health industry[7].

Tabrizi et al. (p. 1,438)[8] conceptualise accreditation 'as the achievement of recognition to pre-determined (practice) standards from a health care organisation, by the external peer reviewer'. Simply put, practice accreditation is peer-reviewed recognition of a health practice meeting the requirements of Australian general practice standards (the Royal Australian College of General Practitioners)[9]. Research points out that accreditation of PHC is a crucial aspect and mechanism of the perceived quality of health services[10–17]. Other studies suggest that accreditation application has a positive impact on patient care[18] and influences PHC efficiency, safety of patient care, effectiveness, timeliness, and patient-centeredness[19,20]. This is in contrast to studies which found that there is no link between the application of

accreditation standards and perceived quality of PHC services[21,22] and client satisfaction[21]. Other studies found that accreditation has a significant negative effect[23], while yet other studies suggest that improvements in health services were significantly higher for non-accredited health services[18]. The evidence is unclear on whether accreditation standards give quality (efficiency or sustainability) or whether there is an intrinsic link between the application of accreditation standards and perceived quality and client satisfaction. In addition, there is no 'one size fits all' approach to establishing accreditation standards as a tool to enhance the quality of PHC services[24]. Quality of health care is defined as the ability to access effective care on an efficient and equitable basis for the optimisation of health benefit/wellbeing for the whole population[25]. Quality PHC services lead to an effective and efficient health care system while reducing healthcare inequality[26]. Therefore, there have been calls to strengthen the research base on the accreditation of PHC services. Accreditation standards should prioritise safe care, care continuity, community-oriented care, quality care and human resource management[26].

There remains little evidence assessing the efficiency and sustainability of multiple standards and quality enhancement tools on ACCO business model efficiencies[27–29]. There is a paucity of evidence as to whether the implementation of quality systems has driven efficiency and sustainability in the PHC sector[29]. The benefit of multiple standards for ACCO services and their impact on the health and wellbeing outcomes of Australian First Nations peoples (and their corresponding community benefit) has not been explored adequately to assert their value[30]. Moreover, there are scant quality PHC accreditation studies, owing to the short history of applying PHC accreditation programs[26]. In an attempt to understand this paucity in the literature, this paper aims to identify and understand these constructs as they are used in academic literature regarding the accreditation of ACCO PHC services.

2.2.2.1 Sustainability and Efficiency as Dimensions of Quality

The core conceptual premise is that accreditation standards give a level of quality and safety. Efficiency and sustainability measures are defined for the purposes of this paper as dimensions of quality[25,31]. The operational and implementation aspects of sustainability are viewed as context-specific[32]-and need a holistic methodology for capturing all its elements[33]. In PHC services, 'sustainability' incorporates several aspects such as environmental, social, economic and health-related elements[34]. The sustainability of PHC is defined as the 'production of health outputs and outcomes at optimised efficiency with uninterrupted inputs' (Knippenberg et al., 1997, p. 11)[35]. The sustainability of PHC refers to the ability of a health service to provide ongoing access to appropriate quality care in a cost-efficient and health-effective manner (Thompson et al., 2015, p.145)[36]. Reeve et al.[37] proposed an ACCO PHC

service sustainability evaluation framework and application in the Fitzroy Valley, Victoria, Australia. According to the authors, sustainability includes environmental enablers (supportive policy, Commonwealth/state relations and community readiness) and essential service requirements (workforce, funding, governance, management and leadership, linkages and infrastructure). The sustainability measure additionally depends upon broader terms of an adequate specialist base, integration with remote communities and attention to organisation and funding issues[38]. Staffing and ongoing funding for resources were some of the factors that affected sustainability and efficiency for ACCOs in a study by Gubhaju et al[39].

More importantly, ACCO sustainability is attained through financial viability, recruiting and retaining skilled human labour and the use of advanced information and communication technology systems[40]. However, ACCOs have not been financially sustainable owing to limited funding[41] to support the application of multiple disparate accreditation standards.

To increase levels of sustainability as it pertains to PHC accreditation in ACCOs these measures are key considerations to funders of ACCOs. At a funder level, McCalman et al.[42] identified resource allocation channels and bottlenecks in hierarchical funding approval processes as key challenges of ACCOs. A good majority of these key measures can be grouped into the principles of clinical governance. Phillips et al.[43] and others performed a systematic literature review on different models of clinical governance to explore their relevance to Australian PHC and their contributions to safety and quality. Their evidenced findings found clinical governance focuses on process rather than outcomes and is fragmented[43]. Is a systems-wide approach to clinical governance on outcomes the panacea to resolving enhanced safety, efficiency, sustainability and the economics of PHC?

Efficiency refers to the assessment of the relationships between costs of organisational structures and processes, processes of care and intermediate outcomes[44]. Efficiency of services is perceived as the second of the main dimensions of quality[35]. Furthermore, research postulates that the analysis of PHC efficiency is a challenging undertaking to complete[45]. It represents the capability of different production units to transform their inputs into outputs[46]. Under-resourcing of ACCOs results from the cumbersome allocation of funding and contributes to inefficiencies[47,48]. However, few studies have investigated the efficiency of the PHC model despite efficiency playing a crucial role in primary health care services[49]. More specifically, ACCOs in rural and remote areas require more efficient resources to meet the minimum health needs of First Nation people[50].

The aim of this review is to identify and understand the definitions, applications and constructs of PHC through the quality measures of efficiency and sustainability within an ACCO context. The review addressed these research questions:

1. What are the definitions, applications and constructs of PHC within ACCOs?
2. What are the definitions, applications and constructs of efficiency within ACCOs?
3. What are the definitions, applications and constructs of sustainability within ACCOs?

2.2.3 Methods

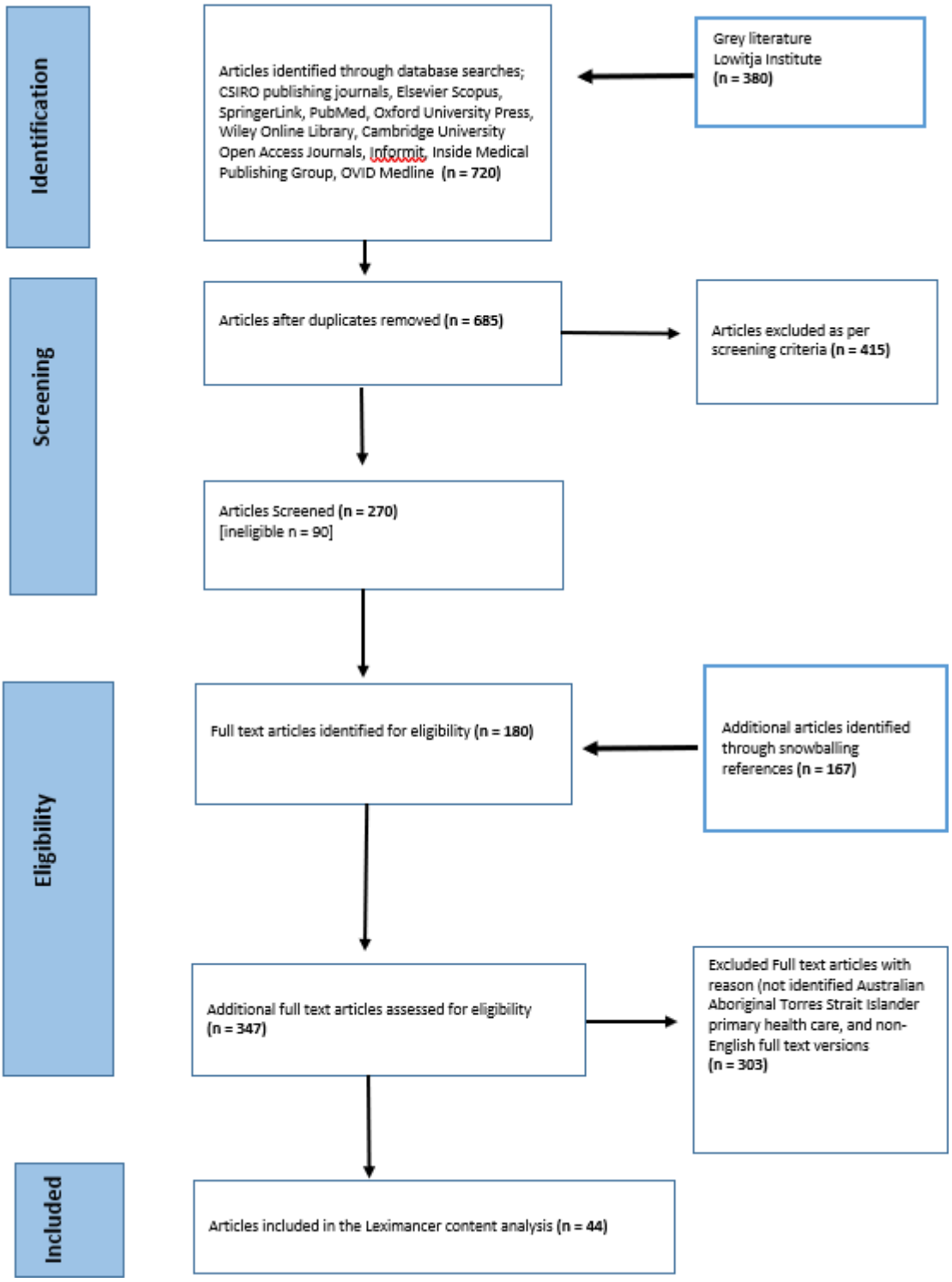
This review of the literature was focused on unpacking the dimensions of efficiency, sustainability and PHC in the ACCO sector via an examination of medical and First Nations Australian health research. The study searched prominent medical databases and a significant collection of grey literature within the Lowitja Institute research collection to explore the concepts and language used to construct a discourse about efficiency and sustainability in the ACCO PHC sector. The PRISMA (see Figure 2.2) reporting standards were used to frame the search development and present the outcomes of the search[51].

2.2.3.1 Search and Information Sources

The selection of databases, search terms and search strategy were designed in collaboration between the first author and the second author to ensure comprehensive coverage and quality of studies to be included in the literature review. In the first step, five databases (CSIRO Publishing Journals, Cambridge University Press Open Access Journals, SpringerLink, PubMed, Oxford University Press) and grey literature from the Lowitja Institute research collection were searched. The initial identification of peer-reviewed journal articles was conducted using a structured keyword search. The search was not limited to any specific period, to gain a comprehensive history of the use of these terms and frequency of use over time in the PHC research literature. Key words included a combination of sustainability, efficiency, quality, equality, social accountability and social responsibility with specific reference to PHC. The keywords were searched separately within each database. The second step involved an expansion of the initial databases to ensure relevant literature in the topic area was identified. The second search included the databases Wiley Online Library, Elsevier Scopus, Informit, Insight Medical Publishing Group and Ovid MEDLINE. Furthermore, in the second step, the keywords were rephrased to be broad. The second search used broad terms that included a combination of the following keywords: ‘primary health care’, ‘efficiency in primary health care’ and ‘sustainability in primary health care’.

Figure 2.2

PRISMA Flowchart for Leximancer Content Analysis



Note. Description of search strategy and article retrieval.

A total of 1,100 peer-reviewed journal articles were retrieved from the keyword searches. The search was restricted to peer-reviewed articles only and excluded book chapters, conference papers, editorials, books, notes, conference reviews and letters. After the

removal of duplicates, it was found that 685 studies were eligible. This was further screened according to the exclusion criteria, producing 415 further exclusions. The remaining 270 studies were then screened against full-text and inclusion criteria to produce 180 eligible articles. At this stage, an additional snowballing approach of references from two seminal articles produced an additional 167 articles. After two more rounds of eligibility criteria screening, the final number of articles included in this study was 44.

2.2.3.2 Data Collection Process and Study Selection

Inclusion criteria. Papers published in peer-reviewed journals and reports that addressed PHC, sustainability and efficiency were included. Under inclusion criteria, references had to focus on one or more aspects of Aboriginal and Torres Strait Islander PHC efficiency or sustainability; that is, the mere mention of the term 'efficiency' or 'sustainability' was not sufficient. Additional inclusion criteria were peer-reviewed journals, the English language and available in full text.

Exclusion criteria. Papers published in languages other than English. Duplicates and articles that did not address the research questions were excluded. Articles without full-text versions in English were excluded from the literature review after strategies of obtaining a full-text English file (e.g. Google Scholar, use of library loans/subscriptions) were exhausted. In addition, peer-reviewed articles that merely mention the terms 'quality' and 'accreditation' were not sufficient. Book chapters, conference papers, editorials, books, notes, conference reviews, letters, trade publications, book series, conference proceedings, publications under review and early-stage publications were excluded. Exclusion criteria were research concerning efficiency or sustainability in health education, hospitals or other subject areas such as business studies, environmental studies and international studies.

Eligibility criteria. According to Groene et al.[52], eligible papers are described in terms of general characteristics (settings, type and level of respondents, mode of data collection), methodological properties (sampling strategy, item derivation, conceptualisation of quality management, assessment of reliability and validity, scoring) and application/implementation (accounting for context, organisational adaptations, sensitivity to change, deployment and effect size). In our research, we opted for peer-reviewed journal articles published in full text in English and studies that provide definitions, applications and constructs of PHC, efficiency and sustainability in the context of ACCOs. Table 2.5 presents the inclusion and exclusion criteria.

Table 2.5

Inclusion and Exclusion Criteria

Aspect	Inclusion criteria	Exclusion criteria
Subject area	Aboriginal and Torres Strait Islander primary health care, OR 'Aboriginal and Torres Strait Islander primary health care efficiency', OR 'Aboriginal and Torres Strait Islander primary health care sustainability'	Other subject areas (i.e. health education, hospital etc.) International studies
Document type	Peer-reviewed journal article	Book chapter, conference paper, editorial, book, note, conference review, letter
Source type	Journals and reports	Trade publications, book series, book, conference proceedings
Language	English	Other languages
Publication stage	Final	Under review, early-stage publication

Note. The final 44 peer-reviewed studies included nine primary health care articles, 23 sustainability articles and 12 efficiency articles.

2.2.3.3 Data Extraction Strategy

Data extracted by the second author included author, year of publication, definitions, applications and constructs associated with ACCO PHC, efficiency of ACCO PHC and sustainability of ACCO PHC (see Section 2.2.9, Appendix or https://research.jcu.edu.au/data/published/be97a090311f11ef83f72ba19396a1c8). The extracted data were entered on a standard Microsoft Word table. Furthermore, the first author independently checked the extracted data from the published peer-reviewed journal articles and reports. The summarised notes provided a precise text as part of the substantial data preparation.

2.2.3.4 Data Analysis

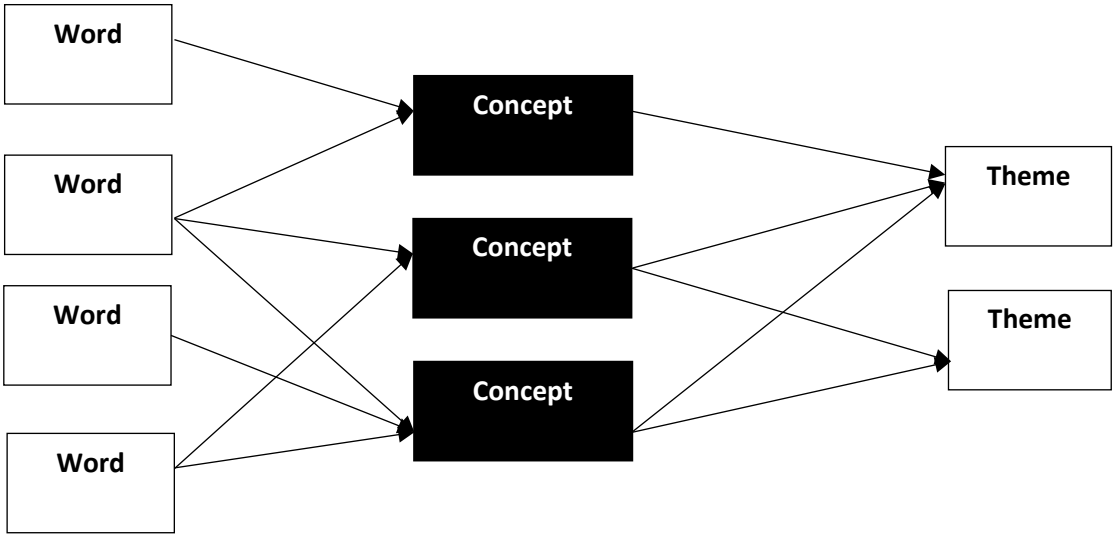
To comprehend, identify and explore the definitions, applications and constructs of PHC, efficiency and sustainability within an ACCO context, a second-level analysis of the 44 articles was performed using Leximancer Version 5 for content analysis. Leximancer is a 'data mining tool used to analyse the content of collections of textual documents and to visually display the extracted information'[53]. Leximancer assists researchers who do not have a framework/model by which to examine available data[54–56]. Leximancer, by design, assists novice researchers who may face the risk of simplifying the data analysis process and painting

erroneous findings and inferences[54]. The Leximancer software is interactive and permits the data analyst to directly search, add, remove and merge terms as well as the above automatic process[55]. Leximancer software creates its own lists and associations based on the input text[57]. The mining of concepts is accomplished through word occurrences by studying terms that signify meaning around a certain keyword[55].

These concepts are utilised to categorise text at a resolution of multiple sentences[53]. As a result, a lexical concept is created when a sequence of associated words is co-located together through the text[55]. From synonyms, adjectives, proper nouns and compounds, seed concepts are formed as an opening point, and a thesaurus is formed[55]. Figure 2.3 presents the semantic pattern extraction process and three major elements in Leximancer analysis.

Figure 2.3

Simplified Model or Semantic Pattern Extraction in Leximancer



Note. Source: Crofts and Bisman (2010) Interrogating accountability: An illustration of the use of Leximancer software for qualitative data analysis. Qualitative Research in Accounting and Management. 2010;7(2):180–207. doi: 10.1108/11766091011050859

Leximancer software uses word occurrence, and co-occurrence counts to obtain main thematic and conceptual content directly from an input text[57]. In this case, fewer simple concepts can index much more complex connections by recording co-occurrences[53]. A semantic meaning is generated through a conceptual analysis attained by the availability and occurrence of words, phrases and co-occurrence of words leading to the generation of a concept[55]. This artificial intelligence process produces a customised classification illustrated graphically via an interactive concept map or as tables indicating key concepts and conceptual relationships[57]. By progressively increasing map resolution illuminating supplementary

concepts, their association is viewed through the spanning tree[57]. The analysis outcome produces explicit and implicit concepts[55]. The data can be further explored for the relational ranking of concepts to demonstrate how pairs of concepts are being applied in the original text through the linking buttons[57].

Leximancer software further strengthens the illustrative process to support the researcher's analysis of concepts in the original text linked to a global perspective of the entire dataset, providing automatically generated concept maps[57]. The Leximancer, 'concepts' are signified by the size of the circles; the bigger the circles, the more prominent the concept. Concepts that attract each other are grouped together in themes, displayed as coloured circles. The most important theme/s is coloured red and orange with colours progressing around the colour wheel, the least important themes being coloured blue, green and purple[58]. Leximancer software triangulates qualitative data analysis to enhance trustworthiness[56]. The concept is statistically reliable and reproducible, being created from input text itself; however, manual analysis requires checks for coding reliability and validity[57].

2.2.4 Results

Of the 44 peer-reviewed articles and reports, nine addressed ACCO PHC, 23 were associated with ACCO PHC sustainability, and 12 addressed ACCO PHC efficiency articles (see https://research.jcu.edu.au/data/published/be97a090311f11ef83f72ba19396a1c8). Data on key study descriptors were extracted (e.g. author(s) and year of publication, title, place published, definitions, applications and constructs of PHC Or sustainability Or efficiency within ACCOs) for Leximancer content analysis. These articles were individually summarised and imported separately to Leximancer software creating three different projects in Leximancer. The extracted data included definitions, applications and constructs. We grouped our content analysis findings under three headings: definitions, application and constructs of PHC, definitions, application and constructs of sustainability and definitions, application and constructs of efficiency.

2.2.4.1 Definitions, Application and Constructs of Primary Health Care

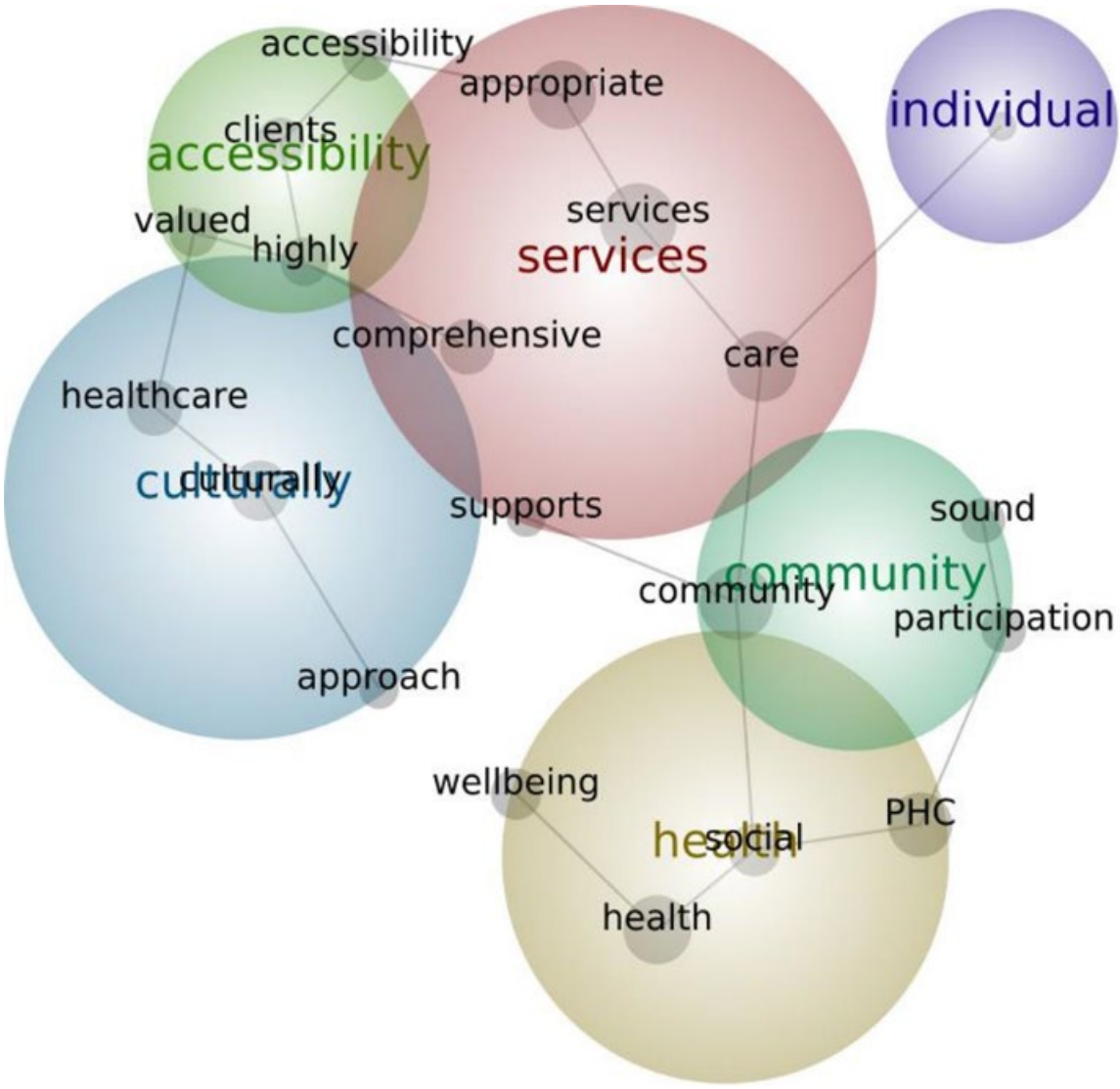
Figure 2.4 depicts the themes and concept definitions of PHC literature that describe the ACCO context. The figure depicts the theme 'Services' (red circle) as being dominant on the concept map and linked to the themes, 'Accessibility', 'Culturally', and 'Community'. The size of the circles indicates the interconnectedness of each of the themes.

The dominant theme 'Services' (red circle) encompasses the concepts of (words appearing on the red circle) 'services', 'appropriate', 'supports', 'care' and 'comprehensive'. The concepts 'comprehensive' and 'supports' are shown to be frequently occurring and strongly connected to the themes 'Services' and 'Culturally'. Other themes illustrated but not

connected to the theme ‘Services’ include ‘Individual’ and ‘Health’. The size highlights the importance of the relationship between Theme 1, ‘Services’, and other themes (Theme 3, ‘Culturally’; Theme 4, ‘Community’; and Theme 5, ‘Accessibility’). The concepts ‘comprehensive’ and ‘supports’ are linked with Theme 1 ‘Services’ and Theme 3 ‘Culturally’. The second most prominent theme, Theme 2, ‘Health’ (gold circle), highlights other areas of research of First Nations peoples PHC. Theme 2, ‘Health’, connects with Theme 4, ‘community’. Theme 3, ‘Culturally’ (blue circle), consists of the concepts ‘approach’ and ‘healthcare’. Theme 4, ‘Community’ (larger green circle), contains the concepts ‘community’, ‘sound’ and ‘participation’. The concept ‘sound’ emerged within Theme 4, ‘Community’, zooming in on the co-occurrence of the concept ‘sound’ with other discovered concepts, such as ‘participation’, ‘individual’ and ‘community’. In Table 2.7, ‘sound’ co-occurred with participation four times. The likelihood score of 100%, (# co-occurrences of ‘sound’ and ‘participation’)/ (# occurrences of ‘sound’) = 4/4, an interpretive example maybe the concept ‘sound’ co-occurs with the concept ‘participation’ 100% of the time.

Figure 2.4

Concept Map Primary Health Care



Theme 4, ‘community’, is linked with Theme 1, ‘Services’, and Theme 2, ‘Hospital’. Theme 5, ‘Accessibility’ (smaller green circle), contains the concepts of ‘accessibility’, ‘clients’, ‘valued’ and ‘highly’. The empirical concept map has only one concept that is in a theme of its own ‘Individual’, indicating that an individual is not serviced as an individual but from a community health care perspective. Table 2.7 lists the concepts in ranked order based on the number of times they occur (e.g. ‘Count’). This statistic is converted into a relevance score, computed as the percentage frequency of text segments which are coded with that concept relative to the frequency of the most frequent concept in the list. The 15 most frequent concepts encountered in this section were ‘PHC’, ‘health’, ‘services’, ‘community’, ‘care’, ‘appropriate’, ‘culturally’, ‘social’, ‘healthcare’, ‘wellbeing’, ‘comprehensive’, ‘accessibility’, ‘participation’, ‘sound’ and ‘clients’. This conception indicates that the literature refers to ACCOs PHC as culturally appropriate, comprehensive and accessible. For ACCO PHC services to

be efficient and sustainable, they should have sound participation among community members, and its major outcome is community wellbeing and sound participation. For further details of Table 2.7, Count and relevance concepts PHC, refer to Appendix 2.2A supplementary material.

2.2.4.2 Definitions, Application and Constructs of Sustainability

Figure 2.5 depicts the theme 'service' as being dominant on the concept map and linked to the themes 'Leadership', 'Sustainability', 'Management', 'Health', 'Regional' and 'Appropriate'. The dominant theme 'Service' encompasses the concepts of 'Sustainability', 'PHC', 'Service', 'Community', 'Local', 'Funding', 'Health', 'Communication', 'Integration' and 'Processes'. The concept 'Communication' is shown to be frequently occurring and strongly connected to the themes 'regional', 'Health', 'service' and 'sustainability'. Other themes illustrated but not connected to the theme 'service' include 'Practice' and 'Program'.

Figure 2.5

Concept Map Sustainability

Figure 2.5 shows the most prominent theme for 'sustainability' is Theme 1 'Service'. 'Service' (red circle) consists of concepts including 'service', 'local', 'community', 'funding',

'health', 'integration', 'processes', 'PHC', and 'communication'. Theme 1, 'Service', is linked to Theme 2, 'sustainability' (gold circle), Theme 3, 'Health' (light yellow circle), Theme 4, 'Management' (blue circle), Theme 5, 'Leadership' (big green circle), and Theme 6, 'regional' (smaller green circle). The size of the circles indicates the interconnectedness of each theme/s, indicating the ACCOs Services are linked to the 'sustainability', 'Health' and 'Leadership' themes. The circle size highlights the importance of the relationship between Theme 1, 'Service', and other themes (Theme 2 ', sustainability', Theme 3 'Health' and Theme 5 'Leadership'). The concepts of 'processes', 'integration', 'communication', 'funding' and 'community' are linked with Theme 2 'sustainability', Theme 3 'Health' and Theme 6 'regional'.

The second most prominent theme, Theme 2, 'sustainability' (gold circle), highlights the concepts 'adequate', 'care', 'staff', 'primary', and 'sustainability'. Theme 2, 'sustainability,' connects with Theme 1, 'service', Theme 2 ', Health', Theme 6 'regional' and Theme 7 'Appropriate'. Theme 3, 'Health' (light yellow circle), consist of concepts 'community', 'essential', 'funding', 'communication', 'adequate', 'care' and 'staff'. Theme 4, 'Management' (blue circle), is linked to Theme 1, 'Service'. However, this relationship is not strong. Theme 5 'Leadership' is linked with Theme 1 'Service' and Theme 3 'Health'. Theme 6, 'regional' (smaller green circle), contains the concepts 'regional', 'communication', 'integration' and 'processes'. The empirical concept map has two concepts that are themes of their own: Theme 8, 'Practice' (light purple circle), and Theme 9 'Program' (purple circle). The 15 most frequent concepts encountered on the concept map sustainability were 'sustainability', 'service', 'health', 'care', 'community', 'funding', 'leadership', 'adequate', 'workforce', 'management', 'local', 'requirements', 'essential', 'staff' and 'appropriate'. Table 2.9 (see Appendix 2.2A supplementary material) displays the co-occurrence of the concept 'sustainability' with other discovered concepts, such as 'funding'. The concept 'sustainability' co-occurred with 'funding' 14 times. This concept co-occurrence held a likelihood score of 93%, (# co-occurrences of 'sustainability' and 'funding') / (# occurrences of 'sustainability') =14/15. The analysis may be interpreted as the concept of 'funding' co-occurs with the concept of 'sustainability' 93% of the time, highlighting funding is contingent on and a core ingredient for services being sustainable. This conception indicates that ACCOs' sustainability is based on funding and financial stability.

Table 2.8 Count and relevance of concept-sustainability is supplied in the supplementary material Appendix 2.2A. Table 2.9 Co-occurring concepts of sustainability to other related concepts can be found in Appendix 2.2A supplementary material.

2.2.4.3 Definitions, Application and Constructs of Efficiency

In this segment, we examined the terms and definitions of efficiency as evidenced by the content analysis tool Leximancer. As Figure 2.6 shows, the most prominent theme across efficiency definitions, applications, and constructs is Theme 1, 'Care' (red circle), with concepts including 'processes', 'PHC', 'care', 'inefficiencies', 'services', 'efficiency' and 'patients'. Theme 1, 'Care' is linked to Theme 3 ', Resources', Theme 4 'Equity', and Theme 5 'Process'. The circle size indicates the interconnectedness of each of the themes. This indicates the ACCO PHC is linked to the 'resources', 'process', and 'equity'. The size highlights the importance of the relationship between Theme 1 'Care' and Theme 3 'Resources'. The second most prominent theme, Theme 2, 'Health' (gold circle), highlights significant areas of First Nations PHC efficiency. Theme 2 'Health' is connected with Theme 3 'Resources'. The concepts 'resourcing' and 'funding' connect to Theme 2 'Health' and Theme 3 'Resources'. Theme 3, 'Resources' (green circle), consists of concepts 'resources', 'resourcing', 'future', 'arrangements' and 'efficient'. Theme 4, 'Equity' (blue circle), contains the concepts 'resource', 'value', 'equity' and 'objectives'. Theme 5, 'Process' (purple circle), consists of two concepts: 'process' and 'government'.

Figure 2.6

Concept Map Efficiency

The 15 most frequent concepts encountered in the concept map efficiency are ‘health’, ‘service’, ‘efficiency’, ‘future’, ‘allocation’, ‘healthcare’, ‘inefficient’, ‘services’, ‘efficient’, ‘sector’, ‘performance’, ‘process’, ‘appropriate’, ‘effective’ and ‘arrangements’. Table 2.11 (see Appendix 2.2A supplementary material) shows the co-occurrence of the concept ‘efficiency’ with other discovered concepts, of ‘allocation’. Table 2.11 shows ‘efficiency’ co-occurred with allocation 11 times. The likelihood score of 64%, (# co-occurrences of ‘efficiency’ and ‘allocation’) / (# occurrences of ‘efficiency’) =7/11, is interpreted as the concept ‘allocation’ co-occurs with the concept ‘efficiency’ and a likelihood of 64%. This conception indicates that ACCO efficiency is discussed in the literature as being based on the allocation of resources and measurable performance.

Table 2.10, Count and relevance of the concept efficiency, is in the supplementary material Appendix 2.2A. The details of Table 2.11, Co-occurrent concepts of efficiency to other related concepts, are in the supplementary material Appendix 2.2A.

2.2.5 Discussion

Worldwide, the accepted proposition for the application of standards is that accreditation standards provide a level of quality and safety for health and other businesses. A previous literature review by this team situated this research and found an absence of studies exploring the extent of a quality management system/standards in an Australian primary care context and its facilitation of efficiency and sustainability for health businesses[30]. This review set out to explore what are the definitions, applications and constructs of PHC within ACCOs. What are the definitions, applications and constructs of efficiency and sustainability within ACCOs? There is a lack of evidence for efficiency and sustainability as measures of quality and their subsequent fit and synergy with applied certification/accreditation standards by ACCOs[30]. The strengths of the gaps in the first literature review set the course and dialogue for this second literature review.

A robust two stage analysis to authenticate the literature review was applied. In Stage 1, PRISMA was used to identify the eligible articles. For Stage 2, a content analysis tool, Leximancer, was applied to the 44 eligible articles.

Our analysis of the Leximancer data found the four concepts of health, service/s, community and appropriateness related to all three major areas of this research: (a) PHC, (b) efficiency and (c) sustainability. Our findings affirm the ACCO service model design focusses on six significant aspects of accessibility, culture, services, health, community and individual. Service accessibility of ACCOs is delivered in a culturally appropriate[59,60,3] and culturally safe manner[61]. The application of accreditation standards by ACCOs should, by all measures, seek to uphold, promote and respect culture. The nimbleness of ACCO service accessibility, sector-wide, is responsive to community health needs and individual care through the use of increased opening hours, affordable services and incentives for check-ups[60]. These mechanisms are enablers to augur and promote trusted relationships and continued shared cultural knowledge and values[62]. After 13 years of ACCOs implementing multiple and different accreditation standards, we give notice to standard owners and certification bodies on the following. The ACCO application and implementation of mandated, industry-based, prescriptive accreditation standards must uphold, promote and recognise culture within their standard indicators. Recognising culture acknowledges First Nations history and existence. Any lesser measure diminishes culture and is biased to the prominent distinction and beneficial wellbeing factor of culture for First Nations peoples and the business of ACCO services.

Anything less renders, industry-based, prescriptive accreditation standards culturally deaf and biased to the sector to which they are mandated. These exposed biases promote non-inclusive practices, asserting a non-Indigenous worldview exclusive in ACCO accreditation assessments. In 2023, First Nations rights and culture must be respected across all quality systems in service delivery. Culture should be embraced as an instrument for increasing awareness, comprehending and improving individual and community health care needs for a more equitable and just health system delivery[63].

Leximancer identified the frequency of prominent themes and co-occurrences associated with the study words of 'efficiency', and 'sustainability', exposing refined levels of relational data. Efficiency and sustainability, as measures for this research, are defined as dimensions of quality[25,31]. The Leximancer relational data builds the interlinking prominent themes of efficiency and sustainability of PHC delivery in ACCOs.

The Leximancer data identified 15 frequent concepts linked to efficiency relative to PHC as being 'health', 'service', 'efficiency', 'future', 'allocation', 'healthcare', 'inefficient', 'services', 'efficient', 'sector', 'performance', 'process', 'appropriate', 'effective' and 'arrangements'. The themes are equity, process, health care, resource and allocation. From these themes, Leximancer identified a likelihood score of 64% co-occurrence with 'efficiency' and 'allocation', a strong conceptual relationship. The ACCOs' efficiency and equity require adequate resourcing of their health care services[58]. Under-resourcing of the ACCOs generates inefficiencies[47] and inhibits implementing Indigenous health care policy[48]. From our triangulated data, one identified area of under-resourcing has been the ongoing financial support for ACCOs to maintain the demand for reporting and the increased number of mandated, prescriptive accreditation standards their businesses apply. The application of multiple and different accreditation standards in ACCOs over the past decade requires a dedicated team of staff with the specialist technical skillsets and requisite knowledge to navigate accreditation standards implementation and maintenance. These teams will be required to apply several standards and prepare for several accreditation cycles at the same time. The potential exists for staff to become weighed down by the volume of work in the preparation time, reported as being 9–12 months of work, for specialist staff per accreditation cycle compared with an assessment time of 4 days by the certification body and standard assessors. This reported reality renders the accreditation readiness processes inequitable in terms of investment. These findings alone set the platform for a robust dialogue on the validity, value and benefit of the ACCOs' return on investment in applying multiple forms of accreditation standards.

The Leximancer data for sustainability identified 15 frequent concepts as service, health, care, community, funding, leadership, adequate workforce, management, local, requirements, essential, staff, appropriate and sustainability. The themes are regional, health, services and sustainability. Leximancer identified a co-occurrence likelihood score of 93% of 'sustainability' with 'funding', indicating sustainability of PHC is intrinsically linked to funding. Thompson et al. (2015) describe sustainability as the ability of health services to provide ongoing access to appropriate quality care in a cost-efficient and health-effective manner (Thompson et al. 2015 p 145)[36]. The enormous financial burden ACCO businesses carry through the application of multiple mandated industry-based prescriptive accreditation standards and reporting is excessive[65]. The budget to employ a team of specialist staff to manage and monitor multiple accreditation standards includes additional cost imposts experienced by ACCOs since the implementation of an Australian national accreditation framework in 2010. The ACCOs sustainability is attained through financial viability, recruiting and retention of skilled human labour and the use of advanced information and community technology systems[40]. To lighten the accreditation standard burden ACCOs carry, we recommend additional federal government support through the design of accreditation Medical Benefits Schedule (MBS) item numbers as a strategy to alleviate this burden on the ACCO sector. These targeted ACCO-designed MBS item numbers will enable the purchase of technical efficiency tools to monitor and manage multiple levels of reporting and assessments for ACCOs in the interest of quality and safety. The design of MBS accreditation item numbers should support the ACCO sector with the financial capacity to employ staff who have this level of specialist skills or who can be adequately trained. These enabling measures assist the ACCOs sector - wide cost recovery from well over a decade of carrying this heavy accreditation burden within existing stretched budgets.

2.2.6 Limitations

This study is unique in its search protocol and analysis. To our knowledge, this is the first study that aims to identify a nuanced understanding of the definitions, applications and constructs of PHC, efficiency and sustainability and how these concepts are applied within the context of ACCO application of multiple forms of accreditation standards. An important limitation of this study is that some of the studies included for Leximancer analysis have been authored by non-Indigenous people who write from a peripheral or 'outsider' perspective on ACCOs. Conversely, these authors provide valuable insight based on their participation and stance on the ACCO business. Another key limitation of this research is that we did not use an existing quality assessment tool on the articles included for Leximancer analysis. Instead, we followed PRISMA reporting standards for conducting a systematic literature review. The

strength of this study is in the dual layers of analysis performed in this study. The initial phase was a review of the literature based on PRISMA (Figure 2.1). The outcome of this literature review was a total of 44 articles. The second-level analysis with Leximancer unpacked these definitions to uncover the driving concepts that efficiency and sustainability are built on in the ACCO sector and to consider how this language use informs thinking and structure in the sector.

2.2.7 Conclusion

There is widespread uptake of accreditation standards with ACCOs using numerous sets of multiple and different accreditation standards[7]. Furthermore, some of the accreditation standards are not easily applicable to ACCOs[1]. Our study provides a deeper and more nuanced understanding of the efficiency and sustainability of accreditation measures and quality dimensions applied in PHC. The findings raise novel questions about accreditation metrics and the value of continuous quality improvement metrics in accreditation. Accreditation standards that adopt a holistic approach acknowledge First Nations people's culture and context, and integrate culturally safe systems are a minimum step to reducing racism and discriminatory practices in the multibillion-dollar Australian accreditation industry. We sound the alarm for the accreditation industry players, policymakers, and government (state and federal) to use this research as important data in their evaluation of the national accreditation legislation for extra support through funding, leadership and workforce training to enhance the efficiency and sustainability of ACCOs. Efficiency and sustainability as quality traits demand synchronicity in the design of accreditation standards by industry-based standard owners to reduce the number (of accreditation standards) ACCOs apply. This study is unique and is the first to examine such issues in this context.

Declarations

Ethical Approval

Ethics number is H7865—JCU Human Research Ethics.

Competing Interests

No, I declare that the authors have no competing interests as defined by BMC or other interests that might be perceived to influence the results and discussion reported in this paper.

Authors' Contributions

The authors confirm their contribution to the paper as follows: study conception and design: Jenifer Darr, Nkosinathi Sithole, Richard Franklin, Kristin McBain-Rigg and Vicki Saunders; data collection: Nkosinathi Sithole; analysis and interpretation of results: Jenifer Darr and

Nkosinathi Sithole; draft manuscript preparation: Jenifer Darr, Nkosinathi Sithole, Kristin McBain-Rigg, Richard Franklin and Vicki Saunders. All authors reviewed the results and approved the final version of the manuscript.

All Authors

1. Drafted the article or revised it critically for important intellectual content; AND
2. Approved the version to be published; AND
3. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Availability of Data and Materials

This declaration is ‘not applicable’.

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2.2.9 Appendix 2.2A: Supplementary Material

Table 2.6

Systematic Review Search Strategies for Selected Databases

Database	Search query
CSIRO Publishing Journals	(‘Aboriginal and Torres Strait Islander’) AND (‘primary health care’) OR (‘sustainability’)
Elsevier Scopus	TITLE-ABS-KEY (aboriginal AND torres AND strait AND islander AND primary AND health AND care) AND (EXCLUDE (PUSTAGE. ‘aip’) AND (EXCLUDE (AFFILCOUNTRY, ‘New Zealand’)) OR EXCLUDE (AFFILCOUNTRY, ‘United Kingdom’) OR EXCLUDE (AFFILCOUNTRY, ‘Canada’) OR EXLCUDE (AFFILCOUNTRY, ‘United States’) OR EXCLUDE (AFFILCOUNTRY, ‘Denmark’) OR EXCLUDE (AFFILCOUNTRY, ‘United Arab Emirates’) OR EXCLUDE (AFFILCOUNTRY, ‘Spain’) OR EXCLUDE (AFFILCOUNTRY, ‘Sweden’) OR EXCLUDE (AFFILCOUNTRY, ‘Uganda’)) AND (EXCLUDE (DOCTYPE, ‘re’) OR EXCLUDE (DOCTYPE, ‘ed’) OR EXCLUDE (DOCTYPE, ‘no’) OR EXCLUDE (DOCTYPE, ‘ch’) OR EXCLUDE (DOCTYPE, ‘le’) OR EXCLUDE (DOCTYPE, ‘sh’) OR EXCLUDE (DOCTYPE, ‘er’) OR EXCLUDE (DOCTYPE, ‘cp’)) AND (EXCLUDE (SRCTYPE, ‘b’)).
Springer Link	‘Aboriginal AND Torres AND Strait AND Islander AND primary AND health AND care AND efficiency’
	‘Aboriginal AND Torres AND Strait AND Islander AND primary AND health AND care AND sustainability’
PubMed	(‘Aboriginal’) AND (Torres Strait Islander’) AND (‘primary care’) OR (‘primary health’) AND (‘efficiency’) OR (‘sustainability’)
Oxford University Press	(‘Aboriginal and Torres Strait Islander’) AND (‘primary health care’) OR (‘primary health care efficiency’) OR (‘primary health care sustainability’)
Wiley Online Library	(‘Aboriginal’) AND (‘Torres Strait Islander’) AND (‘primary care’) OR (‘primary health’) OR (‘efficiency’) OR (‘sustainability’)
Cambridge University Press Open Access Journals	(‘Aboriginal’) AND (‘Torres Strait Islander’) AND (‘primary care’) OR (‘primary health’) AND (‘efficiency’) OR (‘sustainability’)
Infomit	All Fields; Aboriginal and Torres Strait Islander primary health care OR all fields; efficiency or sustainability AND Limit to: Full Text AND Limit To: Peer Reviewed AND Resource Type: Journal AND Identifier: Aboriginal Community Controlled Health Services (ACCHS) AND Subject: Australia
Insight Medical Publishing	(‘Aboriginal’) AND (‘Torres Strait Islander’) AND (‘primary care’) OR (‘primary health’) AND (‘efficiency’) OR (‘sustainability’)

Database	Search query
Ovid MEDLINE	(‘Aboriginal’) AND (‘Torres Strait Islander’) AND (‘primary care’) OR (‘primary health’) AND (‘efficiency’) OR (‘sustainability’)
Grey databases	(‘Aboriginal’) AND (‘Torres Strait Islander’) AND (‘primary care’) OR (‘primary health’) AND (‘efficiency’) OR (‘sustainability’)

Table 2.7 links to Fig 2.4

Count and Relevance Concepts-Primary Health Care

Concept	Kind	Count	Relevance_percentage
PHC	NAME ACRONYM	10	91
Health	WORD	11	100
Services	WORD	10	91
Community	WORD	10	91
Care	WORD	9	82
Appropriate	WORD	8	73
Culturally	WORD	6	55
Social	WORD	6	55
Healthcare	WORD	5	45
Wellbeing	WORD	5	45
Comprehensive	WORD	4	36
Accessibility	WORD	4	36
Participation	WORD	4	36
Sound	WORD	4	36
Clients	WORD	3	27
Highly	WORD	3	27
Valued	WORD	3	27
Approach	WORD	3	27
Supports	WORD	2	18
Individual	WORD	2	18

Table 2.8 links to Fig 2.5

Count and Relevance of Concept-Sustainability

Concept	Kind	Count	Relevance_percentage
PHC	NAME ACRONYM	10	17
Sustainability	WORD	60	100
Service	WORD	44	73
Health	WORD	30	50
Care	WORD	21	35
Community	WORD	20	33
Funding	WORD	15	25
Leadership	WORD	12	20
Adequate	WORD	11	18
Workforce	WORD	11	18
Management	WORD	11	18
Local	WORD	10	17
Requirements	WORD	10	17
Essential	WORD	9	15
Staff	WORD	9	15
Appropriate	WORD	9	15
Regional	WORD	8	13
Policy	WORD	8	13
Program	WORD	8	13
Primary	WORD	7	12
Processes	WORD	7	12
Partnership	WORD	7	12
Changes	WORD	6	10
Organisations	WORD	6	10
Planning	WORD	6	10
Integration	WORD	5	8
Communication	WORD	5	8
Work	WORD	5	8
Evaluation	WORD	5	8
Linkages	WORD	5	8
External	WORD	5	8
Practice	WORD	5	8

Concept	Kind	Count	Relevance_percentage
Coordination	WORD	4	7
Building	WORD	4	7
Outreach	WORD	4	7
Demand	WORD	3	5
Regular	WORD	3	5
Base	WORD	3	5
Capacity	WORD	3	5

Table 2.9 links to Fig 2.5

Co-Occurring Concept: Sustainability to Other Related Concepts

Concept	Kind	Related concept	Related kind	Count	'Likelihood percent'
sustainability	WORD	PHC	NAME ACRONYM	10	100
sustainability	WORD	Health	WORD	30	100
sustainability	WORD	Care	WORD	21	100
sustainability	WORD	Community	WORD	20	100
sustainability	WORD	Adequate	WORD	11	100
sustainability	WORD	Local	WORD	10	100
sustainability	WORD	Essential	WORD	9	100
sustainability	WORD	Regional	WORD	8	100
sustainability	WORD	Primary	WORD	7	100
sustainability	WORD	Processes	WORD	7	100
sustainability	WORD	Workforce	WORD	11	100
sustainability	WORD	Integration	WORD	5	100
sustainability	WORD	Policy	WORD	8	100
sustainability	WORD	Staff	WORD	9	100
sustainability	WORD	Appropriate	WORD	9	100
sustainability	WORD	Work	WORD	5	100
sustainability	WORD	Coordination	WORD	4	100
sustainability	WORD	Evaluation	WORD	5	100
sustainability	WORD	Building	WORD	4	100
sustainability	WORD	Demand	WORD	3	100
sustainability	WORD	Linkages	WORD	5	100
sustainability	WORD	Partnership	WORD	7	100
sustainability	WORD	Regular	WORD	3	100
sustainability	WORD	Base	WORD	3	100
sustainability	WORD	Capacity	WORD	3	100
sustainability	WORD	Changes	WORD	6	100
sustainability	WORD	External	WORD	5	100
sustainability	WORD	Organisations	WORD	6	100
sustainability	WORD	Planning	WORD	6	100
sustainability	WORD	Program	WORD	8	100
sustainability	WORD	Practice	WORD	5	100
sustainability	WORD	Funding	WORD	14	93

Concept	Kind	Related concept	Related kind	Count	'Likelihood percent'
sustainability	WORD	Service	WORD	41	93
sustainability	WORD	Requirements	WORD	8	80
sustainability	WORD	communication	WORD	4	80
sustainability	WORD	Leadership	WORD	9	75
sustainability	WORD	Outreach	WORD	3	75
sustainability	WORD	Management	WORD	8	73

Table 2.10 links to Fig 2.6

Count and Relevance of Concept—Efficiency

Concept	Kind	Count	Relevance_percentage
Aboriginal	NAME GENERAL	11	61
PHC	NAME ACRONYM	6	33
Health	WORD	18	100
Service	WORD	16	89
Efficiency	WORD	15	83
Future	WORD	13	72
Allocation	WORD	11	61
Healthcare	WORD	7	39
Inefficient	WORD	6	33
Services	WORD	5	28
Efficient	WORD	4	22
Sector	WORD	4	22
Performance	WORD	3	17
Process	WORD	3	17
Appropriate	WORD	3	17
Effective	WORD	3	17
Undermines	WORD	2	11
Government	WORD	2	11

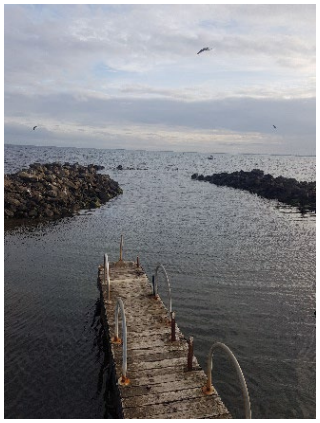
Table 2.11 links to Fig 2.6

Co-Occurring Concept—Efficiency to Other Related Concepts

Concept	Kind	Related concept	Related kind	Count	'Likelihood percent'
efficiency	WORD	PHC	NAME ACRONYM	6	100
efficiency	WORD	Aboriginal	NAME GENERAL	7	64
efficiency	WORD	Efficient	WORD	4	100
efficiency	WORD	Sector	WORD	4	100
efficiency	WORD	Effective	WORD	3	100
efficiency	WORD	Government	WORD	2	100
efficiency	WORD	Future	WORD	11	85
efficiency	WORD	Services	WORD	4	80
efficiency	WORD	Service	WORD	12	75
efficiency	WORD	Health	WORD	13	72
efficiency	WORD	Inefficient	WORD	4	67
efficiency	WORD	Performance	WORD	2	67
efficiency	WORD	Appropriate	WORD	2	67
efficiency	WORD	Allocation	WORD	7	64
efficiency	WORD	arrangements	WORD	1	50
efficiency	WORD	Undermines	WORD	1	50
efficiency	WORD	Healthcare	WORD	3	43
efficiency	WORD	Process	WORD	1	33

3 The Viewing Platform

(Methodology—My Indigenist Lens)



[Old Williamstown Jetty. Photo credit: Jenifer Darr.]

[4]Love is patient, Love is kind. [7]Love never gives up, never loses faith, is always hopeful and endures through every circumstance [1 Corinthians 13:4, 7].

This methods chapter is a labour of love and discovery. This chapter embodies the types of methods and study design used in the research project with our rationale, presented from my Indigenist lens. Enjoy discovering the various research tools employed, to produce academic rigour, validity and poise to this new body of knowledge.

Chapter 3: The Viewing Platform—Methodology Chapter

[Source: stock images|stickers]

Finding flowers, harvesting nectar and making good honey

3.1 Catalyst to the PhD Marathon

A problem is usually the initiator of thinking about doing a PhD. From July 2006 to June 2008, I was engaged as Health Service Manager at a rural ACCHS. The assignment: to build the health service to full capacity again. I learned that, for the health service to access Service Incentive Payment (SIP) and Practice Incentive Payments (PIP),[5] it had to be accredited with RACGP. This meant the health service was required to pay for the services of AGPAL (the certification body licensed to assess against the RACGP standards) to monitor its application of RACGP standards criteria. The monitoring was performed through their online portal and dashboard. Three glaring problems arose (for me) in the process of the health service becoming RACGP registered and accredited. One problem was the fundamental misalignment of accreditation and business type; this led to my astonishment at and questioning of whether the RACGP standards were truly fit-for-purpose in this health service and, more broadly, whether they were a good fit for the nature of the ACCHS business model. The ACCHS business model provides holistic health and wellbeing care, from pre-birth to aged care, for some ACCHSs (Darr et al. 2021). My experience of trying to fit the RACGP standards as an accreditation framework for ACCHSs, the standards were not written to suite the ACCHS business model. The second problem was the nature of the link between accreditation and funding: Why was it mandatory for the health service to have RACGP accreditation to access the MBS SIP and PIP payments? The third issue was data sovereignty: Why were we using a third-party online portal to pour our data into with nothing in return for our efforts—except an RACGP accreditation certificate? These were the driving forces encountered that required our pursuit of a solution and are the 'why' behind commencing this PhD.

3.2 Drawing from the Past and Present to Improve Our Future

From July 2006 to 2010, I was a scholar in the Building Indigenous Research Community (BIRC). The specific purpose of BIRC is to provide an Indigenous-led, culturally responsible system of infrastructure and support centred on building the capacity of

[5] Service Incentive (SIP) and PIP are federal government MBS item numbers claimable for health services and general practitioners linked to a health service. SIPs are claims eligible to GPs linked to enrolled health services for identified services. PIPs are eligible practice (health service) payments for identified services to enrolled health services only.

Indigenous Australians in research skills. The BIRC logo and motto is 'drawing from the past and present to improve our future' (Elston et al. 2013).

The research prism is a critical Indigenist lens and borrows this quote from Elston et al. (2013:6): 'Until recently, the Indigenous voice in "accreditation" research has not been heard, the Indigenous perspective not seen, and the Indigenous experience not expressed'. Paying honour to Professor Elston acknowledges my participation as a BIRC Scholar. The strands woven in this story express, draw from, acknowledge and honour the magnanimous work of Professor Elston's research. The adopted and adapted BIRC principles are the framework in which this methods chapter is immersed. Thank you, Professor Elston, for your commitment, vision and contribution to this body of work. The identified and defined principles appear in Table 3.1.

Table 3.1

BIRC Principles—Adopted and Adapted Framework

Principle	Definition
Indigenous knowledge	Indigenous knowledge incorporates Indigenous knowledge systems and Indigenous research methodologies privileging Indigenous ways of knowing, being and doing within research (Martin and Mirraboopa 2003; Rigney 2001). Indigenous knowledge refers to traditional knowledges and the growing body of scholarship seeking to develop more culturally relevant, respectful research methods and adherence to cultural protocols.
Ownership, Indigenous leadership and respect	Ownership, Indigenous leadership and respect annunciate the core elements advocated for by the Indigenous researcher[s] within an Indigenous research agenda. Furthermore, it emphasises Indigenous leadership, ownership and respect for Indigenous peoples, histories and traditions in research practice, including notions of empowerment and reciprocity.
Identity	Refers to the way both the First Nations and the non-First Nations participants expressed notions of their cultural/spiritual origins and places of belonging, such as Country, family and community.
Cultural interface	Acknowledging the cultural-difference challenges experienced in personal, professional and research relationships occurring between First Nations and non-First Nations project participants, including sensitivities to, as well as respect for Indigenous and non-Indigenous differences in histories, worldviews and understandings.

Note. Adapted from Elston et al. 2013:6.

The PhD research title is 'A Critical Indigenist Examination of the Impact on Efficiency and Sustainability of QMS in Aboriginal Primary Health Care'. The lens this research is performed through is self-determining and demonstrates the uncovering of new knowledge in a rigorous way, privileging an Indigenist standpoint and voices. Our research turns the gaze

upon the Australian accreditation industry players, uncovering a social justice conundrum through the supply of rigorous new evidence for the ACCHS industry to mull over. The focus of our accreditation research and the depth of data uncovered have never been explored. This evidence provides a solid starting point for the hard questions that must be asked and to hold those confronting conversations. Drawing from the past and present to improve the future of the accreditation industry, nationally and globally, has culminated in the PhD thesis; the results are 10 years in the making.

3.3 Prior Experience and Knowledge a Deep Well for the PhD

I stepped into the accreditation milieu in the year 2000. After the experiences described above, I was engaged in a project management role, which had me oversee the project design, project management and execution of a dual accreditation process (implementation of ISO 9001:2008 QMS certification standard and reaccreditation to RACGP standard) at a large urban ACCHS in Queensland, Australia. Their footprint is spread across the city's north, west and inner city, with an active client base of 12,000 clients. This business had 11 managers, including the CEO, across 14 business units plus seven satellite sites. The Commonwealth Department of the Office of Aboriginal and Torres Strait Islander Health Services (OATSIHS) mandated that the ACCHS sector apply a second accreditation standard, ISO 9001:2008 QMS, in 2010. This project was one year behind schedule at the point of my engagement and the dual accreditation process was not known until I was employed—a nice surprise, but manageable. From October 2011 to December 2013, I worked alone, averaging 16-hour days, to complete the task. Within 16 months, certification was achieved, from the initial engagement of the certification body to their receipt of the certification certificate. This experience was not without serious major bouts of health issues: as a result of this demanding assignment, I walked into the service wearing a size 18 and reduced to a size 12 with a loss of 25 kg by the end of this gruelling dual project management assignment of accreditation. On the upside, Box 1 outlines the many 'first experienced' moments as the most noteworthy achievements.

Box 1

Ten Major Achievements from this Dual Certification||Accreditation in 16 Months

1. Oct 2011—December 2013: Worked closely with each business unit manager to ensure the successful implementation and effective interpretation of the ISO standards and execution throughout the organisation.

2. National Working Group [panel of 5] to develop an ISO Interpretive Guide for NACCHO and the ACCHS sector.

3. Nov 2012: Lead Auditor Training.

4. Feb 2013: ISO Stage 1 Certification to Clauses 5–8 9001:2008.

5. March 2013: OATSIHS risk assessment received a low-risk rating across all 41 criteria. The only ACCHS to receive this in Australia.

6. May 2013: Successfully applied for an EQIS grant from the Commonwealth for $ 110K.

7. Developed a suite of Policies and Procedures for a Quality Manual aligned to ISO 9001:2008 mandatory standards.

8. June 2013: ISO Gap Audit in preparation for ISO Stage 2. minor non-conformance noted and corrected.

9. August 2013: Successful ISO Stage 2 Certification with Conformance with clauses 4–8 (excluding 7.3) ISO 9001:2008 QMS—certification granted.

10. November 2013: ISO Certification achieved for this ACCHS in a timeframe of 16 months.

The dual certification accreditation assignment between 2011 and 2013 placed us (myself and this ACCHS) at the cutting edge of the introduction of a second certification standard to the Queensland ACCHS industry and the Australian accreditation industry.

3.4 Valuing History, Being, Community and Cultural Obligations in the Academy to Step onto the Viewing Platform

I was not the average PhD student. Locke et al. (2022) and others identified Indigenous, Māori and Pacific Islander success as doctoral students as something that is to be found in the strength of the student–supervisor relationship. Where supervisors understand and value the family, community and cultural responsibilities of First Nations students, successful relationships are formed, and achievement follows (Locke et al. 2022; Wilson 2017). I stepped into the PhD with 13 years of extensive project management experience, managing the roll-out of multiple accreditation standards in rural, remote and urban ACCHSs, orbiting (in various roles) in the accreditation industry with several solid successes forming my professional portfolio. At the same time as my enrolment, I was contacted by Professor Melissa Crowe, who urged me to submit an application to be part of the JCU Doctoral Cohort program. I was successful and grateful. I could now pick up in January 2013 from where BIRC ended in 2010 with the support I needed.

In July 2013, my clan group elders nominated me as our legal representative for our Country in Mackay as ‘The Applicant’ to prosecute for our lawful acknowledgement and access to our never-ceded ancestral land and sea, Country, with the local, state and federal governments in the Federal Court of Australia. In hindsight, I embarked on, simultaneously, two large-scale, medium-term (seven and ten-year) project-management assignments.

Our successful claim over our never-ceded ancestral land and sea, Country—all 313,000 hectares—was delivered by High Court Judge Justice Robertson[6] on 25 February 2020. A seven-year journey is not without its pitfalls. As a Christian believer, one scripture that encapsulates this entire process is Job 23:10 (NIV): 'But he knows the way that I take, when he has tested me, I will come forth as gold'. I have learned over time how one manages these assignments and that the attitude applied determines where and how you land on the other side. A management adage adding supportive weight, is the 'Pareto principle' or 80:20 rule. Dunford et al. (2014) describe the Pareto principle as meaning that 80% of the consequences are produced by 20% of the causes for the phenomena under study. Their study goes on to examine how this ratio '80:20' is not fixed.

As with any beginning, we started with (in hindsight) a collection of people on our research panel and, along the way, realised we had to find the right mix of people to journey with me. A refinement process had to be worked through. Identifying the right fusion of people with their unique blend of skills, knowledge and disciplines in a shared space is important to my success. Good people whose support for me was significant for this marathon. We arrived at a fusion of people and their blended, unique skill sets in 2017, for which I am grateful, when time matured us all, creating a cohesive unit (Elston et al. 2013; Locke et al. 2021, 2022). This journey took over a decade to arrive at the right appointed time to be positioned for impact. But for the grace of God.

These professional appointments positioned me for the PhD and brought me experiential working knowledge in the application of multiple accreditation standards in different businesses, including a proven track record in real-world project management of eight different accreditation standards into various ACCOs. These settings are a mixture of remote, rural and urban ACCOs. My national accreditation experience was added to through my employment at the Australian Defence Force (ADF) as a quality manager across their bases in Victoria and Tasmania. I, along with my line manager, developed a proposal for the ADF on a systematic quality improvement model moving from an audit tool to an accreditation framework. The replacement—an accreditation standard, Garrison Health Standards (J. Darr personal correspondence Line Manager May 2015)—is for use nationally in the ADF health services across the armed forces of the Airforce, Army and Navy. As this PhD candidature ends, my wealth of accreditation experience and knowledge sits in remote, rural and urban ACCO across two states, Queensland and Victoria, and the national experience with the Joint Health Command in the ADF further adds to the enhancement of my experiential and tacit

[6] https://aiatsis.gov.au/ntpd-resource/1924 accessed 10/11/2023

accreditation knowledge. Large-scale project management in the success of the Yuwi Allodial title and implementing accreditation standards into companies, with more than two decades of experience in project management, health service management and accreditation, is my strength. My entire PhD has been performed as an external student at James Cook University. In a case study, Whedbee (2009) showed that students who exhibited academic persistence held three traits: an appreciation of community support, a strong sense of self-efficacy and an internal locus of control.

3.5 Coupling the PhD Research to Industry—Finding Cadence and Gems in the Field

Wisdom, refined by life experiences, is the trait maturity brings to contemplating a link to the accreditation industry. Our research eventually found a rhythm. A business strategy was needed to keep me linked to the accreditation industry trends with continued hands-on experience while doing the PhD full-time. The solution: in 2018, I started my own consulting business, Jadee Consulting. The sole purpose was to target a marginalised market, giving specialist support to those companies in rural and remote Australia going through first-time accreditation or reaccreditation. This level of specialist skill, knowledge and expertise is in short supply in these settings. This business strategy added support to the identification of community-based participatory research (CBPR) methodology. In 2019, Jadee Consulting secured the engagement of a company situated in remote Queensland who were going through their first-time accreditation for one of their program areas. The company is Kowanyama Aboriginal Shire Council (KASC), which became a partner in our research project. The CBPR methodology in partnership with KASC was twofold. Their accreditation experience provided a direct link into the accreditation marketplace while furnishing the PhD with segments of the field note reports across the three-year accreditation cycle from October 2019, 2020 and 2021, through to April 2022. The accreditation journey for this company became the narrative case study for the thesis. Minkler et al. (2003) make a case for increasing support for CBPR as a valuable tool for action-oriented and community-driven public health research. Reciprocity by way of individual capacity building was offered to staff within KASC. CBPR, as indicated by Wallerstein and Duran (2006), is an alternative research paradigm geared toward improving health and reducing health disparities by integrating education and social action. The emphasis of CBPR is oriented to framing research focused on relationships between research partners and goals of societal transformation (Wallerstein and Duran 2006). Minkler et al. (2003) claim that participants of CBPR give ‘more than informed consent’, based on Green and Mercer’s (2001) research. Participants consent openly to share their knowledge and experiences in identifying key problems to be studied, formulates research questions in culturally sensitive ways, and uses the study results to assist in supporting program and policy

development or social change (Minkler et al. 2003, Green and Mercer 2001). The narrative case study provided insights into what was experienced by the company's staff, their interactions with the assessors (tasked with assessing the application of the accreditation standard in the program) and the certification body In navigating their first-time accreditation experience. The narrative case study is a principal component of this thesis. The generosity of the staff's time and experience is the gift of their story. We hold with weighty responsibility their accreditation experience to retell it with gravitas for the benefit of others.

3.6 First and Second Search and Find Missions—Using PRISMA and Leximancer

The qualitative research was performed through two systematic literature reviews to situate the research and find the gaps in the literature. The aim of the first literature review was to answer: To what extent does the implementation of the International Organization for Standardization 9001:2008 QMS facilitate efficiency and sustainability in the ACCHS sector? This situated the research, and the evidence is found in Chapter 2 The Gap and the Guide—A Work in Progress (See Section 2.1). The second literature review delved deeper to explore efficiency and sustainability as dimensions of quality to the application of accreditation standards in ACCOs. The aim of this paper was to identify and understand the definitions, applications and constructs of PHC, efficiency and sustainability (as measures of quality) and how these concepts are applied within the ACCO sector; it appears in Chapter 2 The Gap and the Guide—A Work in Progress (See Section 2.2). Applied was a second level of content analysis of this literature through Leximancer (Harwood 2015). Ten databases and grey literature were searched. The search strategy included 'Aboriginal and Torres Strait Islander primary health care' OR 'Aboriginal and Torres Strait Islander primary health care efficiency' OR 'Aboriginal and Torres Strait Islander primary health care sustainability'. The keywords were searched separately within each database. Peer-reviewed journal articles and reports within the scope of this review were appraised by the authors. The PRISMA reporting standards were utilised for conducting the literature review to identify those articles with reference to the inclusion criteria (Moher 2009). An additional content analysis was performed using Leximancer Version 5[7] to explore how the definitions, applications and constructs of efficiency and sustainability (as measures of quality) to the application of accreditation standards in the delivery of PHC is applied within the ACCOs context.

3.7 Research Resilience amid the COVID-19 Pandemic

The field work for this research commenced at the same time the entire world experienced the COVID-19 global pandemic (hereafter referred to as COVID). We were forced

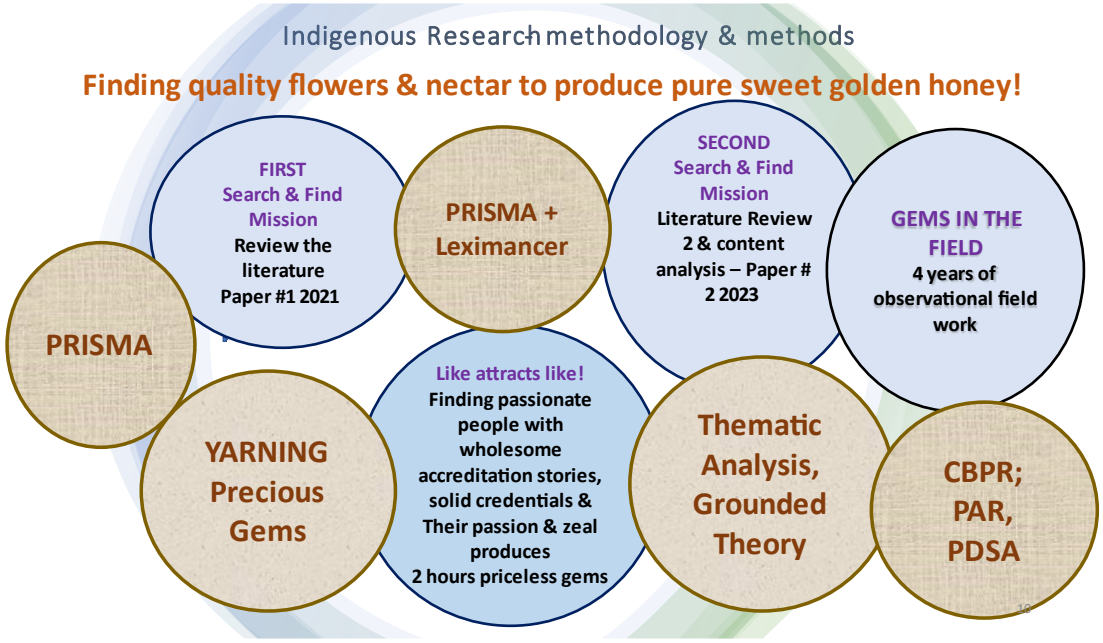
[7] https://www.leximancer.com/ [accessed 24 April 2024]

to rethink the process of how we performed our field work with participants in a highly protective and prescriptive ever-changing policy environment in Australia (Power 2020; Davis and Williams 2023). The impact of these applied restrictions changed with regularity, state by state and at a national level. For those of us situated in Melbourne, Victoria, Australia, COVID-19 hit our shores in March 2020 with draconian restrictions applied across the entire state of Victoria (Clark 2021; Power 2020).

I recall my personal experience. At one point, we were only allowed out of our homes for one hour, including shopping for our groceries and exercise. We could only travel within a 5 km radius and were threatened with army barricades if, as citizens, we did not comply. Victoria endured these prescriptive measures for two entire years, 2020 and 2021, and the residual effects were still being felt in 2022. For the research, COVID-19 affected our ability to address some of our objectives and aims, causing us to pivot in our address of these. COVID limited our ability to successfully engage the ACCHS sector as partners in our research. We are thankful we did engage and received the consent and support of one ACCO in KASC. To the CEO, councillors and the Women's Service staff, we are grateful for your input, wisdom, support, care and time as one of our industry partners. We value the gift of our relationship and partnership.

Figure 3.1

Indigenous Research Methodology and Methods



James Cook University ethics final approval arrived in May 2021: Ethics H7865. The ethics approval upholds the four principles that underpin ethical Australian Indigenous

research as outlined in the AIATSIS (2020) Code of Ethics for Aboriginal and Torres Strait Islander Research (AIATSIS 2020).

A COVID risk management strategy was a JCU requirement before our field research commenced with participants. Our research team were compelled to readjust to pivot our engagement with participants in this new COVID climate. Considered thought was given to our advertising to attract participants from an online platform. We deliberated on the preferred electronic platform to engage participants and the process for how we would receive and follow up with participants who agreed to participate. The preferred platform was one of the research project partners, Radarborg Ltd, and their LinkedIn page because the calibre of users are primarily professionals. Our target cohort criteria were (i) individuals who worked in the ACCOs geographically located in Eastern Australia, in Queensland, New South Wales or Victoria. These were the first three states to roll out ISO 9001:2008 QMS; and (ii) individuals who were working in accreditation in health services or who were part of the Australian accreditation industry.

3.7.1 The Process

We compiled registers of ACCOs on the East Coast of Australia. Emails were sent to every one of the ACCOs listed on our register with the same advertisement content in the emails for consistency of information. We applied two rounds of advertising. The email invites were our first round of advertising. Many of these email addresses were generic and not responded to (in this COVID environment) because many of them were not monitored. Our second round of advertising engagement on the Radarborg LinkedIn profile page proved successful. For consistency, an advert in the form of a flyer was developed and loaded onto Radarborg's LinkedIn page advertisement. We were seeking eligible participants to self-select for our interviews. From June to July 2021, we designed the email advertising campaign. Our persistence paid off and our advertising campaign ran from August to October 2021.

3.7.2 Study Participant Selection and Process

A web-based search by the research associate developed an electronic register of ACCOs listed in Queensland (28, n = 13 valid), New South Wales (38, n = 16 valid) and Victoria (24, n = 13 valid). Ninety organisations on our register were from a network of 145 ACCOs nationally (n = 42 valid). Forty-eight were invalid registrants, meaning we were unable to engage with the business during COVID. The register held their registered business names, addresses with associated details and email contact. The email contacts were generic administration addresses. Our yarning circles [interviews and focus groups] with consenting self-selected participants commenced in the middle of COVID. The majority of businesses in Victoria closed their doors. Most of the business staff were deployed to work from a ‘home

work' environment. Nil responses were received from the businesses we phoned on our register from follow-up calls in Victoria and NSW. Engagement with Queensland services was sporadic, with minimal phone calls answered.

Creativity assisted in attracting eligible participants, the Radarborg LinkedIn page was created as a means of static engagement for self-selection from prospective participants. The LinkedIn page in a COVID environment gave us direct access to the professionals we were seeking. An Eventbrite invitation page captured participant agreement on LinkedIn and their names were held on a separate register. The researcher's JCU email was used to send participant confirmation and nominated interview time. In complying with JCU ethics, three attachments accompanied each prospective study participant's email: (1) the HREC-approved research information sheet (to keep), (2) the HREC-approved consent form (requesting a signed copy be sent back before the yarning circle [interview/focus group] participation)and (3) our white paper (see Section 3.16). The white paper laid out the background to the national accreditation framework, the number of certification bodies and the number of standards, and three questions for each participant to consider prior to their interview (Box 2).

Box 2

White Paper Questions

Question 1. How has the increase in accreditation certification bodies (CBs) in Australia since 2010 affected the quality and efficiency of ACCHOs?
Question 2. In your ACCHO, what does an audit process for accreditation entail?
Question 3. How do you or would you assess the efficiency and sustainability of your ACCHO context? (based on the content of this paper).

3.7.3 Researcher Reflection and Acknowledgement

We gave considered thought and planning to our ability to attract self-selected study participants. We exhausted all avenues for their engagement in our study. To have received 12 people who found our research advertisement in the middle of COVID on LinkedIn is nothing short of a miracle. To have been afforded access to the calibre of interviewees we had was simply incredible.

The development of the white paper was an open invitation to usher each of the interviewees into our online home (the Zoom platform because we were the hosts). The white paper, coupled with a warm, welcoming invitation and introductions, established a safe space for each of them to be who they were. More importantly, the action in preparing the white paper with the research questions let them know we valued each of them, their knowledge, their experience and their pursuit of doing better in their compliance roles. Most of all, we

valued their time. I have learned in management and over the course of my professional career that *time* is the one commodity no one can ever retrieve. Once you have given it, it is spent. Hence, for me, as the researcher, it was important to hold each of the interviewees in this space of appreciation—to let each of the interviewees know we valued their effort, time and commitment in showing up to be interviewed. Their generous experiential knowledge and wisdom afforded us expansive data to shape and inform the research process and outcomes, and this is priceless! For me, as the researcher who knows the accreditation terrain, the white paper was my personal acknowledgement of their emotional, physical and mental spend in an ever-changing accreditation environment. This is precious, like little gems that remain hidden in the busyness of their roles and are only revealed in these moments. Each of them is a trailblazer in this space, and they deserve our utmost thanks and gratitude.

The white paper helped the participants formulate their thinking ahead of time to give generously to our conversations around these open-ended questions as we moved through their yarns (either 1:1 or in a focus group format). Most of the interviews were approximately two hours in length, providing depth and richness to the type of information gathered, adding volume to our large datasets. Kennedy et al. (2022) and others discuss the benefit of decolonising qualitative research through respectful, reciprocal and responsive research in yarning methods for qualitative First Nations health research. Indigenous methodologies and methods are used to shift the research paradigm and privilege Indigenous ways of knowing, being and doing in this chapter and thesis overall (Elston et al. 2013; Kennedy et al. 2022; Martin and Mirraboopa 2003; Rigney 2001; Tuhiwai Smith 2021).

On reflection, what made the yarning circles significant, to draw out the depth and breadth of knowledge we elicited from each participant, came down to a number of converging factors working in unison. The COVID environment and the use of social media via the LinkedIn online platform to advertise our research project was the perfect blend and access point to entice participants to engage in our research. The LinkedIn page, we knew is designed for a professional audience, and the only accessible platform our research required to engage our target audience. Our level of detailed planning afforded us deeper and multi-layered authenticity to their participation in yarning circles via Zoom.

After confirmed agreement was received from each participant, we emailed the white paper, which become the common historical thread for participants to ponder on before moving into the yarning circle. Their multi-layered authenticity were the participants lived experience, meaning what worked and didn't work for them in navigating their accreditation experience as each of them matured in their roles. We listened to their learned, self-taught specialist skills each developed over time and the depth and breadth of their working

knowledge in the Australian accreditation industry nationally and internationally from participants with international accreditation industry expertise.

These multi-layered processes created the deep authenticity; and expertise each participant contributed to the yarning circles. This experience is proof, that we could not have engaged the calibre of participants, or harvested this level of experience and expertise if the yarning circles were performed face to face across each state and territory. Using social media platforms (via LinkedIn and Zoom) provided the access, reach, and targeted engagement without the physical, financial, and emotional constraints of time, travel, and logistics.

The experiences held in the interviewees' yarns are the intangibles that compliance staff wear, but which are very rarely acknowledged and are spent with minimal appreciation. I saw each of them and felt the unspoken emotion behind every one of the interviewees' yarns. I am grateful for their openly generous contribution to this body of knowledge. Kennedy et al. (2022) and Barlo et al. (2021) place importance on the engagement of yarning as an Indigenist research practice, allowing for more flexibility than other interviewing approaches and a protective space for relationality. Yarning as a method opens up an environment that fosters rapport with participants' open discussion and allows for participant-led research to co-create knowledge and privilege Indigenous voices (Barlo et al. 2021; Kennedy et al. 2022).

3.7.4 Study Participants, Value

A total of 16 participants agreed and confirmed their interest in being engaged in a yarn (interview), with representation from Queensland (QLD), New South Wales (NSW), Victoria (VIC) and South Australia (SA). Four out of seven states and territories indicates representation from the majority of Australian states and territories. From these (n = 16), three were no-shows, and one confirmed and consented, then opted out before the interview date. The total number of participants included in the study was 12 (n = 12). The questions were provided to each participant ahead of our yarning circles (interviews). From our perspective, this tactic insured each of the participants stepped into the meeting room (Zoom platform), arriving at the yarning (interview) space with the same base-level knowledge. Interviews from consenting study participants were conducted from November 2021 through June 2022—a total of six months (excluding December 2021 and January 2022). All of the interviewees held a minimum of seven years of continuous experience in the accreditation industry. Seven years' experience assigns each interviewee as a subject matter expert; accreditation is a highly specialised field. Half of the interviewees held dual roles of auditor, surveyor and assessor in the assessment of accreditation standards or auditing certification standards. Three key informants owned their own businesses. The study represented four

states (QLD, NSW, VIC and SA), with study participants holding a combined experience of 154 years in the accreditation industry (excluding the three key informants).

3.8 Unpicking the Realities, Laying Bare the Yarning Threads: Thematic Analysis and Transformational Grounded Theory

Now that we have all this data, what do we do with it? The data analysis process was performed over 12 months—from July 2022 through July 2023. The 12 participant interviews were voice recorded with an approximate time of two hours each. Each interview was transcribed by a professional transcription company. These electronic links held on the cloud were time-limited for download into the researcher and research associate's NVivo 12 plus software[8] (hereafter referred to as NVivo). NVivo provides the electronic means to identify, sift and sort the data for analysis. The first stage for the researcher was to understand and become very familiar with the data gleaned from each study participant and focus group. Each of the transcribed interviews was printed in hard copy with three initial reads of each interview by the researcher to be familiar with the interviewees' data. On the third read, handwritten notes were made on each interviewee's hard copy. From the researcher's handwritten notes, memos were created as the initial refining process to analysing the distilled data. Codes were developed, nodes created and themes evolved from the data. Braun and Clarke (2023) affirm thematic analysis as a method to systematically identify, organise and give insight into patterns of meaning across the dataset. By tunnelling the researcher's focus on the meaning across the dataset, the researcher sees and makes sense of the collective or shared meanings and experiences (Braun and Clarke 2023).

The researcher took handwritten highlight notes of each of the interviews, forming a second bank of notes translated into memos and housed in NVivo 12 plus.[9] To uphold and maintain data integrity, we remained committed to confidentiality and anonymity with the data. This involved protecting the identities and sensitive information of the individuals and entities represented in the data. The secondary data were kept private (not disclosed to unauthorised individuals or entities), and personally identifiable information within the data was removed so that it could not be linked back to specific individuals or entities. The distilling analysis of our large dataset aligned with Creswell and Creswell's (2018) and Saldana's (2016) reductive process to sifting, sorting and analysis of data through a process of coding. They advise an initial read-through of the data, dividing the text into segments of information or whole segments of information (Creswell and Creswell 2018; Saldana 2016). The reduction of

[8] Lumivero (2017) *NVivo* (Version 12) www.lumivero.com
[9] Lumivero (2017) *NVivo* (Version 12) www.lumivero.com

the data initially came down to 12 themes. Regular meetings occurred between the researcher, the researcher's primary advisor and the research associate (from June 2022 to July 2023). The researcher's extensive experience in the accreditation industry allowed an iterative process of inductive reasoning. According to Braun and Clarke (2012), a bottom-up approach is an inductive approach to data coding and analysis. This means the codes and themes are being derived from the content of the data, where there is close alignment mapped against the content of the data and the researcher's analysis (Braun 2012).

The 12 themes were revised and refined down to a manageable seven themes, followed by a further reduction to five themes by September 2023. Creswell and Creswell (2018) advocate for five to seven themes being optimal. A grounded theory methodology was considered for an approach to the thematic analysis. Charmaz (2019) advocates for the value that constructivist grounded theories contribute to social justice research and critical inquiry. She maintains that constructivist grounded theories lead researchers to (i) adopt a reflexive stance to their preconception, position and research actions in support of social justice questions; (ii) use strategies that foster critical inquiry engagement; and (iii) conduct their studies through an iterative process to revisit, revise and refine their methods throughout inquiry (Charmaz 2019; Charmaz and Thornberg 2021), which allows the data to speak. The research of Redman-MacLaren and Mills (2015) is seated predominantly in low-income countries and explores issues of power and decolonising approaches to research and capacity strengthening. Their 2015 paper introduced transformational grounded theory:

> Transformational grounded theory allows for the researcher's experience (of being a woman, a worker, from a particular cultural group, and so forth) to enable engagement with people experiencing the phenomena being researched while maintaining a commitment to a structural critique for positive social change. (Redman-MacLaren and Mills 2015:4)

This theory, Redman-MacLaren and Mills (2015) assert, extends the researcher to a holistic critical examination of the economic, social and cultural structures (of the people's expression of the phenomena under study), affording a holistic opportunity for transformational grounded theory to bring about positive social change. Our research question is as follows: What is the impact of implementing QMS on efficiency and sustainability for the ACCHS? The title of the research is 'Critical Indigenist Examination of the Impact on Efficiency and Sustainability of QMS in Aboriginal PHC'. Our research questions the notion of the colonial construct of accreditation imposed upon the network of Australian ACCOs.

3.9 Selecting Flowers, Harvesting Nectar, Making Golden Honey: Research Methods and Study Design

A number of qualitative research methods were applied to our research project. These are:

1. two systematic literature reviews:
    a. a systematic literature review to verify the knowledge gap and to situate this research project
    b. a second review of the literature and an applied Leximancer content analysis
2. field work observations from four years of field notes, strengthened by a CBPR model
3. case study research
4. narrative inquiry
5. field work, yarning circles [interviews and focus groups] analysed through thematic analysis and transformational grounded theory.

Redman-MacLaren and Mills (2015) unpack the beliefs seated behind transformational grounded theory, as shown in Table 3.2.

Table 3.2

Summarised Beliefs of Transformational Grounded Theory

Element of metatheory	Characteristics
Axiology (values)	Love, social justice, equality
Ontology (nature of reality)	Critical realism
Epistemology (how knowledge is gained about the nature of reality)	Knowledge is culturally and historically situated
Methodology (principles which inform steps taken to gain this knowledge)	Grounded theory combined with PAR and decolonising methodologies

Note. Source: Redman-MacLaren and Mills 2015: 3.

Transformational grounded theory echoes as a natural fluid fit to this body of knowledge, exerting the boundaries of metatheory to focus on the characteristics. We raise questions of power, social justice and equality, allowing the data characteristics to speak. Three overarching themes arose: *Knowledge*, *Power*, *Ownership*, informed and influenced by Brayboy's (2006) TribalCrit framework.

Knowledge raises questions about who the knowledge holders in accreditation are.

Power asks which entity holds power (asserted or assumed) in the relationship of business and service provider (certification body) engagement to the assessment of accreditation standards in companies.

Ownership examines the ownership of the data garnered from the business by the service provider (i.e. certification body) and the deposit of the data into the third party (normally the CBs) online portal.

This description redirects the question, to ask: Whose knowledge? Who has power? And who ultimately owns the data? The results chapters in this thesis examine the themes in full. Our desire for this research is to bring about social change to the accreditation industry nationally and globally.

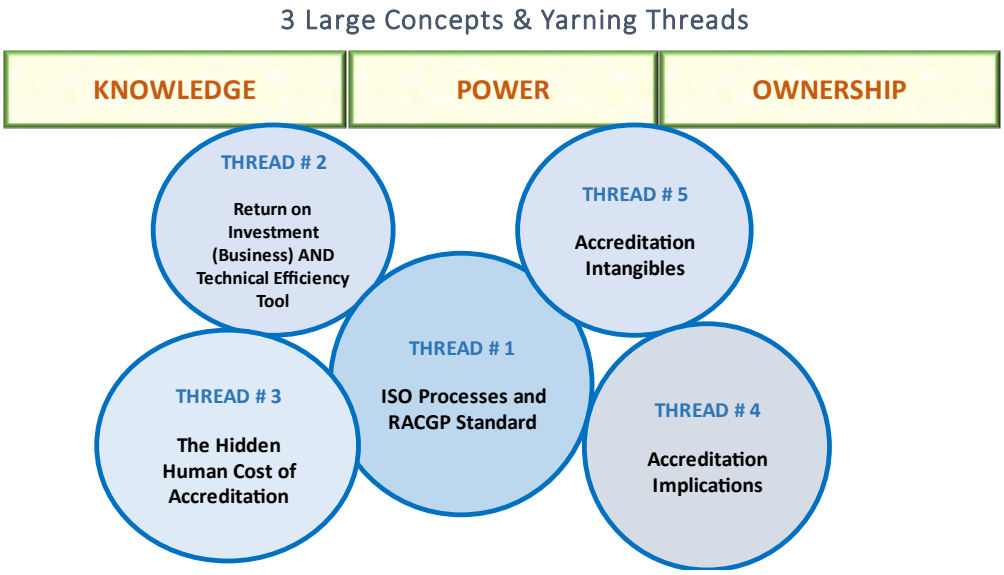
Multiple research methodologies were used in this research, and Wallerstein and Duran's (2006) CBPR was a natural fit for who I am as a First Nations Vanuatu woman, researcher and entrepreneur. CBPR considers engagement with community, family and the cultural obligations of being (Locke et al. 2022; Wallerstein and Duran 2006). Multiple opportunities arose for community engagement in the study, ensuring a holistic perspective was taken to how the data were captured, unpacked and analysed.

These study designs are embedded in Brayboy's (2006) and Elston et al.'s (2013) conceptual frameworks and study designs of participatory action research (PAR) (Baum et al. 2006). Baum et al. (2006) confirm that PAR has its basis in reflection, data collection and action with an aim to improve health and reduce health inequities through the involvement of people to take actions to improve their own health. Dudgeon et al. (2017) and others attest that PAR is an important process that Indigenous people engage in, that is culturally valid and meaningful knowledge production to their lives. Dudgeon et al. (2017) assert that PAR is an orientation to knowledge designed to provide community control over the research processes and outcomes.

The 'Plan, Do, Study, Act' (PDSA) cycle is commonly used in accreditation as an iterative cycle of continuous improvement (Knudsen et al. 2019; Taylor 2013). The key features of these cycles are (a) the use of an iterative cyclic method, (b) the use of continuous data collection and (c) small-scale testing (Knudsen et al. 2019). Transformational grounded theory in the refinement and distilling of our data complemented and further enhanced the appreciation of the data (Redman-MacLaren and Mills 2015). The application of these study methodologies identified five yarning threads: (i) the ISO process and RACGP standard, (ii) return on investment (business) and technical efficiency tools, (iii) the hidden human cost of accreditation, (iv) accreditation implications and (v) accreditation intangibles.

Figure 3.2

Large Concepts and Yarning Threads



3.10 Who I Am: Philosophical and Conceptual Underpinnings

My spirituality and religious beliefs are core to who I am as a Yuwi Vanuatu woman. My spirituality and religious beliefs expressed in this thesis are my human cultural rights. These values are an evolving dynamic expression of our culture and history as a First Nations family in this academic milieu. I am, because of all who went before me, and I am their representative.

Yunkaporta and Shillingsworth (2020) quote Sheehan and Walker's (2001) expression of relationality as the heart of 'being'; in Aboriginal worldview, an entity cannot exist unless it is in relation to something. Hence, our way of being (ontology) is our process of relating to our world (Sheehan and Walker 2001; Yunkaporta and Shillingsworth 2020). Relationality is the connector to my family (past, present and future), my spirituality, religious beliefs and environment in performing this research. My being (ontology) is the culmination of all who I am called to be—my 'being'. In 'Ways of Knowing, Being and Doing' (critical consciousness), Martin et al (2003) assert that critical consciousness is developed over time through connectedness, participation and commitment (Martin 2003). As an individual, seated in an expansive community, educational experiences, life, familial obligations and sacraments are additions. My family and the heritage within which I dwell and am held, births, influences and sculpts the moulding of my world and the experiences I encounter, allowing me to navigate life as a Yuwi Vanuatu woman. All are considered my relationality to the world. My heritage and spirituality are the strengths I draw from consistently to traverse the vicissitudes of life. Both are my moral and individual compasses, valuing my relationship with God first and foremost. I

place great worth in my Aboriginal Vanuatu heritage. These relational values hold me, ground me, position me and centre me in humility in my ethnicity. Finding a cultural voice in the academy, Friere (1970, revised in 2015: 10) explains, becomes a process involving pain and hope, and occupying the position of a forced cultural juggler of subjectivity, to transcend our object position in the society that hosts us, yet is alien. An obligatory cultural juggler, a sound social justice ambit and community beneficence, enmeshed in Indigenist methodologies, guides this research approach, design and outcomes. Our – First Nations wholesome wellbeing encapsulates our emotional, social, and cultural wellbeing to which our status in our own Country as custodians situates us as foreigners, who remain excluded from the Australian constitution.

3.11 Australia, Our Ancestral Lands and Sea—Constrained in Colonial Baggage

Extensive planning across a number of years was accomplished in the lead-up to the latest Australian referendum in 2023. Professor Megan Davis and her team were engaged in a 10-plus year assignment to establish the consultation process to prepare Australia for a referendum. Their efforts were harmoniously and magnanimously captured in the 2017 Uluru Statement:

> We, gathered at the 2017 National Constitutional Convention, coming from all points of the southern sky, make this statement from the heart:
>
> Our Aboriginal and Torres Strait Islander tribes were the first sovereign Nations of the Australian continent and its adjacent islands and possessed it under our own laws and customs. This our ancestors did, according to the reckoning of our culture, from the Creation, according to the common law from 'time immemorial', and according to science more than 60 000 years ago.
>
> This sovereignty is a spiritual notion: the ancestral tie between the land, or 'mother nature', and the Aboriginal and Torres Strait Islander peoples who were born thither to be united with our ancestors. This link is the basis of the ownership of the soil, or better, of sovereignty. It has never been ceded or extinguished, and co-exists with the sovereignty of the Crown (Davis 2017, Davis and Williams 2023).

On 14 October 2023, Australia held the referendum to vote for the inclusion of Australia's First Nations peoples into the Australian Constitution (Davis and Adams 2022; Davis and Williams 2023). For 14 days after the referendum 'no' vote, I grieved. From my perspective, the referendum was our/First Nations peoples' heartfelt invitation to immigrant Australia to reconcile our rightful position in the Australian Constitution. A 'yes' vote honoured

our invitation. The 'no' vote reinforced the negative view wider Australia holds towards First Nations people—all the while living on our ancestral lands.

Stan Grant, a reputable journalist and professor at Melbourne University, 16 days post the referendum, on 31 October 2023, spoke these sobering words at the Australian National University Crawford Leadership Forum. Reporter Andrew Brown (AAP 31/10/2023) reported, 'Acclaimed Journalist Stan Grant has lamented the rejection of the voice to parliament referendum, saying the nation failed to "shoulder the load" of Indigenous Australians.' Australia's First Nations people's reality is that for 234 years, policy has been crafted, sanctioned and applied with malicious intent on Aboriginal and Torres Strait Islander people (K Martin and Mirraboopa 2003; Dodson and Strelein 2001; Baba 2014; Rigney 2001). Australia's history is littered with multiple examples (Dillon MC 2017; Dillon MC 2018; Freeman et al. 2022). Successive Australian Governments weaponised policies designed specifically for First Nations peoples to be dehumanised. Their prior policy purpose was a means of ethnic cleansing through policy weapons designed for mass destruction. The Howard government's Northern Territory Intervention (2007) is a classic example of a policy designed with malicious intent (Freeman et al. 2022). The heavy-handed Howard government act was devoid of evidence, sanctioning xenophobic action; Lea (2020:13) provides commentary on the intervention in her book *Wild Policy*. The enactment of this policy required the racial discrimination act be amended to bring the Northern Territory Intervention into force (Freeman et al. 2022). This raw expression highlights my personal grief in grappling with Australians' 'no' response to the recent referendum. The level of open discrimination towards Australia's First Nations peoples experienced by the referendum outcome is pervasive and real. Our First Nations health and individual wellbeing are supported by a whole-of-community, social, emotional and cultural wellbeing to achieve our full potential and a whole-of-life view (Freemantle et al. 2007). National rejection is a bitter pill to swallow.

In Brayboy's (2006) paper I found scholarly refuge and the language to confront the xenophobic undertones being experienced through this truly important nation-building exercise. The Brayboy (2006) perspective on colonial settler nations' thinking was like finding a large gold nugget amid my darkness. Priceless.

A Native American academic, Brayboy (2006) developed a framework from critical race theory titled Tribal Critical / TribalCrit to understand the level of racialised thinking entrenched in the DNA of colonised countries. The central tenets of Brayboy's emerging theory, tribal critical race theory, appear in the summarised framework quoted in Table 3.3.

Table 3.3

Overview of Tribal Critical Race Theory

	Central tenets
1.	Colonisation is endemic to society.
2.	U.S. policies toward Indigenous peoples are rooted in imperialism, white supremacy and a desire for material gain.
3.	Indigenous peoples occupy a liminal space that accounts for both the political and racialised natures of our identities.
4.	Indigenous peoples have a desire to obtain and forge tribal sovereignty, tribal autonomy, self-determination and self-identification.
5.	The concepts of culture, knowledge and power take on new meaning when examined through an Indigenous lens.
6.	Governmental policies and educational policies toward Indigenous peoples are intimately linked to the problematic goal of assimilation.
7.	Tribal philosophies, beliefs, customs, traditions and visions for the future are central to understanding the lived realities of Indigenous peoples, but they also illustrate the differences and adaptability among individuals and groups.
8.	Stories are not separate from theory; they make up theory and are, therefore, real and legitimate sources of data and ways of being.
9.	Theory and practice are connected in deep and explicit ways such that scholars must work towards social change.

Note. Source: Brayboy 2006:5

The framework addresses the complicated relationship between Native Americans' liminality as a group—racially, legally, politically or individually—and the US state and federal governments. Brayboy developed TribalCrit out of the need to understand the complex relationship between Native Americans and the US Government; the central tenets in his article give insight into our Australian colonising experience. TribalCrit's conceptual framework provides perception and language regarding colonial thinking, stating that 'Colonisation is endemic to Society,' permeating the fabric of society and colonisers' DNA (Brayboy 2006). The framework genesis of TribalCrit has multiple and nuanced historically and geographically located epistemologies and ontologies, all originating in Indigenous communities in story. Stories, Brayboy (2006) claims, are our theories and are not separate from theory: they are real and legitimate sources of data and ways of being.

The similarities in this framework appear astute, with serious cause to review the experience of Australia's First Nations peoples. A double majority 'yes' vote at the referendum would have catapulted Australia's First Nations peoples into a new paradigm and renewed engagement with all levels of government in Australia.

3.12 Partnering with Community, Industry and Other Indigenous Academics

Relationships were made and strengthened with the partners in this research study over the 10 years of this project. These were KASC, the Women's Service staff and advisors at JCU, staff at the University of Queensland, Terra Rosa Consulting and Radarborg and Geoff Gray. Some of these relationships will continue after this research project has been completed. A small circle of external Indigenous colleagues who are studying for a PhD at other universities was established. We held regular quarterly catch-ups to share our experiences in navigating the academy, supervisors, the process of a PhD and the lessons we learned along the way. Most important, though, is our growth—emotional, mental and spiritual—as we traversed this phase of our lives. These are the precious gifts we shared, which we will forever cherish and hold. These relationships will endure past the life of this PhD and are the positive and highly valued outcomes I am able to walk away with to remember with fondness. I know these relationships, like a garden, will continue to grow and be nurtured.

3.13 Delimitations, Discussion and Affecting Change

COVID-19 was the catalyst inhibiting the application of quantitative methods being applied to this research. Our engagement with ACCOs as field sites to test the efficacy in the application of multiple and different accreditation and certification standards demarcated their participation in this study because of COVID-19. One aspect that we did not consciously measure was the real financial outlay ACCOs spend on their participation and application of multiple and different accreditation standards in their business environment. Experience implies, on average, the majority of the ACCO network in Australian (currently 145 organisations) spends approximately $20k per standard. Our study indicated some ACCOs apply up to 11 different accreditation standards. Add the multiplier effect; the spend for one ACCO is around $220,000 dollars. Now add the entire network applying seven standards, and this spend is around $20,300,000 dollars. The irony for Australia’s primary healthcare tier is that ACCOs and general practice health services are the prominent healthcare businesses and providers. Our study found that general practices apply one accreditation standard: The RACGP standard. ACCOs are mandated to apply up to 11 accreditation standards. The controls and continued attempts to standardise industry-designed accreditation standards, mandating frameworks upon ACCHS to mirror a mainstream practice, are the conscious or unconscious enforcement of a colonial construct. The frameworks, by design, enforce the funders’ ideology upon an ACCO industry light years ahead of the general practice network. Fredericks (2009) states that Western research methodologies are colonising practices and supports Tuhiwai Smith’s (2021) call for Indigenous methodologies to challenge the imperial basis of Western knowledge and the images of the Indigenous ‘Other’. In suppressing (covert or overt) racism,

Fredericks (2009) claims, are the ideological wars where fidelity to the struggle for our voices to be heard and our being denied is incessantly tested. This research questions why the colonial construct of accreditation standards is mandated for ACCOs and not for general practices.

The weighty burden of disease among Australia's First Nations peoples is well documented. Questions are raised about the disingenuousness of this conundrum. Is Australia, at its core, a racist country? Is colonisation so deeply embedded as to be endemic in Australian society? Are Brayboy's (2006) explorations of colonised countries' taken-for-granted values correct? My personal experiences, and family stories about how I am/we are viewed and treated contribute to posing these questions. Successive Australian Governments have not been kind to us as the original custodians of Country. We yearn for a day when those in government mature, and our identity and being affords us equal status in Australian society, our Country. Let love prevail instead.

3.14 Conclusion

The research strategy undertaken was a broad approach to data collection for this body of new knowledge. The research direction in this accreditation research has never been under study to this level of depth. Accreditation and certification standard types were examined down to the design of clauses and indicators in determining their ilk. Three large themes percolated and arose as a result of the stages in the research project: KNOWLEDGE, POWER, OWNERSHIP. We explored the realistic interface between the application of accreditation standards and the staff's experience of application within businesses. We listened, heard and expressed the stories of compliance staff's wrestle with the application of accreditation standards into their business environment. We observed and felt the human cost of applying multiple and different accreditation standards by compliance staff in their business environment. The negative physical costs that most of these staff carried as a result of applying multiple accreditation standards we acknowledge. We heard of their long out-of-work-hours labour to understand and apply multiple accreditation standards. We paid attention to the quandary many experienced in choosing a certification body, navigating the CBs assessors and their assessment to the implementation of accreditation standards in their business. We heard and captured the multiple negative experiences of compliance staff and the contracted assessors engaged by the CBs for the onsite assessment and off-site (virtual) assessment of accreditation standard compliance. Our research validates and exposes further the shocking inequity in the number of accreditation standards ACCHS engages in compared with Australian general practice health services. The scoreboard result is 11 to 1.

These alarming standpoints have been braided together in this thesis to highlight to the national accreditation market these glaring issues—to make a good social change in an accreditation industry that has lost its way. This statement, 'accreditation has lost its way', was a recurring statement in multiple interviews. Accreditation standards were originally designed to give businesses a measure of quality and safety. Accreditation standards have become a means to generate substantial revenue from businesses, held hostage by the mantra 'accreditation standards provide quality and safety'. This Australian study found the statement 'accreditation standards provide quality and safety' to be a myth.

The methods employed across the study were systemic observation, two reviews of the literature, transformational grounded theory analysis of yarning circles [interviews and focus groups], case study and narrative inquiry. These are showcased in Table 3.4 for the thesis chapters, their content and applied qualitative approaches.

Table 3.4

Connecting Thesis Chapters to Content to Applied Qualitative Approaches

Chapter	Title and content	Applied qualitative methods Knowledge, Power, Ownership*
1	Our Story of Change—Introduction: Aims & Objectives & Overview of thesis	
2	The Gap and the Guide—A Work in Progress	Lit Review 1 & Lit Review 2 with Leximancer analysis [2 publications]
3	The Viewing Platform—Methodology	Participant selection, interviews, data collection, analysis & calibre of participants—Indigenous lens * [transformational grounded theory of yarning circles (interviews & focus groups) & systematic observation]
4	Strength in Our Collective Voice	Narrative Case Studies & Ethnographic paper 4 years of observational field work, CBPR, PAR & PDSA. [publication]
5	Leading for Sustained Change—Results of five themes in three Chapters	YARNING circles [^Focus Groups & Interviews*], Translation of the data, thematic analysis & transformational grounded theory. Knowledge, Power, Ownership*
6	ACCO Gift to Government || Discussion, Integration of Results and Recommendations	Discussion from three results papers and recommendations*
7	Reciprocity in Action—The Gift That Keeps on Giving. Conclusion and Recommendations	Conclusion and Recommendations* This research is a beginning

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3.16 Appendix 3A: White Paper

JAMES COOK UNIVERSITY AUSTRALIA

JCU Ethics H7865

White Paper: ACCHO Accreditation standards

In 2010 the Australian Commonwealth government introduced vital policy reforms to the Australian healthcare system including a national accreditation framework (Bennett, 2008) as part of the health and hospital reform commission recommendations(Bennett, 2008). Since 2010, well over nine and counting, accreditation standards have been introduced into the ACCHO sector.

This is because of the highly specialised set of care services provided in an ACCHOs. Alongside this policy shift there has been a massive increase in the number of Certification accreditation Bodies (CBs) in Australia. In our recent Croakey article (view the link below) we give a bit of a background to what we mean by this. In conducting this research in First Nations communities and context, the lens through which this research is conducted and influenced by, is informed through our dynamic custodianship of County for well over 65 millennia as First Nations people (National Museum of Australia 2021).

This research explores a number of questions about this policy shift and the increase in CBs has meant for the ACCHO sector. In line with Indigenous research principles provided by Prof Lester Irabinna Rigney (2001), (see https://orcid.org/0000-0002-4756-2399) this work responds to the need to historicise, politicise, strategise and actualise our beings and our futures as sovereign First Nations peoples (Rigney, 2001).

Question 1. How has the increase in Accreditation Certification bodies (CBs) in Australia since 2010 impacted the quality and efficiency of ACCHOs?

Source: https://register.jas-anz.org/accredited-bodies

There has been an exponential increase in Certification Accreditation Bodies (aka – CB's) since 2010 and multiple, different Standards. Eleven years later, the ACCHO sector bears witness to the number of accreditation standards being applied (in their services), having been impacted by these measures, and most not positively. Interpretation of Standards varies in the way an audit process or assessment of ACCHO services are performed.

Question 2. In your ACCHO what does an audit process for accreditation entail?

In 2010 the ACCHOs were ahead of the game in the application of a second standard known as ISO 9001:2008 Quality Management Standards. At this time, the ACCHOs had applied two Standards to their service – RACGP Standards and ISO 9001:2015 QMS.

The current evidence indicates that the ACCHOs apply anywhere from 2 to 9 Standards of Accreditation. We are the most marginalised people group in terms of our health disparity and the business of ACCHOs can ill afford the application of nine (9) disparate Standards. To apply multiple, different accreditation standards for any one ACCHO we argue is not efficient or sustainable service delivery.

Question 3. How do you or would you assess the efficiency and sustainability of your ACCHO context? (based on what is outlined in this paper).

In a recent letter to the Editor of the Medical Journal of Australia, First Nation Authors and Academics - Mohomed, Matthew, Bainbridge & Williams (2021) asked the question – "Who is speaking for us? Identifying Aboriginal and Torres Strait Islander scholarship in health research. A letter, highlighting the necessity of First Nations voices driving solutions to issues (experience by First Nations people) in the research and policy area (Mohomed J, 2021).

There is a ground swell movement to make good of the three key elements for sequential reform in the Uluru Statement – "Voice, Treaty, Truth". From the Heart campaign – **Voice**, we see the continued demand for an enshrined voice to the Parliament for First Nations people. A call to the Australian people for a Referendum on constitutional reform and the inclusion of First Nations people in the Constitution. **Treaty** conversations with First Nations groups is being held in different States – Victoria and Queensland to name a couple by State Government Treaty Commissioners. **Truth**, as told by First Nations people right now, many of you would have seen the series of "Incarceration Nation" being aired on SBS marking the beginning of truth telling of the history of Australia.

ACCHOs play a prominent active leadership role in the Australian primary health care context with a network of 145 plus organisations nationally (Darr, 2021). Inserting First Nations voices into the accreditation industry we believe raises the level of equity on the efficiency and sustainability of multiple and different standards operating in ACCHOs. Let us know your thoughts on what efficiency and sustainability means to you.

https://ulurustatement.org/the-statement **Join us, to help discuss these questions as ACCO industry SME's.**

RESOURCES

The link below is an article we recently published in Croakey on this issue.

https://www.croakey.org/raising-important-questions-about-the-costs-of-accreditation-standards-for-aboriginal-community-controlled-organisations/

NACCHO definitions

"Aboriginal health" means not just the physical well-being of an individual but refers to the social, emotional, and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life (NACCHO, 2014).

An ACCHO is *'**a primary health care service** initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.*(NACCHO, 2014)

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OUR PARTNERS

4 Strength in Our Collective Voice

(Ethnographic Narrative Case Study)

[Online picture. Author is unknown.]

'Your footprint is the mark of your presence in my Country. The decisions you make in my Country will also leave an imprint.'

Credit: Aunty Matilda House, Ngambi Elder. Australian National Museum.

This chapter is my conscience. I am holding centuries of community forbearance to honour the Kowanyama Women's Service accreditation experience. Re-telling the women's story with meekness and integrity. The case studies under scrutiny are the three technical stages of their accreditation assessment. The examination is told as a story yarn (narrative). The ethnographic piece drapes this experience, delivered from the community perspective, laying down their history. When all three stages are combined, it showcases their enduring strength, sheer resilience and love experienced through decades of constant state and federal government adversity.

4.1 Opposing Ideologies—Experience of an Aboriginal Community-Controlled Organisation Accreditation

Note. A reduced version of this chapter has been submitted for publication in *AlterNative Journal*.

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Authors' recognition—we pay honour to our First Nations ancestors and acknowledge the custodians of the land and water Country that was never ceded. Qualification—First Nations peoples is the designated title assigned by the first author for Australian Aboriginal and Torres Strait Islander people.

4.1.1 Abstract

Accreditation standards are measures of compliance for businesses. The accreditation process involves an Australian certification body (CB) assessment against Australian mandatory, prescriptive, industry-designed accreditation standards. Highlighted is the wrestle and quandary Australian ACCOs contend with assessors for compliance to accreditation standard indicators. Under examination: the application of an accreditation standard and accreditation processes within an ACCO in Australia. ACCOs are unique organisations providing comprehensive health and wellbeing services. Implementing accreditation standards poses unique challenges for rural, remote Indigenous businesses. Introduced are the terms cultural deafness, Knowledge, Power and Ownership to inscribe key themes. This story unwraps an ACCO's first accreditation experience: how do you make visible that which cannot be seen? The importance of history, cultural principles, cultural practices and cultural values as Aboriginal knowledge indicators for nuanced service quality are to be appreciated as valid evidence for accreditation compliance.

Key words: accreditation standards, qualitative, yarning, storytelling, ethnography, narrative inquiry case study.

4.1.2 Our Story for Social Change

Prologue

Ideology as a term is not new. According to Zajda (2014), ideology was first coined by the French philosopher Destutt de Tracy (1795) to define ideas to clarify and improve public debate. The use of the term 'ideology' served as a scientific method in Destutt de Tracy's era to define mental phenomena. Providing a rational basis to critique dominant intellectual and political traditions in his era, the term 'ideology' was created by combining the Greek 'idea' (form) and 'logos' (knowledge) (Zajda 2014). This chapter's title sets the scene to examine the different ideologies existent between colonial Australia and the First Nations peoples of Australia. Juxtaposing ideologies formed across centuries. Opposing ideologies that nationally have never been afforded the political space throughout time to mature to a beginning of reconciliation.

These contrasting ideological perspectives play out in the qualitative methodologies assigned to these ethnographic narrative inquiry case studies. Showcased is one Australian prescriptive accreditation standard; all such standards are collectively viewed as colonial constructs. An imposition, under the guise of quality and safety, used as a mechanism to wield their knowledge, upon ACCOs. First Nations businesses whose knowing, being and doing are borne from 65,000 years of evolution (Davis and Adams 2022; Davis and Williams 2023; Dodson and Strelein 2001; Martin and Mirraboopa 2003; Pearson 2021) and a deep historical well where our history is valued as the connecting thread linking the past to the present and our future.

4.1.3 Seeing the Picture in the Frame: Framing the Narrative

The technical results of the accreditation assessment showcase the limitations in the design of prescriptive accreditation standard/s. The technical results are the case studies supporting data in this narrative illustrating the idea of accreditation standards, their quality, use, application and assessment. The assessment is performed by the certification body and the certification body assessors. Arising from the technical results is the cause and effect relative to the process that staff experienced and the assessment of the product. The story yarn (ethnographic narrative) is presented through raw issues recalled in the gracious historical testaments from the staff's lived experiences captured during the Women's Service first-time accreditation.

Our research identified two types of accreditation standards operating in the Australian accreditation market for the primary healthcare tier: prescriptive and open and Tables 4.1 and 4.2 outline their traits.

Table 4.1

Traits of Australian Prescriptive Accreditation Designed Standards in the Primary Healthcare Tier

Trait (PHC tier)	Description
Standard	Multiple in operation, specific to the industry that owns them.
Design of the standard	Prescriptive by design. Closed indicators pre-determine the evidence for businesses; negatively inhibits organic quality improvement for businesses.
Quasi-Mandatory	Indicators are linked to the key performance indicators in contractual funding agreements of state and federal government standard owners. Mumford (2013) et al. introduced this term.
Standard Names	Announce their design for a particular market, population health cohort or disease. The prescriptive designs, holds in silo, (for businesses) each accreditation standard with no mutual agreement or synchronicity between them.
Annual reviews	Erodes consistency and their strength (robustness) diminishing quality (in the standard) for businesses with businesses questioning their return on investment.
Australian-designed accreditation standards	Segment businesses (and the general public) in how they value, view and manage holistic health wellbeing. Designed for one particular program area only of the business.
Australian accreditation standards	As a colonial construct either negatively / positively affect how ACCOs, ACCHS, ACCHOs manage their boutique businesses questioning the standards (cultural) safety.
Systems approach	Prescriptive standards, by design, do not create interlinked internal systems for businesses to sustain their accreditation processes. Their design inhibits (in the business) a systems-thinking and systems approach to accreditation for the businesses holistic health wellbeing management.
Universal assessor training	No nationally certified assessor, surveyor training for conformity, when interpretating and translating Australian prescriptive accreditation standards for businesses. Assessment is assessor / surveyor centric. This deficit questions the assessment validity and assessor process in assessment of the standard/s to ensure quality.
Quality and safety	Prescriptive designed accreditation standards under the guise of quality and safety erodes confidence in businesses who apply them and question these particular standards level of design quality and design safety.
Fit for purpose	Prescriptive designed Australian accreditation standards are not fit-for-purpose for ACCOs, ACCHS & ACCHOs model of comprehensive holistic health wellbeing care.

Table 4.2

Traits of Open Standards Operating in the Australian Accreditation Industry

Trait (PHC tier)	Description
Design	ISO 9001:2015 QMS certification standard is an Open standard.
Name	Announces it is an international standard—ISO means International Organisation for Standardization—9001 denotes the series, 2015 indicates the year of review and change to the QMS standard. It is buttressed by a host of interlinking international standards endorsing its robustness, value, quality and validity.
Series	9001 series are purposely designed for service delivery. One standard designed for application across multiple industries. Assigning the interpretation of clauses and translation of clauses based on the industry, maturity and rurality of the business.
Clauses	Clauses are open to interpretation, allowing businesses to meet the clauses based on businesses maturity and size. Translation is in alignment with the type of industry. Open standards, by design, promote and enable organic quality improvements.
Reviews	The ISO Technical Committee are responsible for changes and hosts a number of member Country representatives, who in 2021 reviewed this standard—now 9 years without changes. Review/changes are made between 5–7 years, providing confidence to businesses.
Standard	This certification is for the entire company, from Governance down to the business's service delivery.
Systems development	ISO 9001:2015 purpose creates business systems to carry a business to compliance and certification. It is not people-reliant, but process-reliant.
Systems thinking	ISO 9001:2015 guides and affects a systems-thinking approach to businesses, value adding to the business systems robustness, stability and quality commensurate to the company's maturity.
Audit criteria	ISO 9001:2015 clauses measure consistency/reliability in their audit criteria.
Language	Reflects their robustness (strength, simplicity and longevity), promotes and advocates their quality to certification. Clauses create systems thinking in the design of a company's business system for compliance based on the company's maturity.
Auditor training	Auditors must be trained for ISO 17025 certification before they can issue an ISO standard certificate of certification.
Fit for purpose	An organic fit for ACCHS, ACCOs and ACCHOs operating in remote, rural and urban settings caters to their maturity to achieve compliance with an international standard ISO 9001:2015 QMS.

Note. Source: Jenifer Darr PhD Thesis.

4.1.3.1 Gems in the Field: Value Through an Indigenous Lens

The data collection methodologies of ethnography, case studies and narrative inquiry are set out in Table 4.3. Historical data, field notes and assessment outcome reports, meeting notes, online education sessions and onsite face-to-face meetings from the years 2019, 2020, 2021 and 2022 represent data collected across four years that supports the ethnographic data and storytelling. The case studies are (i) Assessment 1: outcomes to the Human Services Quality Framework (HSQF) Standard Version 5 (Queensland Government 2019); (ii) Assessment 2: outcomes to HSQF Standard Version 6 (Queensland Government 2020); and (iii) Assessment 3: outcomes to HSQF Standard Version 7 (Queensland Government 2021). These technical results apply to each accreditation assessment from the changes to these three versions of the same standard for the one 3-year accreditation cycle.

The narrative data originates in the adapted certification body processes as the technical assessment outcomes. The representative data from Stage 1, Stage 2 and Stage 3 of the accreditation cycle, combined with our partners' responses captured at specific points, throughout these three technical CB assessment stages, is the narrative storytelling analysis. The stories from Stage 1, Stage 2 and Stage 3 appear with Kowanyama staff vignettes.

Table 4.3

Data Sources for the Three Case Studies

Ethnography	Case study	Narrative
Historical records, field notes, reports, meeting minutes, online education sessions and onsite face-to-face meetings—4 years of extensive data	Case study examines the HSQF standard used over 3 years & the CB outcomes assessed against three versions of the same standard	Accreditation assessment cycle records—Outcomes of the Stage 1, Stage 2 and Stage 3 assessment across 3 years
2019	Case study 1—Version 5 HSQF	Assessment 1 outcome
2020	COVID 19 Pandemic	COVID 19 Pandemic
2021	Case study 2—Version 6 HSQF	Assessment 2 outcome
2022	Case study 3—Version 7 HSQF	Assessment 3 outcome

The phenomena under study are the identified processes a business undertakes for accreditation, measured within the accreditation life cycle of 3 years to an accreditation standard known as stages. The accreditation standard is the HSQF—a Queensland state-government-department-owned and designed framework. The cases being studied are the

assessment outcomes for the three versions of the HSQF standard (Versions 5.0, 6.0 and 7.0 are updated yearly. Versions 6.0 and 7.0 were mandatory). This means annual changes initiate different compliance evidence measures. The Women's Service complied with three versions of the same HSQF standard assessed within the one three-year accreditation cycle. The company is KASC. The program area being assessed is a discrete women's business service known as the Women's Service, seated in the community services business unit of the Kowanyama local government Council.

Our objective from an ethnographic lens, blends in narrative inquiry and case data of each assessment stage, to describe our partner's first-time accreditation experience. The measure of each of these processes is placed under careful examination and simultaneously viewed from three distinct perspectives, creating the story yarn (narrative). The three perspectives are the examination of the certification body, the assessor's actions and the third combines the company and their staff responses. Blending each perspective brings a holistic evaluation. Highlighting a broader comprehensive understanding of the phenomena under study considering multiple dimensions, such as the social, historical, cultural and psychological aspects that shape people's experiences and behaviours—First Peoples' worldviews.

The intervention or phenomena under study and the three perspectives are listed in Table 4.4 with descriptors. Qualitative researchers can employ various forms of narrative research, but all of these distinct approaches utilise perspectival data as the means for contributing to theory (Ryan 2017).

Table 4.4

Perspectival Data: Viewpoint Descriptors of Accreditation Industry Players

Perspective	Descriptor	Evidence/Title
Intervention or phenomena under study	The type of accreditation standard is a specific industry-designed, prescriptive accreditation standard	HSQF Version 5, HSQF Version 6, HSQF Version 7.
Individual consultant who provides their services to a certification body	A consultant engaged by the certification body who is trained to assess specific (CB in scope) accreditation standards for the certification body	Assessor.
Interpretation and translation of the standard indictor by the company's staff	Each accreditation standard has a guide and underpinning criteria referred to as indicators. These prescriptive criteria identify the likely evidence	Indicator evidence found within the service. [Fulfillment is centred on the (company's staff) interpretation & translation to the type of evidence is translated based on accreditation experience.]
Interpretation and translation of the indicator by the CB assessor	Each accreditation standard has a guide and underpinning criteria referred to as indicators. These prescriptive criteria identifying the likely evidence	Indicator evidence found within the service or absent, to be developed for compliance. [Established on the (assessor's) interpretation & translation to the type of evidence is translated based on assessor's experience—assessor centric.]

4.1.4 Our Being—Heart, Soul and Spirit: Positionality

For Australia's First Nations people, history, polities, culture, ideology and government policy are societal and individual influencers—they are accumulative, negatively or positively, endured across time, permeating and punctuating our contemporary daily lives. Our history comprises our individual stories and theories (Brayboy 2006). First Nations peoples have been living on this continent of Australia, our home, for over 65 millennia. (Davis 2017; Pearson 2021; Referendum Council 2017a).

Subjectivity and interpretation are elements of epistemology where researchers are encouraged to reflect on their values, assumptions and biases. One aspect where these elements hold constant is the positionality of the authors. This paper is unique. KASC, an

industry partner, is an Australian local government authority operating within the confines of Kowanyama, a discrete remote Aboriginal community. Three of the authors are First Nations peoples from the following lands and nations: Yuwi (Jenifer Darr), Kuku Yalanji (Kevin Bell) and Kokomenjena (Magdalene Teddy). All bring to this research their unique ways of being, knowing and doing. Their relationships to their respective lands, community and nation upbringing (background, rearing, nurture and education) inscribe their Indigenous standpoints, as echoed throughout this paper (Yunkaporta and Shillingsworth 2020). Professor Lester Rigney (2001) highlights the importance of positionality in writing from a First Nations perspective to include Indigenous research principles to historicise, politicise, strategise and actualise our beings and our futures as First Nations peoples, to always hold and share our strength, as First Nations people, in all we do and all we are involved in.

4.1.5 Privilege, Bias and Process—Tell it With Integrity: Methods and Methodology

The first author draws strength in being from her heritage and nation, and recognises the weight of holding the dual role of consultant to KASC and PhD candidate. In addition to recognising her privilege to influence change for good. To mitigate bias, the triangulation and merging of three datasets was conducted. This process evolved through continuous reflexive activities and discussion over the course of three years with the first authors' primary advisor, Dr Kristin McBain-Rigg, a non-First Nations Australian author. Continuous discussions, input and refinement, were undertaken and received from the Kowanyama Council staff, the James Cook University advisory panel and other First Nations colleagues. These continued discussions, refined over three years, engaged the application of PAR processes (Baum et al. 2006; Dudgeon et al. 2017). Martin and Mirraboopa (2003) first devised the term 'terra nullius research'; Janke (2021: 254), in *True Tracks,* describes the term as research about Aboriginal people without their expressed permission, consultation or involvement. Janke (2021) linked the importance of researchers staying connected to share the benefits with communities whose knowledge they use. We adopted CBPR to honour the Kowanyama community (Wallerstein and Duran 2006). An important iterative cyclical process for continuous quality improvement applied to accreditation processes is the PDSA cycle (Knudsen et al. 2019; Taylor 2013) mirrors Baum et al.'s (2006) PAR process. Incorporating PAR, PDSA cycle with the reverse terra nullius research principles through CBPR fosters a strong community connection in our study design, adding honesty, authority and authenticity to the study design validity. The blending of three study design principles privileges the voices of the Kowanyama people showcasing their community beneficence. Creates a mechanism for the voiceless on an international platform.

Braiding together three qualitative methodologies allows the evidence to resound and speak, amplifying their storytelling experience. The research methodology integrates strands of CBPR. Wallerstein and Duran (2006) et al. state that CBPR orients the focus to relationships between community partners and academics with principles of co-learning, mutual benefit and long-term commitment through incorporated community theories, participation and practices into research holding relationality for the first author (Wallerstein and Duran 2006; Yunkaporta and Shillingsworth 2020). This ethnographic narrative case study applies Indigenist explanations expressing an Indigenist viewpoint (Brayboy 2006) for Western labels. This paper critiques the colonial opining and implications to the research position of applied accreditation standards as colonial constructs in an ACCO business—KASC.

4.1.6 History Links Our Past, Present and Future: Contextual Layers and Critical Events

History, as a study of past events in human affairs, opens up an influential insight into the thinking and psyche of the discoverers of a new (ancient) country (Dodson and Strelein 2001). Australia's First Nations people, history, politics, culture, ideology and government policy are societal and individual influencers. Accumulative influencers, negatively or positively, endured across time permeate and punctuate our contemporary daily lives. Our history is our individual, continuously accumulated stories and theories in memorial (Brayboy 2006). First Nations peoples currently remain excluded from the Australian Constitution. For context, in 1901, those responsible for the design of the Australian Constitution never included Australian First Nations People, nor were First Nations peoples recognised as people (Davis 2023b; Dodson and Strelein 2001; Pritchard 2011; Williams 2013). In a referendum held in 1967, Australians voted to change the Constitution so, like other Australians, Aboriginal and Torres Strait Islander peoples would be counted as part of the population (included in the national census), and the Commonwealth (not the state) is able to make laws for them. A resounding 90.77% said 'Yes' with a double majority enacting this change in the Constitution[10] (Pritchard 2011; Williams 2013).

The twenty-fourth Australian Prime Minister, Paul Keating (1992), in his Redfern speech, said, 'I think what we need to do is open our hearts a bit. All of us. Perhaps when we recognise what we have in common, we will see the things which must be done—the practical things'. The Redfern speech concedes the violence and dispossession perpetrated against Aboriginal and Torres Strait Islander people nationally that long remained unacknowledged.

The Australian nation, on 14 October 2023, went to a referendum to vote for a *Voice to Parliament.* The proposal was to establish an Indigenous body to advise the federal

[10] https://aiatsis.gov.au/explore/1967-referendum#toc-australians-vote-yes-to-change-the-constitution [accessed 25/1/2023]

government and Parliament on policy specifically relevant to First Nations peoples and for the body to be enshrined forever in the Constitution, as reported by Pearson at the Woodford festival on 31 December 2023.[11] The outcome was a resounding NO. For the documents informing the referendum (Davis and Williams 2023: 192–196), see 4.3 Appendix 4A for the *Uluru Statement from the heart.* See 4.4 Appendix 4B *Proposed amendment to the Constitution and* see 4.5 Appendix 4C *Section 128 of the Australian Constitution* (Davis 2023b).

In 2024, the only international document tethering our place in Australian society is the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) (United Nations 2007), to which Australia is a signatory. Luke et al. (2020) state that this document enshrines the equal rights of Aboriginal and Torres Strait Islander people to attain the highest standard of health and wellbeing. The business of a republic, recognition, reconciliation, and constitutional reform remains unfinished business for many Australian First Nations (Davis 2022; Pearson 2021; Referendum Council 2017b; Reid et al. 2022).

4.1.7 Welcome to Country and Community: Where History is Esteemed

Kowanyama community has a population of just under 1,000 people. The Kowanyama Shire Council is an ACCO that operates to the dictates and legislation of the *Local Government Act 2009* in Queensland, Australia. KASC employs two-thirds of the township, manages a multimillion-dollar budget and business, is governed by a board of elected councillors from the community, and is accountable to the community. Kowanyama community is situated on the west side of Cape York Peninsular in far North Queensland. Overland is a seven-hour drive west from Cairns on roads accessible only by four-wheel drive in the wet (rainy) season. Kowanyama's geographic location is seated in the wetlands system of the Mitchell River, in beautiful, lush, bountiful, untamed Country. Kowanyama received acknowledgement and recognition from the local, state and federal government in 2014 (Part D of their Allodial title) as being custodians of Country through their Consent Determination as a result of the Australian Native Title legislation.

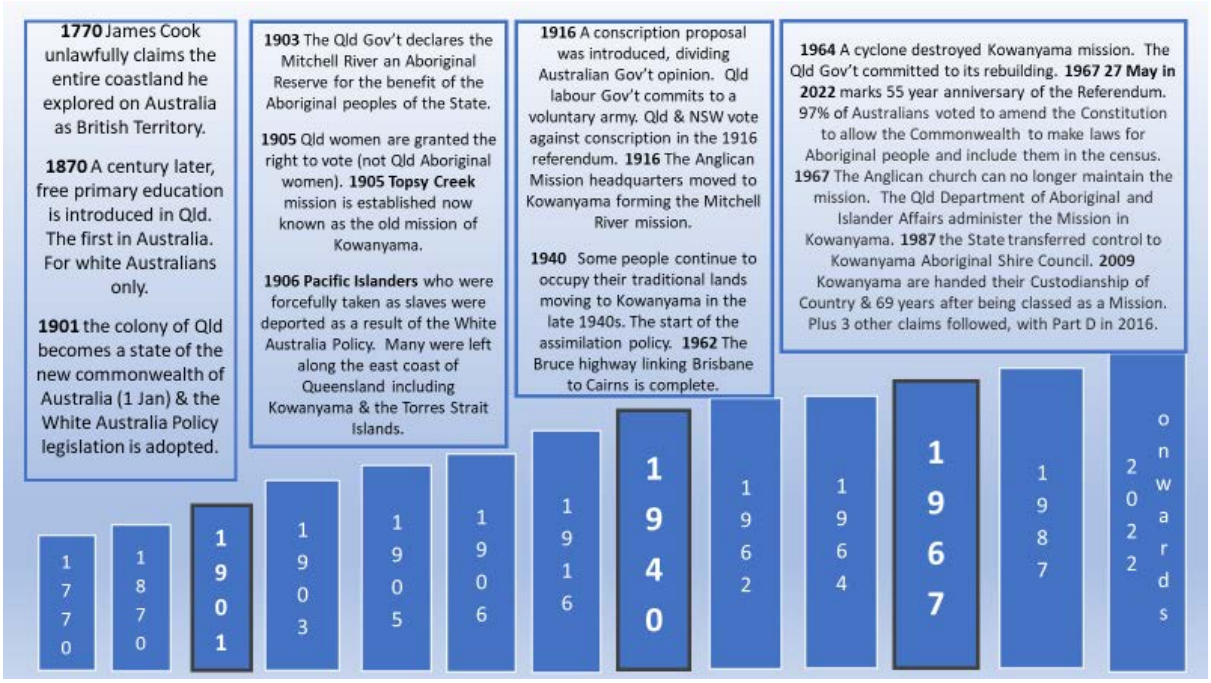
For 83 years, the community of Kowanyama was managed by the Queensland Government and the Anglican Church, from 1903 to 1986, on land set aside as a mission operating under the rules and regulations of the state (McNiven and Russell 2023). Queensland Government policy was detrimental on every level to the clans of Kowanyama. Kowanyama people went from life as a self-governing, self-determining society moving as custodians throughout Country. Organised by a structured kinship system of being and belonging to the environment, nature, each member, and adjoining nations (Gammage 2012):

[11] https://nit.com.au/31-12-2023/9188/noel-pearson-breaks-silence-after-voice-defeat [accessed 4 /1/2024]

a wholesome lifestyle (Pascoe 2018). According to a review by Maria Langton, Pascoe's book *Dark Emu 'is a profound challenge to conventional thinking about Aboriginal life on this continent.'* (Pascoe 2018). Pascoe details the Aboriginal economy and analyses the historical data showing our societies were not simple hunter-gatherer economies but sophisticated, with farming and irrigation practices' (Pascoe 2018), to life on a mission of subjugation and oppression by the federal and Queensland Government laws (Czyzewski 2011; Hunt et al. 2008).

Figure 4.1

Kowanyama Historical Political Timeline



Note.Source:http://www.workingwithindigenousaustralians.info/content/History_5_Assimilation.html#:~:text=1937%20%2D%20The%20Commonwealth%20and%20States,Aboriginals%20was%20held%20in%20Sydney (accessed 28 September 2023). Kowanyama Annual Report 2019–2020, p.11.

One thousand seven hundred seventy kilometres is the distance between Brisbane, a city in Southeast Queensland, and Kowanyama, home to the First Nations peoples of the Kokoberra, Yir Yoront (or Kokomenjena) and Kunjen groups. Figure 4.1 showcases important historical political points in time. Of special significance are the years of 1901, 1916, 1940, 1967, 1987 and 2009. In 1901, the colony of Queensland became a new state of the Commonwealth of Australia, and the *Immigration Restriction Act* (the genesis of the White Australia Policy) legislation was adopted[12] (Williams 2013).

[12] https://www.nma.gov.au/defining-moments/resources/white-australia-policy [accessed 28/9/2023]

In 1916, the Anglican (Church) Mission headquarters moved to Kowanyama, forming the Mitchell River mission. In 1940, some people continued to occupy their traditional lands, moving to Kowanyama in the latter part of 1940. The 1940s marked the start of the assimilation policy. Legal racist legislation enacting the forced removal of Aboriginal children from families, known as the Stolen Generation[13] (Commonwealth of Australia 1997), still affects the personhood of many Aboriginal people today. In 1987, the State of Queensland transferred control to KASC with 37 years of Kowanyama managed by the local Aboriginal Council.

The timeline of 1903 to 1986 represents more than 80 years of subjugation managed by oppressive regimes. The physical, emotional and mental scars experienced from traumatic grief and loss by heinous government policies are referred to as inter-generational trauma (Altman and Sanders 1991; Commonwealth of Australia 1997). Inter-generational trauma pervades the lives of many First Nations peoples (Czyzewski 2011), and an investigation through a federal government inquiry produced the *Bringing Them Home* report (Altman and Sanders 1991; Commonwealth of Australia 1997; Czyzewski 2011).

The Kowanyama Women's Service is one of 16 programs in the Council's community service stream. The service provides emergency accommodation for women and their children where there is a risk of domestic violence. From a community and cultural perspective, this service is a women's business. In 2019, after 18 years of operation, the Women's Service sought its first accreditation. Identifying the historical and political landscape in the contextual layers and critical events lays the foundation to this story.

Australia is yet to reconcile our rightful place as the original custodians of our Country, on this continent (Attwood 2023; Gammage 2012; Pascoe 2018). These perspectives are important historical underpinnings, setting the stage for our critical Indigenist examination of the implementation of accreditation standard(s) in the program area of the Women's Service. The Women's Service, because of their funding from the Department of Child Safety, Seniors and Disability Services (hereinafter referred to as the Department), were required to implement HSQF Standard Version 5.0. Consequently, annual standard changes meant in that, in the ensuing years, they enacted HSQF Standard Versions 6.0 and 7.0 (Queensland Government 2019; 2020, 2021).

[13] http://www.workingwithindigenousaustralians.info/content/History_5_Assimilation.html#:~:text=1937%20%2D%20The%20Commonwealth%20and%20States,Aboriginals%20was%20held%20in%20Sydney. [Accessed 28/9/2023]

4.1.8 Opposing Ideologies: Cultural Deafness and Indigenous Knowledge Indicators

Case Study Assessment Dynamics: Stages 1, 2 and 3

In July 2019, Jadee Consulting was invited to submit a bid for accreditation support to the Executive Manager of Community Services. In October 2019, Jadee Consulting signed a contract to walk the Women's Service through its initial implementation of HSQF accreditation standard version 5.0. This successful bid, was the only bid that included onsite visits and identified ongoing support to the KASC Women's Service, their staff and management. Yunkaporta's research articulates, a relationally responsive standpoint as one that demands that you work with local knowledge to produce cultural processes, not just cultural content. To co-create the shared meanings and language needed for genuine (and productive) inclusion of Aboriginal knowledge in the academy. Relationality is at the heart of First Nations cultural currency (Yunkaporta and Shillingsworth 2020). Jadee Consulting stepped into a support role after the January 2019 Stage 1 assessment outcome. The incumbent manager of the Women's Service resigned soon after, and by October, this position remained under recruitment. For a remote organisation, recruitment of eligible people into any role is an arduous process. Rurality, location and housing are natural limitations of a recruitment process for potential employees to work in a remote business like KASC. From 2020 to 2022, the leadership positions in the Women's Service were intermittently filled with external candidates, inhibiting stability. In 2023, the leadership role stabilised, with a local staff appointment ensuring stability and arresting the rotating door on this role.

A group of four grandmothers manage the Women's Service working part-time rotations. Between them, they hold 45-plus years of continuous service and employment, representing each clan. Surrounding and guiding the Women's Service are a group of Chellie's (grandmothers) who originally, out of need, initiated this service from their own homes. Their role today is integral to the evolution and continuous cultural authenticity of the service. KASC engages the Chellies as their cultural advisory group across other Council services. These women harness their deep experiential knowledge of community, family dynamics, cultural knowledge and safe cultural practices in service to their community. Their knowledges make this service unique. These cultural practices imbued from their traditional kinship and familial ties are the being of who they are. The staff and Chellie's had never been involved in the accreditation of the service. The women's implicit cultural knowledge is the unseen and, therefore less-acknowledged intrinsic cultural practices, protocols and nuances. Their cultural knowledge and practices remain unrecognised in the assessment of applied accreditation standards. The women seamlessly apply their cultural knowledge within the Women's Service for it to hum in this rich traditional setting. Cultural knowledge, together with valuing culture

as an Indigenous knowledge indicator, provides nuanced services to First Nations peoples. This prompts a discussion on the safety of accreditation standards assessment and their fit-for-purpose within ACCO settings. Right now, many of the Australian prescriptive accreditation standards are culturally deaf.

Devalues and rejects the notion of ACCO knowledge; knowing, being, and doing in the provision of culturally sound, safe, nuanced services. Emphasises our statement as accreditation standards being a colonial construct mandated for ACCO businesses, contends their fit for the purpose, being culturally deaf in design.

The HSQ framework contains six Human Services Quality Standards (Table 4.5).

Table 4.5

The six Human Services Quality Standards

Standard 1—Governance and management	Standard 2—Service access
Standard 3—Responding to individual need	Standard 4—Safety, wellbeing and rights
Standard 5—Feedback, complaints and appeals	Standard 6—Human resources

The outcome of Assessment 1 appears in Table 4.6. A total of three major non-conformities and eight non-conformities were assigned by the CB. The assessor, based in Brisbane, performed a desktop audit on a landline phone in January 2019. This means a total of 11 improvements required resolution before the Stage 2 assessment on 4–5 February 2020. The assigned major non-conformity without question must be resolved before Stage 2.

Table 4.6

Assessment Definitions and Outcome of Stage 1 Assessment

Criteria	Definition
Major non-conformance	Must be resolved in a specified timeline.
Non-conformance	Must take corrective action to eliminate the non-conformity to prevent reoccurrence within an agreed timeline. An improvement.
Observation	May be considered but not implemented.

Source: ISO 9001:2015 definitions

Outcome of Stage 1 assessment (January 2019)		
Assigned assessment	Standard number	Indicator definition
Major non-conformity	1.1	1.1 The Service should demonstrate (a) Legislative and regulatory obligations linked to the Domestic and Family Violence Act (2012); (b) Key contractual obligations identified in the Service Agreement with the Department of Child Safety, Youth and Women; (c) The obligation to notify the Department and other relevant authorities of any alleged misconduct and / or major incidents and intervening events; (d) Subcontracting or brokerage arrangements to be consistent with the Service Agreement and or/specific investment specification; (e) All reporting obligations are met. Assessor decision: Closed 5 February 2020 Stage 2
Major non-conformity	4.2	4.2 The organisation proactively prevents, identifies and responds to risks to the safety and wellbeing of people using services.

		The service should demonstrate policies and procedures addressing: (a) the requirements identified in the Working with Children (Risk Management and Screening) Act 2000 and the accompanying 2011 Regulation. (b) the processes for preventing, identifying and responding to risks, harm, abuse, neglect and wellbeing of women and children accessing the Women's Shelter. Assessor decision: Closed 5 February 2020 Stage 2
Major non-conformity	4.3	4.3 The organisation has processes for reporting and responding to potential or actual harm, abuse and/or neglect that may occur for people using services. (a) The service should ensure there is evidence confirming training in reporting and responding to potential, suspected, alleged or actual harm, abuse and/or neglect. Assessor decision: Closed 5 February 2020 Stage 2
Non-conformity	1.2	1.2 The organisation ensures that members of the governing body possess and maintain knowledge, skills and experience required to fulfill their roles. The service should demonstrate that the governing body's induction process addresses the required knowledge, skills and experience in relation to domestic and family violence and other associated practices. Assessor decision: Closed 5 February 2020 Stage 2
Non-conformity	1.3	1.3 The organisation develops and implements a vision, purpose statement, values, objectives and strategies for service delivery that reflect contemporary practice. The Service should demonstrate evidence of a vision, mission, values, objectives as well as a Strategic plan. Assessor decision: Closed 5 February 2020 Stage 2
Non-conformity	1.7	The organisation has effective information management systems that maintain appropriate controls of privacy and confidentiality for stakeholders. The service should demonstrate:

		(i) documented processes for ensuring compliance with the privacy and confidentiality requirements set out in Principle 5: Confidentiality of the Practice Standards for Working with Women Affected by Domestic and Family Violence; (ii) awareness of obligations to comply with the requirements of the Information Privacy Act 2009; (iii) people working in or for the organisation understanding their obligations around the management and overseas transfer of personal information as required by the Information Privacy Act 2009; (iv) compliance with obligations to report privacy breaches to the Department in accordance with the Service Agreement; (v) safeguards required for personal information identified in the Privacy Amendment (Notifiable Data Breaches) Act 2017.
		Assessor decision: Open—5 February 2020 & brought forward to HSQF Stage 3 as improvements.
Non-conformity	4.1	4.1 The service should demonstrate that information is provided to clients about: (i) how their privacy will be safeguarded while at the Shelter; (ii) their right to access personal information held by the service.
		Assessor decision: Open 5 February 2020 & brought forward to HSQF Stage 3 as improvements.
Non-conformity	4.4	4.4 People using services are enabled to access appropriate supports and advocacy. (i)The service should demonstrate its procedures for explaining how advocacy is provided or referrals to other agencies that may be able to provide advocacy to the women.
		Assessor decision: Open—5 February 2020 & brought forward to HSQF Stage 3 as an improvement.
Non-conformity	5.1	5.1 The organisation has fair, accessible and accountable feedback, complaints and appeals processes. The service should demonstrate: (i) processes to address complaints and compliments made by women accessing the Women's Shelter; (ii) how feedback, complaints and appeals processes are communicated to people using services and other relevant stakeholders; (iii) that information is provided to women about their right to access an external complaints agency and external

		advocacy/support agencies; (iv) methods for communicating outcomes from complaints to relevant stakeholders.
		Assessor decision: Closed—5 February 2020 Stage 2
Non-conformity	6.3	6.3 The organisation provides people working in the organisation with induction, training and development opportunities relevant to their roles.
		The service should develop and implement a tailored induction checklist specifically to address the requirements of the Kowanyama Women's Shelter.
		Assessor decision: Closed—5 February 2020 Stage 2
Non-conformity	6.5	6.5 The organisation ensures that people working in the organisation have access to fair and effective systems for dealing with grievances and disputes.
		The service should demonstrate:
		(a) the right of people to access the Department of Child Safety, Youth and Women's complaints process.
		(b) the appropriate manner for addressing grievances and disputes raised by Shelter staff.
		Assessor decision: Closed—5 February 2020 Stage 2
OUTCOME	Observations	Indicators 1.7, 4.1 and 4.4
	Major Non-Conformance	Indicators 1.1, 4.2 & 4.3 Status Closed @ 5 February 2020 Stage 2
	Non-Conformance	Indicators 1.2, 1.3, 5.1, 6.3 & 6.5 Status Closed @ 5 February 2020 Stage 2
OPEN	At Stage 2	Indicators 1.7, 4.1 and 4.4 for assessment

Case Study 1. The above assessment outcomes are assigned from an external desktop assessment by the CB Assessor in Brisbane (via phone conversation) with the incumbent Women's Service manager, who had no reference point of accreditation. Stage 1 assessment outcomes reassessed at Stage 2:- closed three major non-conformances from Stage 1. Five non-conformances were closed, leaving three improvements for Stage 2 (indicators 1.7, 4.1 and 4.4). Discrepancies appear in the data tables with clarification sought by KASC on the correct status of these indicators with the relevant agency.

In summary, 11 unmet criteria of three major non-conformances and eight non-conformances assigned by the Assessor in Brisbane is Stage 1 outcome set the course for every other assessment Stage. The outcome analysis for the Women's Service and KASC as a business is unpacked in the discussion.

This type of CB assessment calls for an examination of the integrity of the CB and its applied assessment method. The method used for a first-time business accreditation should have been a value-for-money question from the CB. Especially being a remote business undertaking initial accreditation. The external desktop assessment questions the quality, validity and value of this assessment, having no understanding of the business and physical sight of the business environment. Accreditation is an expensive undertaking for any business. The business's value for their return on investment should be the outcome businesses use to hold CBs and their assessors to account. Based on Stage 1 assessment outcomes one could deem this entire process inequitable for a business going through first-time accreditation. The integrity of the CB and CB assessor based on their chosen and applied assessment method is lacking. Highlighting this example asserts the power and knowledge held by the CB and CB assessor exerted it with might to the disadvantage of the business. The outcome analysis for the Women's Service and Kowanyama Shire Council as a business is unpacked in the examination and discussion.

Table 4.7

Assessment Overview of HSQF Standards and Indicators Across the Three Stages of Accreditation

Stage 1 assessment improvements—performed via phone January 2019 HSQF v 5.0			
Non-conforming indicator	Major non-conformance / non-conformance	Conforming at assessment	Non-conforming at assessment
1.1, 4.2, 4.3	Major non-conformance	1.1	4.2 & 4.3
1.2, 1.3, 1.7, 4.1, 4.4, 5.1, 6.3, 6.5	Non-conformance	1.2, 1.3, 4.1, 4.4, 5.1, 6.3, 6.5	1.7

Stage 2 assessed improvements—performed onsite 4–5 February 2020 HSQF v 6.0			
Identified Improvements	Conforming to final report	Non-conforming at final report	KASC accreditation certificate is awarded
1.7, 3.1, 4.2, 4.3	1.7, 3.1	4.2, 4.3	27 May 2020
Stage 3 assessment performed on 12–13 April 2022 [postponed owing to COVID and online] HSQF v 7.0			
Maintenance assessment		Prior to 5 August 2021	
Standard for assessment		HSQF 1, 3, 4 & one other	
At Stage 2 and Stage 3 numerous duplicate documents were uploaded into the CB Portal as formal evidence for each standard indicator under assessment. Well over 40 documents were deposited in Stage 3.			

Case Study 2. Stage 2 assessment occurred on 4 and 5 February 2020 onsite in Kowanyama during Sorri business. Present at this onsite meeting are two experienced Assessors. Five Women's Service staff, the Executive Manager, one other Manager and the Consultant. *The Standard 4 indicator 4.2 (d) The service should document the process in place for notifying the Department of Child Safety, Youth and Women or Queensland Police Service where a child or young person is identified as experiencing significant intra-familial harm or is at risk of significant intra-familial harm.* The assessor asked whether the Women's Service holds evidence to validate 4.2 (d).

At this point, one of the grandmothers of the Women's Service graciously offered and softly spoke this factual statement. In response to what unknowingly is a provocative question being raised.

> 'In the early days, in Kowanyama community, we lost 60 children to the Department. They came in and took them from us at the age of two. We never seen them again until they were 18. We had to teach them who they were, who their family was and who they were to us and their culture.' [Women's Service Grandmother and worker]

Case Study 3. Stage 3 assessment occurred on 12–13 April 2022 online via Teams platform.

This assessment stage was considered a mop-up phase as the Women's Service received its accreditation certificate on 27 May 2020. Holding the Stage 3 assessment closed the CB process to their three-year accreditation cycle. Stage 3 is explored in the examination segment below.

4.1.8.1 Narrative Inquiry—An Indigenist Lens

Deficits in Accreditation Standard Assessment

The 60 Kowanyama babies, like so many other Aboriginal children in Australia, were legally removed from their families by the assimilation policy enacted between 1937 and 1962 across 25 years. These children are the 'Stolen Generation'. The crimes perpetrated on innocent babies and children are the mental scars of anguish, hurt and trauma their communities and they as individuals continuously hold and carry as burdens. Their memories of such atrocities never fade, as reflected in this grandmother's heartfelt response. Nor should they. This example should be a constant reminder to all who seek to do business in discrete Aboriginal communities—history affects our daily lives today! Grandmothers, the knowledge holders, have long, long, long memories. Eighty-plus years of oppression by the dominant culture affected Kowanyama. History is vitally important to relationship building in understanding community dynamics (underlying forces) for service provision to discrete Aboriginal communities. Knowing and valuing their history is paramount in accreditation assessment. Without this level of historical understanding, CBs and CB assessors will operate in the space of cultural deafness. Taking a reductionist lens is disingenuous of First Nations communities and businesses, their resilience and uniqueness forged over 65 millennia.

Examination of Stage 1 desktop audit. Accreditation is a specialised field. The Women's Service manager had never been through an accreditation process. No reference point to undertake the accreditation process with confidence. The accreditation territory is unfamiliar, the language for the accreditation process is unknown, and the knowledge of the processes is limited. The understanding and interpretation of the HSQF standard for this program is inadequate based on in-service evidence. There were no visuals of the physical layout of the Women's Service or the community of the CB assessor. Resulting in the Company's rights being compromised, placing a distinct disadvantage to their assessment compliance as evidenced by the number of major non-conformances and non-conformances. The assessors' assigned outcomes and status against the HSQF standards in Stage 1, set the course of every subsequent accreditation stage (2 and 3) for Kowanyama Women's Service. Based on the assessment method and results. The CB Assessor could not have justifiably assigned these assessment results with no visuals of the community, program area and business.

This phone assessment (via landline) was a breach of the signed service agreement with the KASC. Parties agreed Stage 1 assessment was to be performed onsite. The Women's Service in January 2019 claimed 18 years of operation. The KASC's long-standing relationship

with the Department is confirmed by five-year contracts with the Department being the standard owner.

Knowledge, Power, Ownership are the principles being contested in the process of accreditation standard/s assessment. The knowledge holders for business accreditation assessment evidence are the staff. The standards' predetermined prescriptive indicators, by design, will continuously inhibit quality improvements within businesses, and dictate the evidence. The design of prescriptive standard indicators, dispenses the assessment processes to a tick-and-flick checklist exercise, prohibiting organic continuous improvements. The prescriptive indicators dictate the types of evidence the business must have. When businesses do not have the evidence, they must produce evidence to comply with the assessors' interpretation, who has the final say to the standard indicator evidence, irrespective of the evidence benefit to the business.

CBs who do not invest time in relationship building with businesses, hold limited understanding of the community dynamics which discounts their clients' knowledge and usurps ownership of staff for their employer's business; in this case, the Women's Service. This powerplay and tension is constantly on display in the process of accreditation assessment between the ACCOs, the CBs and CB assessors. The study participants expressed a dissatisfaction with the assessor's expectation to the consent process of client interviews and the process ACCOs create for mob to participate in informal client interviews. Two vexing processes were identified; the CB requires the client to sign a consent form to participate in a 1:1 interview with the assessor. Whereas the ACCOs response is to create an environment for informal interviews to happen through food organised either in a morning or afternoon tea with the clients, staff, and the assessor/s. This is one example of tensions arising with ACCOs from CBs who do not invest time in relationship building with ACCO businesses. Intentional relationship building is needed by the CBs to understand and appreciate how ACCOs socialise their clients to the accreditation assessment, through a group yarn over food, and an organic and less intimidating interview process.

Examination of Stage 2. The cultural protocol for Sorri Business with First Nation communities, especially those in rural and remote areas, sees the entire community closed. Meaning, no external services into the community as a mark of respect as the community mourns and tends to the business of laying their loved ones to rest. In the months prior to stage 2 assessment, the CB and their assessors were advised via email, to be flexible if Sorri business was on, the assessment date would need to be moved. The CB advised KASC they would pay extra money if the assessment date was shifted for Sorri business. The Council's hand was forced. Stage 2 assessment was performed during an entire week of Sorri business in

the community, with a number of community members being laid to rest. One is the sibling of the Women's Service worker's where the entire community was closed for Sorri business. To keep with the CB timeline and process, the certification body ignored the cultural protocols of Kowanyama community Sorri business in laying their members to rest.

Additionally, KASC risked the payment of extra money to change the assessment dates. The demand (by the certification body) for extra payment and their inflexibility reflects the cultural deafness and a deficit featured in most Australian prescriptive accreditation standards; is additional proof accreditation standards as colonial constructs detract from First Nations cultures and practices when applied to services. This status devalues the worth of ACCO businesses providing unique, nuanced services.

Throughout Stages 2 and 3, the level of evidence required for compliance with this mandated prescriptive accreditation standard was voluminous, with instances of tripling of the same information. This practice of businesses depositing commercial-in-confidence data into third-party online portals must be examined from a sovereign Indigenous data perspective. The data are the ownership, knowledge and intellectual property of the ACCO business. CB assessors instruct that the business information as evidence must be deposited into the CB online portal for review. There is no indication of the security of the businesses' information held on a third-party portal. Or why this practice is needed. Software used in monitoring accreditation standards now has the capability for assessors to access the business information via their software portal for review, assessment and compliance. Using the monitoring software as a compliance point for assessors ensures access to records is clean and secure, with ownership of the business's commercial and confidential information held by the company only.

The antiquated practice of demanding services deposit copious documents into a third-party portal of CBs must end. This third-party portal holding a business' commercial-in-confidence information raises issues of data ownership and security queries about the level of cyber security a CB can offer if breaches occur within the CB security measures. The CB 'purpose' requires on overhaul to the practice of demanding services deposit their data into CB online portals.

The HSQF standard predetermined indicators, many are replicated in the contractual agreement between the Department and the KASC. This was evidenced by the consultant seeking a review of the contract to cross-check the key performance indicators (KPIs) against the HSQF standards' corresponding indicators to perform a gap analysis. The gap analysis enabled the identification of processes, procedures and policies for design to comply with HSQF standards indicators where in-service evidence did not exist. Mumford et al. (2013) and

others introduced the term ‘quasi-mandatory’. Quasi-mandatory is an inference to industry-designed accreditation standard indicators, being linked to funding (agreement criteria in mutual contracts). Quasi-mandatory standards bring into question the quality of the standard if some of these indicators already are reportable requirements in the funding agreements and replicated in the standard.

Examination of Stage 3. The Women’s Service on 27 May 2020 was awarded their Accreditation Certificate. The certificate being awarded in 2020, stage 3 assessment in 2021 is viewed as a mop-up phase to close out the CB cycle of accreditation and performed online over two days. At this assessment, there was no discussion, or any type of negotiation held between the KASC compliance staff and the assessor as to the types of evidence required to comply with the indicators. KASC compliance staff and the Women’s Service staffs’ knowledge and interpretation of the indicator from the business evidence is usually what is presented as the service’s evidence for compliance. The compliance evidence for this stage became again a tick-and-flick checklist exercise with the Assessor dictating the evidence types. Online assessments are becoming common practice for CBs for rural and remote businesses, regarded by participants, as an inferior replacement to onsite visits. This practice, holds an urban-centric view of the internet technology and infrastructure being available and working in rural and remote communities with continuous electricity supply to host online assessments. The practice of online assessment shifts the burden of visual assessment from the CB assessor to the Businesses compliance staff of visual evidence via photos scanned and emailed to the Assessors. A practice that not only shifts this burden, but abrogates responsibility. Usurps the power of the compliance staff and places the assumed power in the hands of the CB assessor and CB. Diminishing quality, safety, value and the Business's return on investment. Assessments onsite have been the CB, and CB assessor responsibility is now being shifted to the Business. On top of the businesses’ lengthy preparation time for accreditation. Our study participants explained that, on average, the minimum preparation time is nine months for an accreditation assessment. Across the three assessment stages, only stage 2 was performed onsite. The Women’s Services’ accreditation preparation time took 12 months for 4 hours of assessor onsite engagement during Stage 2. This means 12 months of work and preparation of the Women’s Service staff for 4 hours of the assessor’s time for a major assessment phase at Stage 2. Twelve months of work to 4 hours of onsite assessment time by Assessors is the ratio (12 months preparation: 4 hours assessment) and is becoming a normal outcome for rural and remote ACCOs. Online assessments are not a preference for rural and remote businesses, as indicated by our study participants. The 4-hour onsite assessment is indicative of prescriptive

indicators occupying a tick-and-flick checklist exercise. Rendering prescriptive standard assessments as continuous quality improvement impediments.

Over the course of 3 years, multiple and triplicate copies of documents from the KASC and Women's Service were uploaded into the online portal of the CB at the request of the assessor/s for review. Jadee Consulting was onsite for all assessments during Stage 2 2020 and Stage 3 2022 and in October 2019.

4.1.9 So, Let's Yarn This Through: Discussion

The real players observed in this research triangle of ethnography, narrative inquiry and case studies are three concepts used as positioning currency: Knowledge, Power, Ownership.

Tribal critical race theory (TribalCrit), designed by the Native American author Brayboy (2006), captures this interplay perfectly in their framework concerning colonised nations. Tribal critical race theory's basic tenet emphasises colonisation is endemic to society. Emerging from critical race theory (CRT), TribalCrit is rooted in a multiplicity of nuanced and historically–geographically located epistemologies and ontologies found in First Nations communities (Brayboy 2006). American Indian colonisation is not dissimilar to the First Nations peoples' Australian experience. Brayboy (2006:428), quoting Solorzano (1998), explains, 'Although race and racism are at the centre of critical race analysis, they are viewed, at their intersection with other forms of subordination such as gender and class discrimination'.

Knowledge, Power and Ownership arose as concepts in the application of culturally deaf accreditation standards, viewed as colonial constructs. To draw out a discussion from these concepts, Brayboy's Tribal Critical framework is used to elucidate an Australia parallel, bringing understanding to the tensions experienced.

Table 4.8

Australian First Peoples Parallel to Brayboy's Tribal Critical framework

Tribal critical framework	Australian First Peoples parallel and expression
Colonisation is endemic to society	1.Colonisation is endemic in Australian society For 236 years (since 1788) the truth of Australia's colonial history is yet to fully unfold
U.S policies toward Indigenous peoples are rooted in imperialism, white supremacy and a desire for material gain	2. Australian policies toward First Nations peoples are rooted in colonialism, white supremacy and a desire for material gain By 1901 at Australia's Federation, colonies established a long tradition of discrimination against Australia's First Nations peoples. Racism was a founding value of Australian society (Dodson 2001) Our sovereign lands and seas never ceded (Pritchard 2011) Native Title legislation[14] (1993) established by the Howard government is our access point to attain our rightful Allodial title. Where our land/sea Country is commodity being bought and sold
Indigenous peoples occupy a liminal space that accounts for both the political and racialised natures of our identities	3. First Nations peoples occupy a liminal space, our identifies assigned as foreigners in our Country, both politically and racially Racism justified wholesale denial of First Nations peoples' right to participate in the polity that was under construction (Dodson 2001) As First Nations peoples, we are custodians of Country (Gammage 2012) Australia's First Nations peoples are yet to be included in the Australian Constitution
Indigenous peoples have a desire to obtain and forge tribal sovereignty, tribal autonomy, self-determination and self-identification	4. First Nations peoples' desire is to obtain sovereignty, be autonomous, self-determining and assigned our rightful place in the nationhood of Australia This beginning established the fundamental disrespect for First Nations peoples underpinning Australia's legal and political development. Not just experienced between state and First Nations peoples but extends to personal disrespect experienced by First Nations peoples on a daily basis (Dodson 2001) Australian First Nations peoples desire to be self-determining. An affirmative YES vote with a double majority in the 14 October 2023 referendum could have initiated the proposal.

[14] https://www.legislation.gov.au/C2004A04665/2017-06-22/text [accessed 24/4/2024]

Tribal critical framework	Australian First Peoples parallel and expression
	Assigning into our Constitution us & an Indigenous body in perpetuity. Our future charted together with us
The concepts of culture, knowledge and power take on new meaning when examined through an Indigenous lens	5. The concepts of culture, knowledge and power when examined through an Indigenous lens always brings nuanced meaning, value and long-term benefits The business of a republic, recognition, reconciliation and constitutional reform remains unfinished business for Australia's First Nations (Davis 2022; Reid et al. 2022; Pearson 2021; Referendum Council 2017b) Let justice prevail!
Governmental policies, educational policies towards Indigenous peoples are intimately linked around the problematic goal of assimilation	6. Government policies designed for First Nations peoples are intimately linked around the problematic goal of assimilation, white supremacy and denial of us The federal government holds the power to make laws for Australia's First Nations peoples without our knowledge. Section 51 (xxvi) of the Australian Constitution, (Williams 2013; Davis 2023) The Howard government (2008) Northern Territory Intervention is Australia's most recent xenophobic example (Lea 2020)
Tribal philosophies, beliefs, customs, traditions and visions for the future are central to understanding lived realities of Indigenous peoples, but they also illustrate the differences and adaptability among individuals and groups	7. First Nations philosophies, beliefs, customs, traditions and vision for the future are central to understanding our lived realities of Indigenous peoples, illustrating our difference and adaptability among individuals and groups across time Our history is our evolution over 65,000 years as First Nations peoples on our ancestral lands (Pearson 2021; Davis 2022; Reid et al. 2022) This fact should be cause for the federal government to embrace our beliefs, customs, traditions and vision. Building with us our future. Let hope arise!
Stories are not separate from theory; they make up theory and are, therefore real and	8. Our stories are our theories. Our stories are the songlines whispered across our interlinked lands and waters holding our connectedness to Country, on Country and with Country, are legitimate sources of data and ways of being

Tribal critical framework	Australian First Peoples parallel and expression
legitimate sources of data and ways of being	Our stories are our theories. Relationality is at the heart of 'being'. In First Nations worldviews, an entity cannot exist unless it is in relationship to something. Our way of being (ontology) is our process of relating to our world (Yunkaporta and Shillingsworth 2020)
Theory and practice are connected in deep and explicit ways that scholars must work towards social change	9. Theory and practice are held in deep and explicit ways that government, policy makers and academics must work towards social change Aboriginal and Torres Strait Islander-led transformation 'Whether in health, justice or other rights. Aboriginal and Torres Strait Islander people have had to lead on every issue, in every generation, every campaign since colonisation Aboriginal and Torres Strait Islander people will continue to do so until we are sovereign, until our denied history is acknowledged through the strength of those who have gone before us and our allies who go with us' [Mohammed 2020 Lowitja Institute Close the Gap Report] (Lowitja Institute 2020) Let love prevail!

Source: Adapted from Brayboy (2006)

Australia as a Country must concede the murderous colonial frontier wars fought on this soil for power; historical frontier wars deserving of a prominent place in our national war museum to bring to light the truth about Australia's unlawful settlement. History gives insight into the colonial founders thinking as researched by Dodson and others. (Dodson and Strelein 2001; Sullivan 2007). Colonial thinking is ingrained in the psyche of Australia, pervasive in a society where First peoples are viewed mostly as problematic (Altman and Sanders 1991; Altman et al. 2008; Davis 2023a; Fogarty et al. 2018). Racism, Dodson claims, justified the wholesale denial of Aboriginal people and marked the beginning of disrespect for Aboriginal people in the creation of Australia's Constitution (Dodson and Strelein 2001).

The indifferent discrimination exhibited in the narrative case study experienced by the local government authority, Kowanyama Council and their staff represents the ingrained racism. Further illustrated through a level of disrespect and cultural deafness experienced in the assessment process throughout all three stages. Placing assumed power in the hands of the CB and the CB assessor/s. Assumed power openly wielded with might, disadvantaging the local government authority staff during their initial accreditation. Knowledge, the second concept from our data collection appears with tension in this story yarn (narrative). Professor Yu (2012) ascribes to and reminds us of the benefits and value of data in Indigenous peoples'

hands. Good data or information in First Nations peoples' possession is valuable for Our priorities (Sullivan 2007; Yu 2012). Observed is a struggle for the status of knowledge and the holders of knowledge, probed from two perspectives in the accreditation assessment. Knowledge holder as viewed from the business and the staff knowledge of the company processes, history, community dynamics and interactions of clients with the Women's Service. Staff who are responsible for understanding, implementing, interpreting, and translating the accreditation standard indicator[s] into the business environment. Staff who know this environment and community intimately. Versus the assessor who knows the standard but not the business environment or the intricate machinations of the Organisation or the community, yet whose interpretation of the standard evidence is final. In Table 4.1, universal training is highlighted as a deficit trait. Currently there is no universal training giving consistency for assessor or surveyor assessment. The assessors' interpretation and translation of indicator evidence are loose with a wide variance, being assessor-centred in comparison with the ISO suite of standards. Auditors must undergo and complete ISO 17025 training standards before a certificate of certification is awarded.

Ownership, the third concept, becomes the ultimate end product of a business's accreditation experience. Vast amounts of KASC intellectual property across the three-year cycle were dumped into the online portal of the CB. Information is stored and kept by the CB with no understanding of what happens with the business's intellectual property. This practice brings into sharp focus Indigenous data sovereignty. Trudgett et al. (2022) identify exploitation, misuse and misinterpretation of Indigenous data as commonplace. Indicating, as claimed by Trudgett et al. (2022) a growing recognition by Indigenous leaders and academics to protect against the misuse of data. The concept of data sovereignty is defined as a need to ensure information is managed according to 'the laws, practices and customs of the nation-state in which it is located'(Trudgett et al. 2022:2). This definition aligns with the UNDRIP articles (United Nations 2007). United Nations Declaration on the Rights of Indigenous People is the only document that tethers and acknowledges the rights of Australian First Nations peoples to a legal and binding framework outside of our inclusion in the Australian Constitution.

4.1.10 Evidence We Have, Now to Make Good of It: Conclusion

This ethnographic narrative case study is littered with experiences of discrimination that should have been avoided by service provision delivered (by the CB and assessor) with empathy and less arrogance. This example serves as a poignant reminder to CBs, standard owners, standard developers and other players in the Australian accreditation industry. The design of your product for and engagement with ACCOs must be a true partnership with

integrity, designed and dispensed with equity and respect. Relational, where knowledge, power and ownership are always held by the business/company. The certification body holds the role of service provider only in the contractual relationship of accreditation assessment.

The owner of the HSQF standard is the same state government department, a different iteration, that enacted the assimilation policy on the community of Kowanyama in the 1940s. The CB and the CB assessors were bereft of these national historical facts, including racially designed policies the Queensland Government enacted on the Kowanyama community over eight decades. This historical knowledge deficit in the CB and CB assessor created a degree of palpable tension experienced in this story. The design of prescriptive accreditation standards for ACCOs, nor how they are assessed, is not fit- for-purpose, as indicated in Table 4.1, argued with rationality in this ethnographic narrative case study.

On the characteristics of quality and safety, our cautioning is—not every accreditation standard is the same in design, purpose, quality and value. Accreditation is a specialised market. The standard owners and design must match this level of specialism. Our research on the quality and safety of prescriptive accreditation standards is being debated and challenged. Table 4.1 identifies these traits.

There is pernicious inequity in mandating an ACCO apply an accreditation standard that is not fit-for-purpose and requires urgent review. Open accreditation standards are a superior standard for ACCOs. These standards allow for open interpretation and translation of the clauses based on the maturity of the business, size and geographical location to meet compliance. These traits are identified in Table 4.2. The use of open-ended standards reduces the financial cost to the business and simply is a certification standard for the entire organisation. Not segmented for different areas of the health market in an ACCO business.

4.1.11 Nuggets of Wisdom—For Review: Recommendations for the Accreditation Industry and the Australian Government

1. A review of the number of mandated accreditation standards ACCOs apply.
2. Accreditation standard owners assign mutual agreement to the indicators/criteria across the multiple prescriptive accreditation standards in operation.
3. Review and remove the duplication of quasi-mandatory criteria from the standard indicators that appear in the contractual service agreements.
4. Design less prescriptive standards promoting organic quality improvement in the indicators enabling iterative (over time) continuous improvements in businesses applying the standard/s.
5. Provision for a level of mandatory universal training for assessors and surveyors in Australia, enhancing consistency in the performance of assessments.

6. Development of inclusive standards removing cultural deafness, installing respect and acknowledgement of Australia's First peoples' culture, knowledge and practices in providing nuanced, safe services.
7. Repeal the antiquated practice of uploading commercial-in-confidence ACCO business data into third-party portals as identified by *Maiam nayri Wingara.*[15]
8. Consider and comply with Indigenous data sovereignty measures in accreditation assessments of standards and in accreditation standard design as identified by *Maiam nayri Wingara*.

Our research is over a decade in the making, adding new knowledge to the accreditation industry. These recommendations are produced from our research findings for social change to bring equity back to the Australian accreditation industry.

This accreditation story is not a one-off experience but the experience of many ACCOs. Publishing this story highlights the real issues encountered by this first-time accreditation experience. Their story deserves amplification. We implore the accreditation industry players to stop, reflect on their practice and consider the research findings for good social change.

The Rudd Gillard government legislated a national accreditation framework in 2008, 16 years later, this requires a health check. Our data are the evidence. Our experience and research flag that most industry-designed prescriptive accreditation standards are culturally deaf and offer ACCOs applying these types of standards no level of quality, safety, benefit or value. The accreditation process for prescriptive industry-designed standards as a tick-and-flick checklist measure hinders continuous quality improvement and, for ACCHS, arrests good clinical governance processes and outcomes.

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[15] https://www.maiamnayriwingara.org

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4.3 Appendix 4A: Uluru Statement from the Heart

We, gathered at the 2017 National Constitutional Convention, coming from all points of the southern sky, make this statement from the heart:

Our Aboriginal and Torres Strait Islander tribes were the first sovereign Nations of the Australian continent and its adjacent islands and possessed it under our own laws and customs. This our ancestors did, according to the reckoning of our culture, from the Creation, according to the common law from 'time immemorial', and according to science more than 60,000 years ago.

This sovereignty is a spiritual notion: the ancestral tie between the land, or 'mother nature', and the Aboriginal and Torres Strait Islander peoples who were born thither to be united with our ancestors. This link is the basis of the ownership of the soil, or better, of sovereignty. It has never been ceded or extinguished, and co-exists with the sovereignty of the Crown. [p 192]

4.4 Appendix 4B: Proposed Amendment to the Australian Constitution

Chapter IX—Recognition of Aboriginal and Torres Strait Islander peoples

129. Aboriginal and Torres Strait Islander Voice

In recognition of Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia:

(i) there should be a body, to be called the Aboriginal and Torres Strait Islander Voice.

(ii) the Aboriginal and Torres Strait Islander Voice may make representations to the Parliament and the Executive Government of the Commonwealth on matters relating to Aboriginal and Torres Strait Islander peoples.

(iii) the Parliament shall, subject to this Constitution, have power to make laws with respect to matters relating to the Aboriginal and Torres Strait Islander Voice, including its composition functions, powers and procedures. [p194].

4.5 Appendix 4C: Section 128 of the Australian Constitution

128. Mode of the Altering the Constitution

This Constitution shall not be altered except in the following manner:

The proposed law for the alteration thereof must be passed by an absolute majority of each House of the Parliament, and not less than two nor more than six months after its passage through both Houses the proposed law shall be submitted in each state and territory to the electors qualified to vote for the election of members of the House of Representatives.

But if either House passes any such proposed law by an absolute majority, and the other House rejects of fails to pass it, or pass it with any amendments to which the first-mentioned House will not agree, and if after an interval of three months the first-mentioned House in the same of the next session again passes the proposed law by an absolute majority with or without any amendments which has been made or agreed to by the other House, and such other House rejects or fails to pass it or passes it with any amendment to which the first-mentioned House will not agree, the Governor-General may submit the proposed law as last proposed by the first-mentioned House, and either with or without any amendments subsequently agreed to by both Houses, to the electors in each state and territory qualified to vote for the election of the House of Representatives.

When a proposed law is submitted to the electors the vote shall be taken in such manner as the Parliament prescribes. But until the qualifications of electors of members of the House of Representatives become uniform throughout the Commonwealth, only one-half the electors voting for and against the proposed law shall be counted in any state in which adult suffrage prevails.

And if in a majority of the states a majority of the electors voting approve the proposed law, and if a majority of all the electors voting approve the proposed law, and it shall be presented to the Governor-General for the Queen's assent.

No alteration diminishing the proportionate representation of any state in either House of the Parliament, or the minimum number of representatives of a State in the House of Representatives, or increasing, diminishing, or otherwise altering in limits of the state, or in any manner affecting the provisions of the Constitution in relation thereto, shall become law unless the majority of the electors voting in that state approve the proposed law.

In this section, 'Territory' means any territory referred to in Section 122 of this Constitution in respect of which there is in force a law allowing its representation in the House of Representatives. [pp 195–196]

Book: Everything you need to know about the Voice [2023] Authors: Megan Davis and George Williams

5 Leading for Sustained Change

(Results and Discussion)

[Goanna tracks on Yuwi Country. Photo credit: Jenifer Darr.]

Knowing the lay of the land, to read the signs, to see and hear what it speaks.

My role as an author and researcher in this business is to present the lay of the accreditation landscape in these results chapters, where the data has been refined through focused analysis from a disparate gathering of genuinely interested people who are specialists in their fields representing different aspects of the Australian accreditation industry. Together they hold in excess of 154 working years in accreditation. Being presented is new knowledge, opening up conversations through good data to make a sustained change to a disingenuous national accreditation market for Aboriginal PHC.

5.1 Paper 1: Reciprocity in Action: Results of a Critical Indigenist Lens Upon the Australian Accreditation Market—PHC Tier

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Authors' recognition—we pay honour to our First Nations ancestors and acknowledge the custodians of the Country on whose lands and waters was never ceded. Qualification—Respectfully, First Nations peoples is the designated title for Australian Aboriginal and Torres Strait Islander people used by the first author—custodians of Country for over 65 millennia.

5.1.1 Abstract

As identified by Darr et al. (2021), there is a need to understand what quality systems are being used in the ACCHS sector and how they are being used to (i) drive and holistically measure the quality of care delivered by clinical teams and (ii) measure the quality of organisational development through corporate governance. This qualitative study explores quality systems used in the ACCHS sector, as reported by ACCHS sector staff and key stakeholders in yarning circles (interviews and focus groups) held after COVID-19 (2021–2022). The thematic analysis used a TribalCrit theoretical framework to explore how these results reflect power, knowledge and control issues in the Australian accreditation industry.

Reciprocity is innate in the DNA of First Peoples. These results provide information and knowledge for Aboriginal community-controlled businesses engaging with the accreditation industry that apply multiple and disparate accreditation standards. We establish a universal language for businesses to navigate the accreditation industry with success. This series of papers establishes a universal language for businesses to help traverse the accreditation industry. This paper gives insight into the content inside the accreditation industry 'Pandora's box' for those businesses that engage and apply multiple accreditation frameworks.

5.1.2 Introduction

Australia has a history of monitoring health care system performance. The Australian Government instituted the *Hospitals and Health Services Commission Act (1973),* which established a Commission charged with health policy development and implementation across the health sector. In 2008, the Rudd government instituted the National Health and Hospital Reform Commission, which sought to examine the Australian health care system in its entirety to improve health outcomes for all Australians (National Health and Hospitals Reform Commission 2008). In 2010, as a direct result of recommendations from the Health and Hospitals Reform Commission, the Rudd/Gillard government legislated a policy introducing a compulsory accreditation framework throughout the Australian national health system for tertiary, secondary and PHC (Bennett 2008; Darr et al. 2021). The policy shift mandated that all providers of health care engage in and apply relevant accreditation standards. Since 2010, there has been a measurable increase in the number of CBs—the companies responsible for assessing accreditation standards—from fewer than four CBs registered in 2010, to 141 a decade later (J. Darr, pers comms ISO expert 2019). In 2023, there were 11 Australian-designed accreditation standards operating nationally across the PHC tier. Aboriginal PHC providers are also required to implement the certification standard of ISO 9001:2008 (QMS) (noting that this standard had a version change in 2015—ISO 9001:2015).

This research study aimed to understand the experiences of the ACCO accreditation processes, with a focus on the sustainability and efficiency of the applied process for these services. It also aimed to consider whether the current standards and processes are culturally fit-for-purpose in these unique boutique services. This study used yarning circles [focus groups and interviews] with ACCO and accreditation stakeholders from November 2021 to June 2022. Participant engagement included various agencies linked to health services accreditation. Most participants had in excess of seven years' experience in the sector and held extensive technical knowledge in health industry accreditation. This quality and quantity of experience, technical knowledge and skill offered critical insights into the effects of accreditation in the ACCO sector and the complexities of managing multiple and different accreditations within individual organisations. Twelve sessions of yarning circles (three focus groups, four by 1:1 interviews and five key informant interviews), lasting an average of two hours, were audio recorded and transcribed in full. A thematic analysis (Braun and Clarke 2012) conducted on the transcripts resulted in five major themes: (i) ISO processes and RACGP standard, (ii) return on investment and technical efficiency tools, (iii) the hidden human cost of accreditation, (iv) accreditation implications and (v) accreditation intangibles.

The TribalCrit theoretical approach was utilised in analysing these five themes, which opens discussion on the three larger concepts of KNOWLEDGE, POWER, OWNERSHIP and how these relate to the accreditation of ACCOs. The five themes are organised under the KNOWLEDGE, POWER, OWNERSHIP concepts, with the study participant experiences, triangulation of data, reflexivity, member checking and peer debriefing adding credibility, transferability, dependability and confirmability (Creswell and Creswell 2018; Creswell and Miller 2000).

5.1.3 Knowledge: Identified Knowledge Gaps

In our first literature review (Darr et al. 2021) it was identified there is a need to understand what quality systems are being used in the ACCHS sector. This paper explores the use of accreditation standards as part of a quality system and critiques the value that these mechanisms provide to the ACCO business structures (Darr et al. 2021). It is important to describe some key terms within the accreditation sector because this is one of the deficit areas identified within the literature.

5.1.3.1 The Lay of the Australian Accreditation Landscape

Types of standards operating in the primary health care tier.

Assessment Model Types

There are differences between accreditation and certification as a process for engagement in the application of accreditation standards. The Royal Australian College of General Practitioners (RACGP) defines accreditation as peer-reviewed recognition of a health practice meeting requirements of Australian general practice standards, known as practice accreditation (Royal Australian College of General Practitioners 2010). Certification is a process whereby an authorised independent agency recognises individuals or service delivery organisations as meeting clause requirements (established by the business based on maturity) beyond those set by licensure (Buetow and Wellingham 2003) as indicated in Box 1.

Box 1

Australian Primary Healthcare Assessment Models

Assessment type	Aim	Rationale	Method	Outcome
Peer review of professional performance	Assesses professional performance of	Professionals can self-regulate to improve	Systematic site visit based on systems	Assessment report only with no certificate of achievement

	individuals and practice team	professional performance	criteria and peer review	
Practice accreditation	Assess organisation and delivery of specific practice services	Practices need to demonstrate public accountability	Peer assessment against explicit standards	Accreditation of practice development necessary for quality improvement for medical care of clients
International Organisation for Standardization (ISO)	Implement international norms & systems thinking for the development of quality systems	Quality systems and management processes can be strengthened and standardised to achieve efficiencies	Audit by ISO experts, (not peers) against generic international standards	Certificate of compliance standards for whole-of-organisation development
Adapted from Buetow and Wellingham (2003)				

In the Australian accreditation market at the primary care tier, accreditation standards are national and state government or other industry-designed standards and international designed standards (referred to as certification standards) such as the ISO suite of standards. At the primary care tier this highlights two different levels of standards operating in the market and are referred to as (i) Industry-based standards and (ii) International standards.

5.1.3.2 Standard Names, Owners, Type and Descriptors

Industry-based standards are designed by industry leaders and stakeholders and often named according to the industry they relate to. Such standards include the RACGP Standard, HSQF Standard, National Disability Insurance Scheme (NDIS) Standard, Aged Care Standard, National Safety Quality Framework Health Standard, Mental Health standard, Rainbow Tick Standard and Spirometry Standard, just to name a few. These industry-based standards, by design, are prescriptive, meaning their indicators/criteria are predetermined and closed to interpretation. Their prescriptive nature renders the assessment activity a 'tick-and-flick' checklist exercise. Their prescriptive nature keeps businesses locked into continuous cycles of accreditation without installing any business systems change. The prescriptive indicator/s and

criteria disable any form of internal business system improvement through an iterative PDSA cycle. Their specific industry-based design deems their purposes independent, with little to no mutual recognition between them. Each one of these standards addresses a specific program area or health issue, creating silos to the application of accreditation standards in a business. These mandated, independent, industry-based standards become problematic for organisations that seek to provide holistic client-centred health wellbeing care, such as that seen within the ACCO sector. ACCOs provide a boutique, holistic model of client care programs from pre-birth throughout the lifespan, covering every population and public health area through to aged care in some instances. Currently, this holistic service delivery accommodates multiple and different standards being applied and accredited for these services to act in compliance with each siloed standard. These standards of mandatory compliance interrupt the opportunity for truly holistic care models and debate their direct opposition to Aboriginal and Torres Strait Islander holistic meaning and beliefs of health. Figure 5.1 outlines the number of prominent accreditation standards currently operating at the primary healthcare tier in the Australian accreditation landscape.

Figure 5.1

National Accreditation Standards Operating in Australia

Table 1. NATIONAL ACCREDITATION STANDARDS OPERATING in AUSTRALIA	
RACGP standard	QIC health & community services standard
Mental Health standard	Human Services Quality Framework (HSQF standard Qld) Victorian Human Services Framework (HSF standard) Australian Service Excellence standard (ASES)
National Disability Insurance (NDIS) standard	National Safety and Quality Health Service standard (NSQHF)
Aged Care standard	National Quality Framework for Drug and Alcohol standard NSW Clinical care standards Alcohol and other drug treatment Alcohol and other Drugs Service standards and guidelines (Victoria)
Spirometry standard	Rainbow Tick standard
INTERNATIONAL CERTIFICATION STANDARD- ISO SUITE of STANDARDS	
ISO 9001:2015 Quality Management System (QMS)	Whole of Organisation certification
Is there value for multiple and separate accreditation standards in ACCO businesses?	

5.1.4 What's in a Name?

The accreditation standards appearing in the first five rows and two columns of Figure 5.1 are Australian industry standards. The last standard noted in Figure 5.1 is ISO 9001:2015 QMS from the International Organization for Standardization and ISO suite of standards. The last two standards on the fifth line are minor because specific standards of Spirometry and the

Rainbow Tick are not mandatory, whereas the other nine are mandatory for ACCOs. The study participants shared their experience of the sheer number of standards in operation:

> ISO. It's an international standard. There's nothing we can do about that. But in our sphere of influence, so AGPAL and QIP together accredit about 27 frameworks (accreditation standards), and they have either ownership or significant influence over about four of those. [$urban_2$]

> so, we're up to 12 (standards) now. Eleven of the Australian industry-designed Standards, none of them have got (a level of) synchronicity (between them). So, staff working in the service / ACCOs have to see where which ones align (across the standards that ACCOs applies). [$remote_1\_aud_1$].

The study participants similarly shared their experience of their observed qualities on the difference between the standards operating at the primary healthcare tier in Australia:

> a relatively new staff member recently asked me to explain the ISO standard. … the way I explained was to say that the ISO 9001 standard basically allows the organisation to develop, monitor, maintain, review its own quality management system. It's not prescriptive about what that quality management system is. It has nine separate clauses around how to put that together but it's not prescriptive as to what that actually is. [$rural_1\_aud_1\_asr_1\_sur_1$]

> I think it's (ISO 9001 is) a classic evolutionary process. Whereas the majority of companies these days seeking certification are service based organisations like ACCHOs. The language had to change from, manufacturing and process control to service delivery and customer facing, feedback from customers, etc, and so it's (ISO 9001 is) a much better model now. [$urban_1\_aud_1$].

> Whereas all of the other standards I've worked with (outside of ISO 9001) are much more prescriptive, they're actually telling you what you're expected to have for each particular standard. [$rural_1\_ aud_1\_asr_1\_sur_1$]

ISO 9001:2015 QMS is an international standard that, by design, is open to interpretation; its focus is on establishing measurement of growth over time commensurate with the organisations' maturity. ISO 9001:2015 QMS is repetitive and consistent to avoid variation in the outcome, allowing businesses to attain a level of consistency in measures across time, showing clear trends relating to growth in the business environment through systems design. In this standard, certification is the term applied only to the process outcome

of applying the ISO 9001:2015 QMS standard in your business. Auditor is the title given in reference to individuals trained in ISO certification who will perform the audit on the business/company processes through interpretation of the ISO standard[s].

5.1.4.1 Quasi-Mandatory Standard

A common feature acknowledged by participants, found only in industry-based prescriptive standards, is the multiplication of KPIs/criteria found in the businesses' funding agreements, replicated as indicators in the accreditation standards by the standard owners. Mumford et al. (2013) introduce this concept as being a 'quasi-mandatory' standard in their paper, the *Economic Evaluation of Accreditation.* According to Mumford et al. (2013), quasi-mandatory, as reported, is an inference to industry-designed accreditation standard[s] indicators being directly linked to funding. This feature was a point of discussion; our participants noticed the repetition of funding agreement criteria housed in the industry-designed accreditation standards for some indicators and criteria:

> And I suppose that's where that frustration comes in around the duality, and the multiplication (of criteria) across all of the different standards. [$rural_1$_aud_1_asr_1_sur_1]

> (this is the thing) …all of the independent review bodies (certification bodies) have regular liaison meetings with funders (owners of the standards) because the funders set their benchmark about what they expect out of their performance (accreditation standard indictors) with the people (organisations) who are being reviewed (accredited and assessed). [$rural_1$_aud_1_asr_1_sur_1]

Silburn et al. (2016) et al., in their report *Is Funder Reporting Undermining Service Delivery?*, discuss the role of ACCO reporting and identify discrepancies in the vertical and horizontal levels of reporting by ACCOs in Victoria. ACCO funding is obtained in three main ways: Historical funding arrangements, reporting with government (state and federal) departments on annual, triennial delivery of specified PHC services; the second is through fee-for-service arrangements in payments for medical services through Medicare; and thirdly through competitive processes such as tenders or applications to funding rounds. These arrangements required 409 reports against 46 funding agreements. The types of reports were 53 annual reports, 52 half-yearly reports, 88 quarterly reports and 216 monthly reports (Silburn et al. 2016). The reporting requirements to operate a business, such as a regulator, tax and legal requirements, is additional to the accreditation reporting for the multiple standards ACCOs apply throughout continuous cycles of accreditation. The ACCO level of reporting is excessive.

5.1.4.2 No Mutual Recognition or Synchronicity Between the Australian Industry-Designed Standards

As a glaring deficit in the standards design, participants discussed the lack of mutual recognition of similar criteria across each of the Australian industry-designed accreditation standards. They also identified a lack of synchronicity between each of the Australian industry-designed accreditation standards. Standard owners have not recognised or achieved mutual agreement to check off similar indicators/criteria for those businesses applying more than one accreditation standard. Those in the ACCO sector across the country are likely applying multiple standards. Yet each accreditation process requires data to be collected and evidenced in slightly different ways, creating a disproportionate burden on compliance staff and the business's efficiency. The study participants' responses based on their experiences appear below:

> So, there's no synchronicity between any of the standards that you've got at the moment that says look, as the standard owners we will work together, so that we can ultimately provide some sort of process whereby if you've done this, we'll actually tick you off the list. [$urban_3$_AUD_3_ASR_3_SUR_3]

> there's no mutual recognition between any of these standards that say, well you're accredited there so we can cross those three, standards off the list. [$rural_2$_ASR_2]

> And even within the (industry-based) standards themselves, there is duplication and multiplication of criterion within the standard. [$rural_1$_aud_1_asr_1_sur_1]

RACGP Standard Definition

In the Australian context, the RACGP develops the standard for general practices (5th edition) (referred to forthwith as the 'Standard') with the purpose of protecting patients from harm by improving the quality and safety of health services. The Standard supports general practices in identifying and addressing any gaps in their systems and processes (RACGP 2020).

The term accreditation is the assigned reference to the outcome of this standard's compliance. Surveyor is the title assigned to those who are responsible for the accreditation assessment of health services who apply the RACGP standard. The quality assessment type is termed practice accreditation, with an aim to assess an organisation and delivery of specific practice services. The rationale is that general practices need to demonstrate public accountability. The method used is peer assessment against explicit standards. The outcome is

the accreditation of practice and the development of processes necessary for quality improvement for the medical care of clients.

5.1.5 Fit-For-Purpose Standards: RACGP Standards Are Designed for GP Clinics, Not ACCOs

The RACGP standard is a non-legislated industry standard specifically designed for the business of general practice clinics. Some of the study participants identified the design of the RACGP standard by nature, and the purpose is prescriptive because it pertains to the application of accreditation standards into businesses, particularly ACCOs. By prescriptive, we mean that the evidence the business develops, produces and assigns (to meet the indicator/criteria) is prearranged within identified criteria parameters. Study participants made these comments based on their experience of the RACGP standard:

> Because, even particularly in the RACGP (standards), they're written for general practices, not for AMSs (ACCOs). [$rural_2$_aud_2]

> my experience of RACGP as the only Standard we had to apply (in our ACCO) was placing a square peg in a round hole. RACGP (standard) was so prescriptive and to apply it in a remote (ACCO service) setting, in town X was just hard! [$remote_1$_aud_1]

In October 2023, the Australian Government engaged a consulting firm, Allen and Clarke, to examine why GP practices are not applying the RACGP standard. This examination is based on a report released in October 2021 titled *Review of General Practice Accreditation Arrangements Report* by MP Consulting (2021). A glaring outcome in this report indicated that mainstream GPs and GP practices find the RACGP standard to be a 'tick-and-flick' checklist exercise, with many choosing not to apply this particular standard. An article by Gordon et al. (2022) identified a desire for more data on general practices after COVID-19 and how they operate their health services so they remain viable.

5.1.5.1 Prescriptive Standards, Siloing of Standards, Software and Services

The subtheme of prescriptive standards, siloing of standards, software and services addresses the independence or siloing of standards in the Australian accreditation industry. A good majority of the standards are designed for a specific market, population health cohort or disease. The invasion of the accreditation market by numerous Australian industry-designed prescriptive accreditation standards creates a siloing effect. The standards' predetermined nature of indicators and criteria means the evidence needed for compliance can forcefully determine the actions of a business. It does this by inhibiting any level of quality improvement, limiting a business to actions aligned closely to their funding agreement, and limiting the creativity, flexibility and responsiveness to client needs in holistic environments. The lack of

mutual recognition or agreement between the owners of these standards creates an inequitable chasm for businesses, especially the ACCO, ACCHS and ACCHO sectors.

The ACCO, ACCHS and ACCHO network are the only PHC providers in Australia who are mandated to apply up to 11 disparate accreditation standards. To achieve alignment between each of the disparate accreditation standards, some participants reported their task as compliance staff is to perform a mapping exercise to identify the replication of criteria in each of the standards' indicators/criteria for compliance:

> When I came on board, I looked at all the standards that we have, sat down, and we mapped the procedures to each and every standard and joined them where we could—That's what I had to do! [$rural_2$_aud_2]

> That's where it gets complicated, trying to marry all that together (multiple accreditation standards criteria) so you can have one set of policies and procedures that will cover all those (requirements in the) standards. [$rural_2$_aud_2]

> Our organisational example (to prepare staff in the organisation for one accreditation) starts probably 12 months out. Quoting for the assessing agency, dates (for assessment), …. Internal gap assessment (where we are at)….monthly meetings across the organisation (to bring everyone along on the journey)…evidence collection along the way…. [$urban_3$_asr_3]

> This accreditation space needs to be a bit more equitable than what it is. [$remote_1$_aud_1]

The mapping exercise can be a significant undertaking if an ACCO business runs 5–11 disparate accreditation standards. The siloing of accreditation standards in ACCO services is an assault on and disregard for the ACCO holistic business model. The mandated application of prescriptive accreditation standards as representing dimensions of 'quality and safety' measures is a denial of First Nations peoples' holistic view of their health and wellbeing. The mandated application of multiple disparate prescriptive accreditation standards is a significant expense year on year for Aboriginal PHC. Participants expressed that this money should be used for their clients' care. Moreover, the Australian accreditation industry (through their standards) segments how clients and businesses value, view and manage health wellbeing. To the extent the Australian industry-designed, prescriptive accreditation standards dictate how ACCOs manage (negatively or positively) their boutique businesses being locked into the extraneous burden of additional reporting under these forced conditions—Australian industry-

designed prescriptive accreditation standards are colonial constructs. The colonial construct definition is premised on First Nations sovereignty, and identifies measures of quality and safety designed by external entities without the expressed consideration of Aboriginal and Torres Strait Islander history, heritage and being in our Country, and how holistic health wellbeing is viewed and practised. Brayboy (2006) introduced the term 'locating theory' to connect First Nations community stories, personal narratives and theory through the importance of making connections between different types and forms of knowledge to meet the higher community goal of sovereignty. Colonial constructs (i.e. accreditation standards) separate elements of human experience into 'manageable quantifiable chunks', which is not reflective of human experience and further denies the value of Indigenous knowledge systems and ways of being. For over half a century, the ACCOs' innovative holistic business model has been a contributing dynamic to the Australian primary healthcare tier.

Phillips et al. (2010) describe clinical governance as a framework of strategies including clinical audits, clinical competence, client-directed interventions, risk management, education and training schedules and use of service information, such as accreditation performance. Phillips says integration and a systematic approach to these strategies ensure services deliver quality and accountable healthcare. Phillips' endorsement of the ACCHS model as a systems approach at an organisational level may lead to effective PHC regionally, a decrease in chronic disease and an efficient business model. Phillips' systematic research of clinical governance models positioned the ACCHS sector as a leader in clinical governance in Australia, with valuable lessons for primary care more broadly (Darr et al. 2021; Phillips et al. 2010).

5.1.6 Reflection

For well over 13 years, the Australian primary healthcare tier has applied various frameworks to elements of operation. Our research indicates that not all primary health services apply an accreditation framework. The ACCO sector, however, has carried its weight and burden in supporting a growing and burgeoning Australian accreditation industry, a multibillion-dollar industry. The ACCO sector, since its inception in 1972, has remained innovative at the cutting edge of its service delivery for First Nation peoples. Our data indicate that the ACCO sector nationally applies the mix of accreditation standards shown in Table 5.1. The majority of Australian industry-designed accreditation standards are mandatory for ACCOs. For some states, ACCOs adopt QIC Health and Community Services standards instead of ISO 9001:2015 QMS.

5.1.6.1 ACCO National Uptake of ISO 9001:2015 QMS

Table 5.1

ACCO Uptake of Mandated ISO 9001:2015 QMS and Other Standards in Australian States and Territories Since 2012

Standard	State and peak ACCO affiliate	Number of member services (includes full and associate)
ISO 9001:2015 + other industry standards	Queensland (QAIHC)	31
ISO 9001:2015 + other industry standards	Northern Territory (AMSANT)	25
ISO 9001:2015 + other industry standards	Western Australia (AHCWA)	22
Mix ISO 9001:2015 & QIC + other industry standards	New South Wales (AH & MRC)	45 (ratio unknown)
QIC + other industry standards	South Australia (AHCSA)	12
QIC + other industry standards	Tasmania	unknown
Mix ISO 9001:2015 QMS & QIC + other industry standards	Victoria (VACCHO)	33 (ratio unknown)

Note. Source: State and Territory Peak ACCO affiliate websites (2024)

According to our study participants, the average cost for one accreditation standard is approximately $20,000 dollars. ACCOs apply, on average, seven accreditation standards. When $20K is multiplied by seven accreditation standards and apportioned across each member organisation, the results are astounding. Table 5.2 shows the indicative value for ACCO contribution state by state to engage and apply an average of seven mandated prescriptive industry-designed accreditation standards.

5.1.6.2 Indicative ACCO Value of Accreditation Spend Across Australia

Table 5.2

Indicative ACCO Value of Accreditation Spend Per State/Territory

State	Number of standards for eligible ACCOs per state (based on Table 5.1 figures)	Indicative spend for seven standards at $20K average
QLD	186	$3,720,000
NT	150	$3,000,000
WA	132	$2,640,000
NSW	270	$5,400,000
SA	72	$1,440,000
Tasmania	Data unavailable	Data unavailable
VIC	198	$3,960,000
Total average cost		$16,200,000
Cost across 10 years	For all States & Territories	$162,000,000

The indicative average ACCO expense nationally over the decade at a conservative $162 million dollars is excessive. For those who orbit in the ACCO sector, it is known that the ACCO sector carries the weighty burden of unnecessary accreditation standards as colonial constructs and a denial of the ACCO holistic business model.

The ACCO sector and the GP practice sector are the only two prominent networks providing PHC in Australia. This status shows how one tier of the Australian healthcare industry, the primary care tier, is experiencing two extreme outcomes as it pertains to the application of accreditation standards. The experiences of ACCOs in attaining accreditation status show excessive surveillance and unwarranted, disingenuous engagement of the accreditation industry and government standards with the ACCO sector. The data from the consultant company Allen and Clarke will produce interesting findings as to why the GP practice sector does not apply the RACGP standard.

We have real-time data from two separate streams of research activity for the primary healthcare tier. The results from these two streams of research collectively paint a holistic picture of what is happening in the Australian primary care accreditation landscape. One is the gap analysis to the review of general practice arrangements by the Commonwealth Department of Health and Aged Care. The other is the findings from this study that the ACCO sector applies up to 11 disparate accreditation standards, viewed as colonial constructs. The design of these colonial constructs denies the ACCO model of health care, segments the ACCO

service delivery and is simply not fit-for-purpose. We recommend an urgent review of the number of accreditation standards/colonial constructs ACCOs apply. Our study participants stated:

> one of those accreditations (standards) should be able to prove that we can operate (our business) in the right way. [$remote_2$_asr_2]

> So, when you look at a service our size (an urban ACCO), we're basically throwing $100K away just to be able to produce (accreditation) certificates and provide reassurance to funders. [$urban_3$_asr_3]

Historical events are important markers to gauge the maturity of a country. March 2024 marked the assignment of Australia's new Race Discrimination Commissioner, who is quoted as follows:

> A united approach to anti-racism is essential if our society is to better address and ultimately dismantle systemic racial discrimination in all its forms…. and commits to developing Australia's first National Anti-Racism Framework…Australia urgently needs a national coordinated approach to anti-racism legally adhered to and empowers people to take meaningful action.[16]

The pitfall to the Commonwealth implementing an accreditation framework in 2008 is that within these 15 years, minimal attention has been given, and an evaluation of the benefit of this legislation at the PHC tier has not eventuated.

5.1.7 Recommendation

Our recommendation to the Australian Government is to create additional Medicare accreditation item numbers for ACCOs specifically as a cost recovery measure.

5.1.8 Conclusion

The ACCO sector has carried the accreditation burden for well over 13 years without review, recognition or recompense for the implementation of multiple and different frameworks. The convergence of two streams of research activity, (i) review of the uptake of RACGP accreditation standard for GP practices and (ii) the results on multiple and different standards ACCOs apply, when viewed together, provide timely evidence for the players in the primary healthcare tier, the Australian Government, the NACCHO and the accreditation industry more broadly.

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[16] https://humanrights.gov.au/about/news/media-releases/giridharan-sivaraman-commences-race-discrimination-commissioner [accessed 24/04/2024]

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5.2 Paper 2. Power—Real or Perceived: Applying a Critical Indigenist Lens Upon the Australian Accreditation Market—PHC Tier—The Results

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Authors' recognition— we pay honour to our First Nations ancestors and acknowledge the custodians of the Country whose lands and waters were never ceded. Qualification: Respectfully, First Nations peoples is the first author's designated title for Australian Aboriginal and Torres Strait Islander people, custodians of Country for over 65 millennia.

5.2.1 Abstract

Employing context. This paper is the second in the series of three and continues the exploration of the need to understand what quality systems are being used in the ACCHS sector. Being explored as the concept is POWER and how 'power' is used consciously or unconsciously as the control in the application of accreditation standards by the certification body and the assessors with ACCOs. Power wielded for dominance by the accreditation industry players has dire effects for ACCOs. Especially if the experiences of ACCOs in attaining accreditation status show excessive surveillance, and unwarranted and disingenuous engagement of the accreditation industry colonial constructs towards the ACCO sector. The ACCOs status in the Australian accreditation market is based on understanding and asserting their power of self-agency, and self-determination through reciprocity and the spirit of integrity with the standard owners and industry players, armed with these research results as evidence.

Reciprocity is innate in the DNA of First Peoples, where agency and the interdependencies of all living things are held and where Aboriginal and Torres Strait Islander people enjoy a quality of life through whole-of-community self-determination and individual, spiritual, cultural, physical, social and emotional wellbeing. These results represent good data and knowledge for those in the health service industry who apply multiple and disparate

accreditation standards to their businesses. Established is universal language for businesses to successfully navigate the accreditation industry.

5.2.2 Power

5.2.2.1 Perceived or Real: Is the Australian Accreditation Industry Disingenuous?

TribalCrit framework (Brayboy 2006) addresses liminality for First peoples as both legal/ political and racialised beings in the experience of colonisation (Brayboy 2006). In the Australian example, at the core of colonisation is a usurping and denial of the rights of the original inhabitants of our unceded Country by dominance and power. For over 240 years, this has been our liminality or 'inbetweeness' post-colonisation.

Professor Peter Yu quotes Sir Francis Bacon—'Knowledge is Power'—to express the importance of good data as knowledge in First Nations peoples' hands to make good decisions to direct our future (Freemantle et al. 2007; Walter et al. 2020; Yu 2012). VicHealth (2023:9) identifies in their summary report a definition of the commercial determinants of health (CDoH), describing it as 'systems, practices and pathways through which commercial actors drive human health and health equity'. VicHealth (2023) CDoH definition claims this focus is on commercial actors is neutral, with commercial actors having a negative or positive impact on health and wellbeing. The VicHealth (2023) states the definition is broad, focusing on human and planetary health and health equity as key outcomes of concern. Crocetti et al. (2023), in 'Commercial Determinants of Indigenous Health', indicate a lack of oversight of corporate social responsibility strategies identified through the exploitation of Aboriginal culture by commercial industries.

Quality and safety are traits synonymously associated with accreditation standards. Over time, these have been replaced with power, money and denial, especially in the design of colonial constructs via Australian accreditation standards for the PHC sector, marginalising the ACCO sector. In the previous section, we stated three concepts that arose from the data. In part 1, there was a discussion on the over-surveillance of the ACCO sector, where up to 11 disparate accreditation standards are applied. The mainstream GP health services apply only one standard—the RACGP standard. In this segment, we discuss and explore i) a systems approach to certification, ii) the assessor, surveyor and auditor quality; iii) return on investment and technical tools.

5.2.2.2 A Systems Approach to Certification

The standard ISO 9001:2015 QMS promotes discipline in systems thinking through the design of processes, procedures, instruments/tools, and the establishment of committees within the business for alignment to the clauses (see Table 5.3). Enabling systems thinking enhances and promotes change management within the business environment. The

interpretation of the clauses is always proportional and in direct response to the entire business's maturity and demography. The successful implementation of ISO 9001:2015 QMS must have management commitment leading the change for compliance with staff and client buy-in.

> And I've always said for 30 years that successful implementation of ISO 9001 is directly proportional to management commitment [urban$_1$_aud$_1$]

Table 5.3

Clauses in ISO 9001:2015 QMS Are Open, Giving Flexibility

Clause 1–3: Scope	Clause 4: Context of the Organisation	Clause 5: Leadership	Clause 6: Planning
Clause 7: Support	Clause 8: Operation	Clause 9: Performance Evaluation	Clause 10: Improvement

There are seven ISO 'principles' underpinning the above clauses: 1) Customer focus, 2) Leadership, 3) Engagement of people, 4) Process approach, 5) Improvement, 6) Evidence-based decision-making and 7) Relationship management. These seven quality management principles sit at the core of the ISO 9001 standard, guiding the organisation to implement the QMS efficiently, as generic measures applicable to any business. The ISO 9001:2015 'certification standard' consists of 10 clauses. Each clause concentrates on the requirements involved in the relevant aspect of the QMS.

The seven ISO principles are the guide to the interpretation of the ISO 9001 clauses for the company's compliance staff. The first step in the application of a certification standard is to gauge the gaps in the organisation, usually through an internal gap assessment across the various business units in the organisation. Each manager and their staff are engaged in monthly meetings, bringing them along on the journey. This strategy creates a systems approach to how information is disseminated, identified, gathered and produced to keep everyone informed. Based on the gap analysis, in alignment with the clauses, the identification of missing evidence is recognised. Where gaps exist, processes, procedures, policies, or instruments/tools can be developed to fill these evidence gaps. These important steps are the development of systems thinking for interlinking system-designed processes, creating discipline, value, and efficiency for an alignment between and within each business unit in the organisation to meet each clause systematically. These developments create robust internal business systems for sustainability in the application of the ISO 9001:2015 QMS certification standard.

Participants who apply ISO 9001:2015 QMS discussed monthly meetings, committees and audit schedules as instruments for the identification and design of systems to meet the ISO 9001:2015 QMS clauses:

> 'We start with an internal gap assessment, of where we are at and tend to start with monthly meetings across the organisation to bring them along on that journey. And then we start talking about obviously evidence collection along the way. We talk about staff interviews, stakeholders for interviews and clients' [$urban_3$_asr_3]

> 'everything's (we do is) fed back through the executive committee and management. It's for governance as much as it is for practice' [$rural_2$_aud_2]

The mandatory audit schedule is the notable difference between the process of accreditation and certification in the application of their respective standards. The ISO 9001 audit schedule is an inbuilt system of self-monitoring activities for the certification process. Audits routinely identify gaps for improvement, augment an organisation's risk management and are integral components of clinical governance. The audit schedule builds risk awareness in the business and staff of the company. Routine audits allow all staff to play their role in this crucial activity, producing discipline to being risk averse through continuous improvements.

> 'We have an internal audit schedule that we audit monthly or bimonthly so that's a tracking exercise for quality improvement on an ongoing basis.' [$rural_2$_aud_2]

> ' some of them think it (the implementation of ISO 9001) can be done in seven days, others know that it'll take six to 12 months. So, implementation has ranged from very poor to excellent, and I'm taking about all industries.' [$urban_1$_aud_1]

Auditors called to a business to carry out the certification must be trained in and understand the clauses of ISO standard 17025. This standard ensures the 'certification to ISO 9001:2015 QMS' compliance, which has been predicated on this set of standards adhered to by the certification body. These measures give authenticity, validity, and rigour to the audit of systems created in the company (by staff) for the auditor issuing the certificate. In essence, ISO standard 17025 is the auditor's training manual and ISO licence to issue the certificate through a certification body. ISO 9001 is buttressed by other supportive standards.

> 'Anything that we issue a certificate with, you've got to have (ISO) Standard 17025'. [$urban_1$_aud_1]

Assessors, surveyors and auditors are responsible for assessing companies against standards for compliance. CBs engage consultants (referred to as assessors, surveyors, and or auditors) trained in the assessment of accreditation/certification standards relative to the certification body's scope of practice. Certification bodies can only assess against those standards they are registered to assess under JASANZ (the CB registration body in the Southern Hemisphere) scope of practice. This assessment is commonly performed within the three-year accreditation cycle. Over the past 13 years, one area where the standard of assessment has diminished, as identified in this study, is the quality of assessors. The quality of the assessor (surveyor, auditor) can be the determining factor of a company's compliance with a standards indicator/criteria/clause or not. What we discovered in this study is the training for assessors, surveyors and auditors has wide variance based on the certification body, which engages individuals to be their assessors and surveyors for different standards and auditors for certification standards. The interpretation of the standard indicator and the translation of the standard is dependent on the individual assessor, surveyor and auditor. The study participants are compliance staff who hold a minimum of seven years of experience in the application of multiple disparate accreditation standards, including certification body personnel and key informants with 20-plus years as notable accreditation industry experts. Of all of the standards operating in the Australian accreditation landscape, ISO 9001:2015 QMS is the only international standard. Study participants noted the ISO clauses are open in their interpretation, to how a business designs their QMS based on the company's maturity. As a quality assessment type, the International Organization for Standardization (ISO) model is the gold standard for certification. The **aim** is to implement norms for quality systems across the entire company. The **rationale** is the designed quality systems and management processes can be strengthened and standardised to achieve efficiencies. The **method** of certification is an Audit by ISO experts (not peers) against generic international standards. The **outcome** is a certificate of compliance with standards for whole-of-organisation development. In layman's terms, as one of our key informants remarked:

> Certification is minimising repetitive mistakes, it's improving businesses, and getting their act together so that everyone is on the same page, it's just those three things. [$urban_1$_aud_1]

If the business proves persistent discipline in the maintenance of the systems, continual engagement in an ongoing three-year certification cycle is not a necessity. The systems become robust to withstand consistency; therefore, intermittent disengagement in continuous certification should be a management consideration. To be an ISO auditor, auditors

must meet standard 17025 to perform their role with authority in issuing a certificate of compliance. The standard 17025 ensures training rigour and status as a professional ISO auditor. Engagement in the ISO 9001 standard ensures that at every level, there is evident proof of levels of systems adherence to ISO 9001 to attain compliance status to an international certification standard. Based on the evidence of standard types, if a business chooses to apply ISO 9001:2015 QMS as their whole-of-organisation certification, their choice is the gold standard. Our findings indicate this one standard should be a sufficient level of certification/accreditation for any company to prove compliance with a standard of quality.

> 'They're all quality systems, they're the same, aren't they? Well, no they're not. So that's the beauty of ISO 9001. ISO 9001 gives you discretion to tell your story in your own special way as long as you meet all the outcomes of ISO (clauses). Auditors need to be nimble and flexible to work hard, to see how the business has interpreted ISO for their particular business.' [$urban_1$_aud_1]

5.2.3 Value of Training and Quality of Assessors, Surveyors and Auditors

5.2.3.1 Assessment Quality

Definition: auditor/assessor/surveyor is the title reference to individuals who are engaged by CBs to assess accreditation standards. Auditor is the title reference for auditing to the ISO suite of certification standards. The term assessor is used for assessing prescriptive Australian-designed standards. Surveyor is a title used for assessor with licensure under AGPAL and GPA + assessment to the RACGP standard. The undertaking for a company to implement accreditation standards is a weighty and expensive business decision. The position of whose lens is the better fit-for-purpose the interpretation and translation of standards, lends weight to examine the design, purpose, quality and value of Australian accreditation standards. In addition, performing an examination of the training and quality of assessors who assess accreditation standards in a business. There are two streams of activity as it pertains to a company's implementation of accreditation standards into their business environment. Each Australian accreditation standard has, dependent on its design, indicators/criteria to support each standard. Each indicator is supported by a guide and provides the scope of exampled evidence required to meet the indicator criteria for the standard. The implementation of the standards and their **indicators** relates to Australian industry-designed standard terminology.

Study participants discussed the focused shift in the quality of assessment over time. Supporting this shift, the COVID climate introduced the move towards CB assessment being performed virtually, through Teams or Zoom meeting platforms. Participant experiences centred on the assessor/surveyor's appropriateness to assess ACCOs and work in the ACCO

sector as an assessor. The issue and relevance of client interviews in the ACCO sector and how this process is performed, many indicated as being culturally unsafe. Study participants gave examples of the ineptness and cultural deafness many assessors displayed in their assessment. The performance of virtual assessments remains a challenge for the ACCO sector accreditation. The assessor/surveyor, auditor interpretation and translation of accreditation and certification standards versus the interpretation and translation of the staff who work in the company encountered real opposition. In this landscape, the contention remains in gathering and designing evidence to meet compliance with prescriptive standards. Another avenue of contention pertains to who has the power in this business relationship: Is the power held by the assessors/surveyor/auditors? The examples given by study participants highlight the power assumed by the CB and CB assessor, surveyor and auditor:

> Over the years we've seen a shift in the assessors, particularly in the ACCHO space who are respected and skilled and (now) we see a lot of mainstream assessors who don't understand the nature of the beast (ACCOs). [$urban_3$_asr_3]
>
> Occasionally I've pushed for a staff member to sit in the room to just help (the client) to navigate (the interview questions in anticipation) that if there had been issues, but generally they (the assessors) don't want us in there. [$urban_3$_asr_3]
>
> At some points (in the assessment) it was a stick and carrot approach to how they (compliance staff) have to develop the evidence to appease the standard or the indicator within the standard (based on the assessors directive). [$remote_3$_aud_3]
>
> Usually we'd do the client stuff (interviews) by having a morning tea; no one wants to sign a form and say they're going to talk to assessors (it's important for assessors to know how we operate our business with clients—very important). [$remote_4$]

These types of comments add weight to the CB and their consultants carrying a level of power in this relationship, placing the business always at the behest of their directives. These comments speak to our claim of the assessor/surveyor / auditor being culturally deaf supporting the design of the accreditation standards as colonial constructs. Designed to dismiss, devalue and deny the innovative business model of the ACCOs. The study participants openly expressed their experiences with assessors:

> Another challenge that's come more recently is the fact that we have completely culturally unaware assessors. [urban$_3$_asr$_3$]

> So, we would like to see more culturally appropriate auditors/assessors out there… trying to do an audit last year via Zoom was really bad. The assessors just didn't get how things worked for us. [remote$_4$]

> I think it's (accreditation and assessors) really lost its approach and it's lost its way over the years 'cause it really was designed, when it was introduced to the sector was, (with) a focus on quality improvement and it's not there. It is very much a tick and flick exercise. [urban$_3$_asr$_3$]

ACCOs hold a well-established reporting culture to draw from. ACCOs operate solid measures of clinical governance frameworks for higher standards of care, as identified by Phillips et al. (Phillips et al. 2010) and are always responsive to community needs and aspirations. ACCOs are innovative in their continued leadership ability and forerunners in providing holistic, culturally nuanced boutique services. The ACCO sector punches above its weight. The sector has operated since 1972—50 years—a generation of responsive, adaptive healthcare. Purposely designed to provide health and wellbeing care to Aboriginal and Torres Strait Islander people, 3.8% of the Australian population, with a network of over 145 organisations nationally (Darr et al. 2021; Sibthorpe et al. 2016). Should this Australian health sector's providers and client population be carrying the weighty burden of applying up to 11 accreditation standards? How much is enough in accreditation standards to prove your business provides quality, safe, nuanced care to your clients? As one of our study participants stated:

> The push for ACCOs to invest heavily in quality management processes is a good thing….although it's a big burden on the sector and puts a lot of cost on the sector. [remote$_4$]

5.2.4 Return on Investment and Technical Tools

These themes relate to the relative return on (business) investment (ROI) and Technical efficiency tools being used by ACCOs to facilitate the management of accreditation processes. The siloing of standards is based on a burgeoning of standards for particular specialist areas, population health cohorts or diseases. Opening the market to certification body (CB) expansion in the accreditation space where current standards have no mutual agreement. In addition, participants discussed the developers of software designed specifically to organise the evidence of compliance. Investment in such software support can be very

costly, especially for those small to medium ACCOs in rural and remote locations. Where services have to implement multiple accreditation frameworks, owing to the diverse nature of their business, this specialised software has proven invaluable.

5.2.4.1 Return on Investment Definition

Return on Investment definition is taken from a financial position. Return on investment (ROI) is a performance measure used to evaluate the efficiency or profitability of an investment or compare the efficiency of a number of different investments. ROI endeavours to directly measure the amount of return on a particular investment relative to the investment's cost.[17]

"ROI is a popular profitability metric to evaluate how well an investment has performed. ROI is expressed as a percentage and is calculated by dividing an investment's net profit (or loss) by its initial cost or outlay. ROI can be used to make apples-to-apples comparisons and rank investments in different projects or assets. ROI does not take into account the holding period or passage of time, and so it can miss opportunity costs of investing elsewhere. Whether or not something (an intervention) delivers a good ROI should be compared relative to other available opportunities"[17].

5.2.4.2 Efficiency and Sustainability of Multiple and Disparate Accreditation Standards

For companies, undertaking accreditation for the first time and then making the business decision to continue with the mandatory application of multiple and disparate accreditation standards is an expensive experience. As evidenced by Table 5.2, indicative ACCO value of accreditation spend data presented in the previous chapter. Accreditation is a specialised area. There is the additional cost of recruitment and secure employment of (on average 4) specialist staff to apply these standards. To operate seven accreditation standards, designated teams work solely on the maintenance of accreditation for businesses applying multiple standards. The study participants expressed their views on the efficiency and sustainability of the sector overall:

> We (the ACCO sector) run as lean as we possibly can to enable those services to continue, … to be delivered to clients. This is where it becomes challenging, but I think the sector is very good at running on an oily rag and making, (or) getting the biggest bang for their buck because we've always had to. [$urban_3$_asr_3]

[17] https://www.investopedia.com/terms/r/returnoninvestment.asp accessed 16/4/ 2023

> Our Clients (as in the ACCO users of our product) are highly complex, highly regulated and lean management. [urban$_4$]

The question remains: why are there so many standards operating within the Australian accreditation industry at the primary care tier? This section explores and presents i) the intricate steps to the application of accreditation standards to raise comparative costs to gauge the business ROI; ii) the capability of staff to navigate (with success) in understanding the indicators and clauses for each accreditation standard for the businesses' compliance. How compliance staff interpret and translate these indicators and clauses is i) based on the business environment and ii) service to clients and for staff who keep the business operating. All these facets are important in the engagement of applying accreditation standards for businesses. The burden, cost, and risks of engaging in the application of accreditation standards weigh heavily on the company and compliance staff.

According to the 2018 National Association of Testing Authorities (NATA) accreditation report from a survey of 1,919 NATA member organisations, the quantifiable dollar figure of accreditation revenue to the Australian economy is $1 million dollars per day for these standards. The total economic yearly value of NATA accreditation in Australia is estimated between AUD $315M and AUD $421M (Agarwal et al. 2017). As a comparison, those companies applying from 5–11 standards at the primary care level would, no doubt, significantly contribute to the $1 million-plus dollars per day in accreditation revenue for the Australian economy.

Study participants highlighted the difference between Australian prescriptive industry-designed standards and the ISO 9001:2015 QMS. For businesses, our caution, caveat and qualifier is, accreditation standards are not the same in design, purpose, quality and value!

5.2.4.3 Technical Efficiency Tool—Logiqc QMS and Zoom

The subtheme technical efficiency tool is an inference to the use of technology to enhance the accreditation experience either negatively or positively for ACCOs. The specific technical tools this study focused on were Logiqc QMS and the online meeting technology via Zoom.

Logiqc defines QMS as software purposely designed to manage quality, compliance and risk. To support complex, constantly evolving challenges comprising many moving parts of accreditation into one tool in today's increasing digital workplace—Logiqc QMS.

> The way Logiqc QMS is built enables certain cultures and doesn't allow other certain cultures to manifest. So Logiqc is designed to give back the data that people put in so there's a value. [urban$_4$]

> Efficiency and sustainability of and between standards is manageable with Logiqc QMS. With Logiqc QMS in operation, at our ACCO, we just did three major (different assessments—RACGP, ISO & HSS) reviews in 3 months. All that is required with this system is to review the modules and involve the relevant teams. [$rural_1$_ aud_1_asr_1_sur_1]

> Electronics has come a big way in helping us. We have what we call a dashboard,(on Logiqc QMS) that pulls all our information together from our health sector, which feeds into our other sectors. And that pulls all that together and we get a report on it every month as to how we're managing against our KPIs and funding things. We've linked them all together so we have that overview that we can see at any given time. [$urban_3$_asr_3]

> So, for us, I've had in the accreditation module (in Logiqc QMS) built each standard into that. So, for each standard all I need to do is go into the module for NDIS, work my way through the module, and from the information that's already in the system, I can populate the evidence into the module based on the requirements of the standard. [$rural_1$_aud_1_asr_1_sur_1]

5.2.4.4 Zoom Technology/Teams Meeting Platforms

Definition: Zoom and Teams meet are electronic meeting platforms that allow connectivity and engagement to keep businesses operating across borders and internationally on multiple devices. CBs initiated performing virtual assessments with companies in many rural and remote areas as a means of cost savings. Performing virtual assessments may be beneficial for the CB. However, this strategy heavily disadvantages those rural and remote companies seeking first-time accreditation or reaccreditation. Virtual assessments shift the responsibility (to sight the indicator evidence for prescriptive mandated accreditation standards) from the CB assessors to compliance staff in rural and remote businesses.

The core responsibility of the certification body assessors to view evidence onsite has now become the burden for compliance staff employed by the business. The shift in responsibility (from the assessor to trace, view and examine the evidence to meet the criteria/indicator) is a demand transferred to the business. Onsite compliance staff are tasked with chasing down the evidence and depositing the evidence into the CB portal for the assessor's online review. Study participants' experience of e-meeting platforms used positively and negatively is expressed:

> I do auditor training for a group in the Northern Territory out of Darwin, and they come from all over the Territory to go to a hotel in Darwin every 12

> months, we usually have 16 people, some drive 800 km there, stay two nights, and then drive 800 km back home on roads that are not very good. The last two years we've done it via Zoom, technology. No-one had to spend money staying overnight, no-one had to drive and risk their lives from driving in unsafe conditions for 800 km. All those risks have been mitigated, all that money has been saved, everyone did the course from home, everyone was comfortable and we had the same outcome. [$urban_1$_aud_1]

> Because of COVID, we had a virtual assessment. We had two auditors that hadn't been to us before. Due to our internet connectivity the assessors resorted to doing staff interviews on their phones with our managers. [$remote_4$]

A small or medium-sized rural and remote ACCO, without the support of a technical efficiency tool such as Logiqc QMS, invariably will find themselves manually managing the implementation, monitoring and management of multiple and different accreditation standards. These comments from the study participants' experiences show how difficult and costly manual processing was:

> The risk assessment of ACCOs going through ISO certification, all of the risk was around governance and finance. Our challenge was in embedding ISO (without a tool) in our service. [$remote_4$]

> Accreditation (in a small remote ACCO) was lumped on the side of my full-time role … I had no prior exposure to what (accreditation) meant…I was basically trying to figure it (accreditation) out. There was no team and admin support…I was doing the majority of the work myself. It (the accreditation implementation) was being largely driven by myself and the CEO (manually). [$remote_2$_asr_2]

5.2.5 Reflection

The national ACCO contribution to the Australian accreditation industry has an indicative average annual value of $16,200,000 dollars. This cost is only the average estimate to engage in seven disparate accreditation standards. Not included or estimated in this value is the cost for 1 ACCO to recruit and employ specialist accreditation staff and the cost of software to monitor and manage multiple accreditation standards, such as Logiqc QMS. Plus, the shift in burden from the CBs to the compliance staff in businesses to identify and deposit evidence into the CB portals for assessor review. The ongoing costs to engage in multiple,

mandated, disparate, prescriptive accreditation standards every three years for an accreditation cycle are burdensome. These are the exponential accreditation costs this study did not measure owing to COVID-19. Although the processes required to engage in accreditation standards identified in this paper provide a good snapshot of the exponential costs, ACCO businesses would be engaged in applying seven accreditation standards. The recommendation we presented in Part 1 to the Commonwealth for the creation of ACCO-specific accreditation Medicare item numbers would assist in the recompense to the ACCO sector nationally, where, for over a decade, the accreditation standard owners have mandated their application of multiple accreditation standards upon the ACCO sector. Yet there is limited proven value in the outcome these prescriptive frameworks provide to their business. Our study offers reasonable evidence there is limited quality, value and benefit to Australian industry-designed prescriptive accreditation standards.

We further believe the revenue from our recommended ACCO-specific accreditation Medicare item numbers would assist those small to medium ACCOs operating in rural and remote areas with access to needed software like Logiqc QMS. The introduction of a second accreditation standard for the ACCO industry in 2010 gave birth to this industry being the target of multiple accreditation owners' standards without any level of monitoring mechanism. The ACCO industry has carried the weighty burden of the disingenuousness of the Australian accreditation industry. The GP health services application of one RACGP standard (if that) to the ACCO 11 accreditation standards speaks to the inherent racism systematically embedded.

5.2.6 Recommendation

The creation of ACCO-specific accreditation Medicare item numbers is a recognition by the Australian Government of the ACCO sector inconvenience for over a decade. In addition, it is an overdue acknowledgement of the burden the ACCO sector has carried for 13 years without recognition, review or recompense to an unchecked accreditation industry at the primary care tier in Australia. ACCOs as one business sector in the PHC sector that is already overburdened and swamped with triennial, annual, quarterly and monthly reporting requirements. A business sector that can least afford to be burdened with these framework costs has contributed the lion’s share of investment into the Australian accreditation industry.

5.2.7 Conclusion

The title of this paper is ‘Power: Real or Perceived’. We chose this title in the knowledge, that a contractual arrangement exists between the company to engage a certification body to provide a service of assessment against one/multiple accreditation standard[s], with the outcome being compliance and an accreditation certificate. The tension for power is expressed through the actions of the certification body, the assessors, the process

of assessment and the ACCO compliance staff with the power struggle real, as evidenced by the responses from our study participants. Their experiences are made known in the sub-themes of i) technical efficiency tools used either negatively or positively in the accreditation process; ii) ROI when compared with the mounting costs of accreditation standards for an ACCO and the outcome; iii) their lived experiences on the views of efficiency and sustainability to applying multiple and disparate accreditation standards; iv) their experience about the quality of assessors across time and their value; and v) a desire for one standard that provides a systems approach to their businesses accreditation. The study participant testaments express a physical lack of self-agency experienced through their identified deficits in becoming accredited.

This paper began with Brayboy's (2006) TribalCrit framework addressing liminality. Liminality is a term derived from the Latin *limen* meaning 'threshold'—liminal refers to a transitory, in-between state or space. Brayboy uses 'liminal' in a post-colonial context as a potentially disruptive inbetweeness.[18] Australia's post-colonial experience of inbetweeness/liminality assigns Aboriginal and Torres Strait Islander people as foreigners in our own Country. The third statement in the TribalCrit framework is that Indigenous peoples occupy a liminal space that accounts for both the political and racialised natures of our identities (Brayboy 2006). The Australian parallel supported by Dodson and Strelein (2001) states that racism justified the wholesale denial of First Nations peoples' right to participate in the polity that was under construction pre-1901 Dodson and Strelein (2001) give this account—by 1901, at Australia's Federation, colonies established a long tradition of discrimination against Australia's First Nations peoples. Racism was a founding value of Australian society. For 13 years, the Australian national framework legislation at the PHC tier remained unchecked, as evidenced by the ACCO sector's experience (in applying multiple disparate frameworks) bears witness to Dodsons' claim—Racism is a founding value of Australian society. The wholesale denial of 'us' as a people group in our own Country, is the palpable tensions of racism First Nation people experience everyday, adding to the social, political, and environmental degradation of our culture, our daily socialisation, our emotional, and economic wellbeing.

The multiple, disparate mandated accreditation standards ACCOs are obligated to apply to their business models is a disingenuous over surveillance by the accreditation standard owners, the certification bodies and their assessors and surveyors. The lack of review by the Federal Government on the national accreditation framework (in 15 years at the

[18] http://borderpoetics.wikidot.com/liminality accessed 27/3/2024

primary health care tier) has seen the ACCO industry sector carry the lion's share of unwarranted accreditation frameworks under the guise of quality and safety without any real benefit or value for the ACCO businesses. Their involvement in multiple and disparate accreditation frameworks add no value to their individual clinical governance.

The Australian accreditation frameworks are prescriptive and are culturally deaf. Being devoid to the consideration of First Nations history, culture, the ACCO business model and their clinical governance. The label of colonial constructs assigned to Australian designed accreditation frameworks reinforces the disingenuous ilk of the accreditation standard owners over surveillance towards ACCOs. Whereas the general practice sector has one accreditation standard to apply and is not mandated, but specifically designed for general practice – the RACGP standard. For many reading this thesis one could question why there is such a heavy penalty paid by the ACCO sector in applying multiple, disparate mandated accreditation standards having no real benefit or value for their businesses. As evidence, the research findings are presented.

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5.3 Paper 3. Ownership: Accreditation, Whose Business is it? Results of a Critical Indigenist Lens Upon the Australian Accreditation Market—PHC Tier

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Authors' recognition—we pay honour to our First Nations ancestors and acknowledge the custodians of the Country on whose land we live and work. Qualification—Respectfully, First Nations peoples is the first author's designated title for Australian Aboriginal and Torres Strait Islander people—custodians of Country for over 65 millennia.

5.3.1 Abstract

Cementing Context: This third paper of the series follows on and extends the exploration of quality systems used in the ACCHS sector.

Innate in the DNA of First Peoples is reciprocity with relationality as our currency, whereupon self-agency and the interdependencies of all living things are held, allowing Aboriginal and Torres Strait Islander people to enjoy the quality of life through whole-of-community self-determination and individual, spiritual, cultural, physical, social and emotional wellbeing. Brayboy's (2006) fifth TribalCrit concept is that the concepts of culture, knowledge and power take on new meaning when examined through an Indigenous lens. Our Australian parallel, noted by Pearson (2021), Reid et al (2022), Davis (2022) and the Referendum Council (2017b), claim that the business of a republic, recognition, reconciliation and constitutional reform remains unfinished business for Australia's First Nations. The concepts of culture, knowledge and power through an Indigenous lens bring nuanced value and ownership. These results present valuable data for social change to those in the health service industry who apply multiple and disparate accreditation standards to their businesses. Established is a universal language for businesses to navigate the accreditation industry.

5.3.2 Ownership

In the first and second papers in this series we discussed KNOWLEDGE and POWER as concepts coursing through the application of accreditation standards as experienced by the study participants. Their diminished self-agency is palpable and real. This overarching concept is OWNERSHIP. An important solid recommendation when applying a certification standard is for the business to engage in a cyclical iterative process of continuous quality improvement. This applied methodology to certification processes is the PDSA cycle (Knudsen et al. 2019; Sibthorpe et al. 2016). The steps to each phase indicate the iterative (over time) quality activities assigned to the Plan phase, Do phase, Study phase and Act phase employing quality improvement measures (Taylor 2013). This cycle assists the business in monitoring their planning for embedded continuous quality improvement for the certification standard. An example of a PDSA cycle process is a project plan to implement the certification standard where management of the different phases is monitored closely, creating a system approach to the change management certification process. An academic research equivalent is a PAR methodology, as indicated by Baum et al. (2006), where engagement with the community becomes central to the cycle embedded in the PAR methodology and acts as continuous community checkpoints to align their needs with the research (or accreditation assessment) activity. Quality improvement is one pillar of a clinical governance framework.

The themes explored in this paper are Ii) The Human cost of applying accreditation standards, (ii) Accreditation implications and (iii) Accreditation intangibles. The themes are discussed relative to the overarching concept of ownership. Discussion of these themes will flag to the Australian accreditation industry the gaps our study identified, to bring about social change, promoting equity in the national accreditation landscape.

5.3.3 Human Cost of Applying Accreditation Standards

For a company to implement accreditation standards or a certification standard for the first time is a huge undertaking. The extent of the total costs is not really known until the accreditation process starts, and the gap assessment is undertaken on the business to identify the accreditation process deficits. The magnitude of implementing multiple standards continuously, as expressed and observed by the study participants, is explored in this chapter. The hidden human costs of accreditation/certification for businesses, the industry, the implications for services and the hidden human costs (or intangibles) participants experienced are also discussed.

5.3.4 Accreditation Implications

A company's business decision to implement accreditation standards for the first time, to quote an adage, is like opening Pandora's box. The unknown elements are the extent of the

requirements contained within the prescriptive indicators (or criteria, clauses dependent upon the type of standard being applied). This, in turn, has a direct effect on the area undergoing the change management process, at either a program level or a company level. The magnitude of the work involved and the continuing costs are often unknown. In addition, the level of tacit knowledge required in staff to successfully navigate this expensive business decision becomes exposed incrementally. Only when the standard/s implementation process is commenced is the magnitude of engagement in the accreditation process fully realised. The only saving grace—there is hope! Once the company is engaged (in the accreditation process), it becomes easier to remain committed to executing the change process. Change is uncomfortable and never easy; however, dependent on the type of standard, the end product is the reward!

The sustainable and efficient application of accreditation and certification standards in businesses demands experienced specialist skill sets. This statement is particularly relevant for those individuals tasked with the responsibility to project manage multiple accreditation standards within a company. The ability to rapidly acquire these specialist skills to understand and interpret the accreditation standards in the company and business environment is paramount. To fully understand how the specific standard indicators, criteria or clauses articulate with the program area or business requires an incremental planned sombre approach. The requisite skills are technical, supported by a combination of leadership qualities, business acumen, change management and project management skills, overlaid and embedded in a systems-thinking framework for certification standards only.

The national accreditation policy introduced in 2010 was the catalyst for the emergence of a new workforce to support the application of standards across every level of the Australian healthcare system. Darr et al. (2021) state that, at the regional ACCO level, diverse new roles were established to support the application of multiple standards in individual ACCOs. New roles included quality coordinators, quality managers, compliance staff and auditors to accommodate the increase in accreditation standards, certification standards and CBs (Darr et al. 2021).

5.3.4.1 No Commonwealth Funding to Support the Increase in Accreditation Costs Over Time

From 2010 to 2012, the Commonwealth provided support funds for ACCOs to apply a second framework to their businesses. This was ISO 9001:2008 QMS—now 2015. After 2012, support funding ceased. The ACCOs carried the burden of supporting two accreditation standards. Since 2012, the number of mandated accreditation standards ACCOs apply has grown to 11. The burden and ongoing cost of applying multiple and disparate standards has been continuously carried by the ACCO sector for over a decade.

This study highlights the disingenuous nature and impact Australian accreditation industry players impose on the ACCO sector—control tactics on a national scale. The number of accreditation standards ACCOs apply as one service provider of PHC in Australia is disproportionate. In contrast, Australian general practice clinics apply one standard—RACGP. While each of these Australian PHC providers is very different in their service model and provision, this poignant fact has important value in being raised (Thomas et al. 1998). Study participants shared their initial experience of applying a second accreditation standard in their ACCOs and the EQIS funding:

> You know, we were offered that carrot (EQIS funding) initially within the sector, you know here's some money for you to get accredited. That's wonderful, I think a lot of (ACCO) services jumped on board and jumped through the hoops, only to discover after the first round the cost, (and) the ongoing cost involved. [remote$_2$_asr$_2$]

> Even the Commonwealth went down the path of oh we'll build it (the accreditation dollars) into your service agreements. Well, that's great, that gets lost in a big bucket of money and we never see an increase on that money and yet (accreditation) costs continue to skyrocket. [urban$_3$_asr$_3$]

5.3.4.2 Leaders of Change—Compliance Staff Skillset

This theme identifies the issues arising from capacity and capability from multiple perspectives, including the capability of the ACCO company to engage in the accreditation process. Location is a defining feature of their capacity to engage with success to implement accreditation standards. For example, if the company is in a rural and remote location, their engagement in the successful application of accreditation standards is hindered through access to staff with the technical capacity. The capacity of all staff within the ACCO to understand the implementation of accreditation standards as a change management process and to be engaged with a level of buy-in to the process is a defining success factor in the application of accreditation standards. The capacity and requisite technical skills of compliance staff are pivotal, as leaders in this space to interpret, navigate and translate the implementation of either or both accreditation and certification standards into a business environment is a real requirement.

The size, location and internal economies of scale of the ACCO matters greatly, to successfully engage in the application of accreditation standards as a change management mechanism is standard-dependent. The ACCO's geographical location can be problematic and

has an impact on access to specialist staff to assist in the successful implementation of accreditation standards into their business. With the calibre of tacit and learned knowledge of the responsible compliance staff to interpret, navigate and translate with success and efficiency, the implementation of the accreditation and certification standard/s is an arduous and costly process. Implementing accreditation standards manually adds to the laborious process. Our study participants shared personal health stories they encountered—yet still delivered. No amount of money could compensate for their personal health issues. These are the personal costs compliance staff experience, which are not acknowledged, identified or talked about. Our study participants bared their hearts, expressing the personal health issues they faced while navigating the implementation of multiple accreditation standards manually.

> Vignette from a rural ACCO experience:
> They relied on me as the (one) person who managed all of those disparate systems and processes and... tried to manage a whole pile of independent spreadsheets and staff. …. basically, the only time they (management) paid any attention to what I needed them to be doing was when we had an accreditation looming. I (left and) came out of that organisation fatigued from the constant stress and trauma (experienced from limited support). It (my experience) was horrendous because they didn't have any internal processes in place. [small rural ACCO experience]

> Vignette from an Urban ACCO experience:
> The ACCO was a year behind schedule in implementing ISO and a re-accredit to RACGP standard, requiring dual accreditation. I applied for and received $110K from the EQIS funds to support the continued rollout of ISO at this ACCO. The workload was demanding.
>
> Most of my work nights ended at 7–7:30 pm and my working day started with 5 am gym session and up at 4 am every day, to be at work by 9 am. We executed the roll out of ISO in 16 months—which is less that the normal 3 year accreditation cycle. Plus, RACGP via AGPAL.
>
> During this time, I experienced a number of unbelievable health issues. I did gym classes 6 days a week to maintain a healthy status. Gym finished at 6 am and home by 6:30 am. I would sleep for an hour & out the door around 8 am to work. This regime was constant. The only day I had off was Sunday. In my time there, health wise, I experienced graves' disease. My hair was thinning & fell out. I experienced massive weight loss from a size 18 down to a size 12–

> three dress sizes in a spate of 18 months. I had a frozen shoulder and experienced bouts of high blood pressure spikes at 2 pm every afternoon from 120/80 to 210/100 to the point I had these blinding headaches. This happened for well over a period of 3 months. Every morning I experienced fog brain up until around 12 midday. [Urban ACCO experience]

These vignettes are the human costs of applying accreditation standards that are not ever talked about or known. These human costs are the expressive compliance staff examples from our study, who paid a heavy personal price for their companies to achieve the award of accreditation certification. The study participants, who are assessors, surveyors and auditors, discussed their views on the interpretation of accreditation certification standards based on their experience:

> Nimbleness of auditors … this conversation raised two important points. One is around the interpretation of standards by the auditors (assessors/surveyor) and the other one is the translation. [remote$_3$_aud$_3$]

> But I think consistency, it's something that the accreditation space has been struggling with for a long time because (of surveyors views) and that's unfortunate. It's incredibly difficult and people get bug bears that they just will not let go. [urban$_2$]

> Whilst you may not do home visits in the way that the standards say you do home visits, you're doing home visits in a manner that is suiting your population and your service. So, okay, I understand the intent of that indicator. I'm going to mark you met. [rural$_3$_sur$_3$]

A stressor adding to the human cost of implementing accreditation is the exploration of assessor, surveyor training and their consistency in the interpretation and translation of accreditation standards in a business. The views of our study participants who hold dual roles indicate this gap in the accreditation industry.

5.3.4.3 Certification Bodies (CBs)—Numbers of and Their Impacts and Tendering

A CB is a company whose purpose is to provide accreditation assessment to those businesses that apply accreditation standards. To operate as a certification body, these companies must be registered with JASANZ. JASANZ is the Joint Accreditation System of Australia and New Zealand. JASANZ is the responsible agency for CB registration in the Southern Hemisphere whose purpose is to help businesses, products and people work better. JASANZ provides internationally recognised accreditation services, creating economic benefits.

We examined the number of certification bodies operating in Australia, exploring the impact of the wrong fit-for-purpose certification body and CB assessors for a company. We explored a remedial measure companies can apply to ensure a certification body is fit-for-purpose. In 2010 there were fewer than 10 CBs operating in Australia. Almost 13 years later, there are 141 CBs registered and operating in Australia. The certification body increase is a direct correlation to the number of accreditation standards flooding the market since 2010, creating a supply and demand-driven accreditation market. As previously reported, operating in the Australian health industry at the PHC tier are 11 disparate industry-designed accreditation standards. Choosing the right CB to meet your company's needs in a flooded market is not an easy decision. The wrong CB fit and CB assessors affect the company's clients and, in some experiences, negatively influences a company's service delivery. The participants in our study afforded us their experiences:

> For our company, we were looking at almost $30, 000 every three years for that one accreditation, one! And so, we're still accredited but we're accredited by a different certification body at a lower cost because it was just ridiculous. [$urban_3$_asr_3]

> We felt the impact when we made the decision to move (to another accreditation standard and certification body) in terms of the workload required to make that shift, and it was like starting again just in terms of realigning all the evidence and reorientating staff to those new standards. [$urban_3$_asr_3]

> This $30K that we're giving you, is giving us nothing in return. [$urban_3$_asr_3]

Some ACCOs have taken affirmative action to choose the right certification body. The affirmative action sought is to go to tender to find the correct fit and right certification body's for their company's business. The tender process gives validity and transparency to the engagement of the certification body. Tendering promotes competitiveness to purchase a certification body service from the company's expectations, placing control, ownership and purchasing power with the company:

> Here's a fact, your engagement with a CB is a contractual arrangement and you (as a company in the business of health) are the client. Take this out to tender and place your criterion in the tender document. [$remote_1$_aud_1]

> They're (the CB & CB assessors) our client... yeah. We're a client and we've engaged them (the CB & CB assessor) to do a service, and yeah, I agree, I think we've gotta refocus. [remote$_4$]

For this study, we adopted the definition of sustainability as the 'production of health outputs and outcomes at optimised efficiency with uninterrupted inputs' (Knippenberg et al. 1997: 11). The sustainability of PHC refers to the ability of a health service to provide ongoing access to appropriate quality care in a cost-efficient and health-effective manner (Thompson et al. 2015: 145). Adopting these definitions connects the definition of sustainability with the PDSA cycle for continuous improvement in the application of accreditation/certification standards. Quality improvement is one pillar of clinical governance.

> Vignette. An experience of a study participant in a small rural ACCO:
> My time there in a small rural ACCO, was my first (experience in accreditation). I came in as a program manager, managing the social support programs with accreditation lumped on the side. I had no prior exposure to accreditation and what that meant. Here I was trying to figure it out basically. There was some funding provided with external consultant support to assist with a gap analysis. The journey was a self-directed upskilling process and for a service that size to have the systems required for accreditation, is actually really difficult.' 'The risk I think with this scenario, is that much of the changes and experience lives with one person. When you move on, and my great fear is, what happened to all of that work after you left because you can try and hand over as much of it as you can (with a manual system in a small rural ACCO).
>
> There was no team, no admin support, it was a lean 25–30 FTE staff. I was doing the majority of the work, trying to write policies, trying to implement systems, the process was being largely driven by myself and the CEO to develop the system to make it work. We developed the skills, but we didn't have them to start with. It was a real challenge and we, (myself and the CEO) were both working absolutely ridiculous hours to get things over the line because we had no capacity in our day job to spend any extra time on accreditation.
>
> These are the actual extra added hours that aren't assessed or considered or (have) dollar amounts (attached to them) in order for a small service like that to get over the line (for accreditation).

The sheer enormity of the tasks associated with first-time accreditation revealed through this vignette with a limited understanding of what is required was real and came at a high personal cost for everyone involved in this scenario.

5.3.4.4 Accreditation Market Monopoly

The Australian accreditation market is competitive. Since 2010, the number of CBs has increased from fewer than 10 to 141 registered with JASANZ. The increase in CBs is a result of supply and demand on the new industry-designed accreditation standards that have flooded the market in 13 years:

> Our head of business wants to build a self-assessment tool that sort of encompasses all of them (the Standards). When you upload a piece of information to one, it will cross over to the other in the back end of the system, cross over to the others and be uploaded there so that they can submit all of their assessments at once. [urban$_2$]

> And if training went well and if all of the things went well, we have a number of assessors and surveyors that are eligible to assess against a number of standards. The only catch to that is that they'd (the ACCOs) need to have all of their accreditations with AGPAL and QIP. [urban$_2$]

In this crowded market, ACCO management must understand who owns the accreditation standards to determine who has the monopoly on these standards mandated for the ACCO sector.

5.3.4.5 Accreditation Readiness

The subtheme of accreditation readiness examines the ability of ACCO staff capacity to gain the level of specialist knowledge to successfully navigate with confidence the implementation of accreditation and certification standards. In this space, staff need to know and understand comprehensively the business of the company to align the standard requirements to the business environment, interpret the standard and perform the necessary gap assessment to ready the company for Stage 1 assessment/audit, and prepare a wide-ranging mapping tool for the alignment of multiple standards the company applies to limit internal duplication of source evidence meeting the indicator or clause. Compliance staff also need to develop a comprehensive project plan, and project manage the implementation process of either or both multiple accreditation and or certification standards. From the gap analysis, the mapping template and the project plan, committees, processes, templates, procedures, policies and systems must be developed to prepare for the stages in the accreditation cycle, termed Stage 1, Stage 2 and Stage 3. This often requires the development

of an internal advertising plan to bring all staff along on what is required in this change management process (be it program-wide or organisation-wide) so that compliance staff can operate with confidence and esteemed knowledge, bringing everyone along on the change management experience through the application of multiple accreditation standards.

A company's business decision and engagement in the application of accreditation/certification standard/s represents a company's free will to do and desire to be better in their supply of a quality, safe business and environment for their staff and clients. The company wears the ultimate cost for their engagement in the application of accreditation standards. There is enormous goodwill, a significant financial outlay and incremental change undertaken in the business across three years. There are immeasurable unpaid work hours and the development of processes, procedures and systems in the preparation of a company for Stage 1, Stage 2 and Stage 3 certification and or accreditation, juxtaposed with the preparation time for ACCO accreditation readiness and financial costs with the time assessors, surveyors and auditors spend in the company, is, at a minimum, three days.

5.3.4.6 Accreditation Preparation Time and Unpaid Work Hours

Participants described the time required in the lead-up to accreditation assessment and the pre-planning requirements such as internal gap assessment, and manual assessment process starts 12–9 months prior:

> I would need to start my planning 12 months out (between assessments / audits, when applying accreditation standards manually in the company). [$rural_1$_ aud_1_asr_1_sur_1]

> So that really starts probably 12 to nine months out with a sort of quoting & talking with the assessing agency about dates and trying to lock something in fairly early. We then start with a gap, an internal sort of gap assessment, (of) where are we at. [$urban_3$_asr_3]

> Because I had to break down every standard as a standalone standard and send that (criterion) out to each of the program managers (indicating what I required as evidence for accreditation). [$rural_1$_aud_1_asr_1_sur_1]

> And then of course you'd get to a point where you'd look at all of the evidence from all of your different program areas across all of your criterion and you'd have to do your gap analysis (on the unmet evidence). [$rural_1$_ aud_1_asr_1_sur_1]

For first-time accreditation, participants expressed their experiences in navigating the application process without any prior knowledge or reference points. One of the negatives is

the extra unpaid work hours for accreditation readiness with limited knowledge, skills, service budget, and capacity:

> I got there (at Company Z and was employed in a different role) and here I was trying to figure it (the accreditation standard, process and its implementation) out basically. [remote$_2$_asr$_2$]

> So, there are the actual extra added hours (of work) that aren't assessed or acknowledged in dollar amounts in an order for a small service like (what I described) that got us over the line. [remote$_2$_asr$_2$]

> At company Z (when I first started in accreditation) I was doing the majority of the work myself, trying to write policies, trying to implement systems, it was being largely driven by myself and the CEO to make (it work), to develop the system to make it work. … we developed the skill's but we didn't have them to start with. It was a real challenge. [remote$_2$_asr$_2$]

5.3.5 Accreditation Intangibles

Participants in the study described the process of evidence gathering to meet the indicators' predetermined criteria manually, including the readiness of staff, board and client preparation. The replication of this process for Stages 1, 2 and 3 is very time-consuming. They explained the enormous amount of information gathering required to prepare for each assessment. When this process is reviewed, from the point of view that online assessments is now the CB's and CB assessors' normal practice, the shift in burden increases for service staff—to view the evidence, take photos, copy, scan and upload the evidence into the CB Portal increases their workload during each assessment stage. What was normally the role of the assessor performed onsite with onsite visuals has become a shifted burden from CB assessor to compliance staff.

Across the accreditation life cycle of three years, compliance staff in our study spoke of the inordinate amount of evidence (sometimes in triplicate) that was uploaded into the CB online portal. The study participants spoke of having to do a gap audit on the required business evidence across multiple accreditation standards when managing this process manually. The gap audit on multiple accreditation evidence adds extra work hours compliance staff perform to ensure all evidence across multiple accreditation criteria is captured:

> Because I had to break down every standard as a standalone standard and send that (criterion) out to each of the program managers (indicating what I required as evidence for accreditation). [remote$_5$_aud$_5$_asr$_5$_sur$_5$]

> And then of course you'd get to a point where you'd look at all of the evidence from all of your different program areas across all of your criterion and you'd have to do your gap analysis (on the unmet evidence).
> [remote$_5$_aud$_5$_asr$_5$_sur$_5$]

Rurality plays an enormous feature in the success of applying accreditation/certification standards particularly in the employment of compliance staff. Employing people who have a knowledge and understanding of systems and systems thinking to embrace and employ each accreditation standard is of benefit.

5.3.6 Reflection

The lack of Commonwealth support for ACCOs who are mandated to apply up to 11 accreditation standards requires urgent review. This heavy-handed practice is viewed as a disingenuous action and control by the accreditation standard owners. The level of compliance staffs' technical skills (developed within the ACCO industry over time), created a new specialised layer of employees within the ACCO sector with no real acknowledgement, career path or recompense for this level of expertise. There is no recognition by either the Commonwealth (who mandated a second level of accreditation standards for the ACCOs) or the accreditation industry for the burden of multiple accreditation frameworks ACCOs carry. The shift in the original purpose of accreditation standards as providing quality and safety is disproportionate to the evidence required and has migrated to revenue raising and control. This is proven by the inordinate amount of evidence businesses are compelled to produce in triplicate (across the accreditation cycle) deposited into the online CB portals as a measure of control. Dr Janke et al. (2023) explore Indigenous data sovereignty based on UNDRIP Article 31 and *Maiam nayri Wingara.*[19] Understanding the legal and cultural considerations for Indigenous data sovereignty is a good start to developing holistic, mutually agreed Australian industry-designed accreditation standards.

Manual management of multiple and different accreditation standards is a painstakingly arduous process. This shift in responsibility, which started out as an alternative form of assessment during COVID-19 and cost savings for the certification body and their assessors to virtual assessments has become a shift in burden to the business and their compliance staff.

The migratory shift in the burden of responsibility by the CB and assessors to virtual assessments in exchange for face-to-face assessments is commonplace and raises questions of CB integrity, quality and safety in the assessment process. Are virtual assessments a process of

[19] https://www.terrijanke.com.au/post/indigenous-data-sovereignty-the-legal-and-cultural-considerations accessed 24/4/2024

quality and value to the business and its employees? Is the performance of virtual assessment with the use of multiple different technologies in an open environment considered secure and confidential? All these issues raise questions of power, knowledge and ownership. Who holds power in this relationship? Who are the knowledge holders in the business's compliance with accreditation standards assessment? Who owns the data, and whose responsibility is it to keep the business's data safe?

The shift in the abrogation of CB responsibility for face-to-face assessment has become a migratory burden for companies who engage in accreditation assessment. This virtual practice of assessment experienced by the study participants shifts this migratory burden to businesses and diminishes the level of quality and safety for compliance.

Utilising electronic meeting platforms may not be the best strategy for rural and remote ACCOs.[20]

This combination of results in these three papers highlights many gaps in the Australian accreditation industry at the primary healthcare tier. To audit with success is to always find the root cause of the issue/s and work with the business to fill the gap to the measure of their maturity.

The Australian accreditation industry lacks a systems approach in which to perform regular health checks and balances on itself. The federal government sanctioned in legislation a national framework, but never established a systems approach to regularly evaluate the legislation or the frameworks being designed and applied and their target market. Right now, there is a glut in the market to the number of standards ACCOs apply.

5.3.7 Conclusion

Many of our study participants discussed whether industry-designed accreditation standards offered any level of value, quality and benefit to their services and the program areas to which these standards are applied. Our study indicates the prescriptive nature of many industry-designed accreditation standards. One of our papers, 'Ethnographic Narrative Case Study', outlines these in detail in Table 4.1 and Table 4.2. Observational data, focus group and interview data lead to the conclusions outlined in Table 5.6.

[20] Caution: The use of this technology must be assessed from the rurality of the ACCO and their access to ICT infrastructure. Not an urban-centric perspective. CBs who use electronic meeting platforms as their default for face-to-face assessment do so at their demise.

Table 5.4

Australian Industry-Designed Accreditation Standard Traits

Trait	Descriptor	Purpose	Outcome
1	Australian standards are designed by specific industry players	Holds ownership of their standard	Designed for a particular market, population health cohort or disease
2	Are prescriptive in design	Criteria is predetermined within each indicator	Company must comply with the predetermined criteria at each assessment
3	Closed in the design of their indicators	Indicators are not open to interpretation as they hold pre-established criteria	Inhibits organic quality improvement in the businesses program areas these standards are applied to & Renders the company's compliance to a tick-and-flick checklist exercise at assessment.
4	Majority of standard indicators are linked to the KPIs in contractual agreements of funding agencies	Quasi-mandatory in design replicating links to funding in agreements of the funder	Repetition and duplication of criteria in both the contractual agreements and the standard. This outcome questions their design, value and benefit. Is a duplication in reporting measures by the business.
5	Their names dictate their design for a particular market, population health cohort or disease	Keeps the design of these particular standards locked into a perpetual process of segmenting the accreditation market	Businesses who provide wraparound services like ACCOs, applying prescriptive standards, are forced to segment their business offering

Trait	Descriptor	Purpose	Outcome
		Provides increased revenue to the Standard owners and keeps the accreditation market segmented No systematic approach to the development, design and measurement of multiple and disparate accreditation standards	Increases the financial costs for ACCOs with multiple disparate standards applied Segments how clients & businesses value, view and manage health wellbeing Diminishes the very concept of standards providing quality and safety
6	Their prescriptive design holds in silo, each accreditation standard with limited synchronicity	Businesses applying multiple and disparate prescriptive standards are forced to silo each standard within their business environment	The application of multiple and disparate accreditation standards with no level of synchronicity between any of these prescriptive standards. Holds each of these standards in silo for businesses providing wraparound services like ACCOs Significantly increases the accreditation costs for ACCOs Debates these standards value, purpose and benefit
7	Industry-designed standards are frequently reviewed & updated, in some instances yearly	Unable to provide a plausible explanation why prescriptive standards are	Yearly prescriptive standard reviews erodes their value, diminishes consistency and

Trait	Descriptor	Purpose	Outcome
		reviewed with this level of regularity	robustness for many businesses Represents the fickle nature of prescriptive industry-designed accreditation standards.
8	There is no mutual recognition between the industry-designed standards	No mutual recognition, forces ACCOs to apply multiple and disparate accreditation standards to segments of their businesses only, raising questions of quality, value and benefit	Companies are obligated to apply multiple industry-designed standards that continuously segment their businesses like an accreditation jigsaw puzzle
9	Many industry-designed standards are non-legislated	The prescriptive nature of industry-designed accreditation standards are non-legislated Designed for a particular, market, population health cohort or disease only	The onus rests with the company to prove their compliance to governance, human resourcing, financial and legal requirements for each of these disparate prescriptive standards Multiple reporting performed to other legislative reporting requirements for company compliance Creates increased levels of unwarranted & meaningless repetitive reporting for ACCOs.
10	Australian industry-designed accreditation standards are quasi-	Flooded the Australian accreditation market with multiple and disparate	Only ACCO companies are obligated to apply up to 11 accreditation

Trait	Descriptor	Purpose	Outcome
	mandatory, and are mandated for particular company's	accreditation standards with no applied systematic framework to monitor or evaluate the Australian accreditation market	standards to their businesses at the primary healthcare tier Reveals the disingenuous and biased nature of the Australian accreditation industry. Sanctioning flickers of discrimination, racism and excessive practice Design of Australian-designed accreditation standards are culturally deaf Denial of First Nations peoples ownership, knowledge and being. Through the mandated application of a colonial construct of accreditation standards for ACCOs Quality and safety have been replaced with a voracious economic appetite by many accreditation industry players

This quote from Albert Einstein describes the systemic deficits at the primary healthcare tier for the Australian accreditation industry: 'Insanity is doing the same thing over and over again, expecting a different result.'

In our second literature review titled ‘Sustainability and Efficiency with Aboriginal and Torres Strait Islander Community Controlled Primary Healthcare Services—Disrupting the Status Quo: A review of the literature’, we identified and provided language to ACCOs to describe the meaning of efficiency and sustainability as dimensions of quality. The operational and implementation aspects of sustainability and efficiency require a holistic methodology for capturing all its elements. Sustainability incorporates environmental, social, economic and health-related elements. Sustainability of PHC is defined as the ‘production of health outputs and outcomes at optimised efficiency with uninterrupted inputs’ (Knippenberg et al. 1997: 11). The sustainability of PHC refers to the ability of a health service to provide ongoing access to appropriate quality care in a cost-efficient and health-effective manner (Thompson et al. 2015: 145). Efficiency refers to the assessment of the relationships between costs of organisational structures and processes, processes of care and intermediate outcomes. Efficiency represents the capability of different production units to transform their inputs into outputs.

When the definitions for sustainability and efficiency as measures of quality are applied to the required processes to ready the business and apply accreditation standards, the results are clear. Efficiency is the assessment of the relationship between the costs of the business structures (in this case, the number of accreditation standards applied along with full-time staff to monitor and manage seven accreditation standards) and intermediate outcomes. Intermediate outcomes, being the end result to applying an accreditation standard,which shows the chasm is wide between these relationships. In addition, Tables 5.5 and 5.6 display the uptake of accreditation standards by general practice health services and Aboriginal primary healthcare services with average indicative costs quantified by the study participants. Not all GP practices apply an accreditation standard. Those who do, apply RACGP only (MP Consulting 2021).

Table 5.5

General Practice Health Service Average Costs (Non-Bulk Billing)

Accreditation standard type & cycle (3 years)	Cost (average)	Compliance Staff / Cycle (3 years)
RACGP	$20,000	Supported by the PHN network for targeted and 1:1 accreditation support Or backfill for a Practice Manager for 8 weeks @ a rate of $55.15 per hour for accreditation and surveyor readiness— $16,765.60 (Stage 1)
Cost	20,000	$33,531.20 (3 years)
Total spend for 1 RACGP accreditation standard		Outcome
Efficiency spend $53,531.20 to apply the RACGP Standard of accreditation with backfill cost across 3 years		RACGP accreditation certificate via GPA + or AGPAL

The assumption pertaining to the data displayed in Table 5.6 occurs when seven accreditation standards are applied together. That is, through the CBs engagement for all seven frameworks by the company started in a 3 month timeline of year 1. Meaning each of the seven standards falls due within the accreditation cycle of 3 years. This is a common practice when compliance staff are not aware of the nature of the accreditation landscape as indicated by our study participants and observational data.

Table 5.6

Aboriginal Primary Healthcare Services Indicative Average Costs to Apply Seven Accreditation Standards and Four FTE Compliance Staff to Manage Seven Disparate Frameworks

Accreditation standard type & cycle (3 years)	Cost (average) per cycle	Cost—4 compliance staff (manager, coordinator & 2 officers) per cycle / 3 years
ISO 9001:2015 QMS Certification standard)	$20,000	$1,620,725.90^
RACGP	$20,000	$cost neutral
HSQF (Qld)	$20,000	$cost neutral
NSQHS	$20,000	$1,620,725.90^
NDIS	$20,000	$cost neutral
Mental Health	$20,000	$cost neutral
Aged Care	$20,000	$1,620,725.90^
Cost	$140,000	$4,862,177.70
Accumulative spend for seven accreditation standards & 4 (FTE) Compliance staff.		Outcome
Efficiency spend is $5,002,177.70 to apply 6 standards of accreditation & 1 certification standard across 3 years		6 accreditation certificates & 1 certification award
^ 4 compliance staff combined salary x 3 years / 1 cycle to monitor & manage 7 accreditation standards. Manager:$170,123.20; Coordinator: $131,912.30; 2 x Officers: 238,206.80. Total: $540.242.30		

Accreditation standards currently operating in the PHC do not afford businesses measures of 'quality or safety'. They, in fact, offer the opposite. There is no existing systemic approach to how the Australian accreditation industry institutes standards to the market monitors or evaluates standards in operation at the PHC tier of the accreditation industry (MP Consulting 2021). Our theme of the hidden human cost of accreditation standards exposed the emotional, mental and physical trauma and health cost of compliance staff applying multiple and disparate accreditation standards in our study. Our identification of the traits of Australian-designed accreditation standards and ISO certification contrasts the stark difference in these frameworks. The theme of accreditation implications examined the decline in assessor and surveyor quality and assessment techniques over time with assessor training being a priority issue. The accreditation implication discussions were held on the siloing of standards and their impact on ACCOs. The last theme of accreditation intangibles underscored the unpaid work hours staff encounter in navigating the accreditation landscape and the value of

First Nations assessors for the ACCO sector, who bring their nuanced knowing, being and doing to influence a landscape that traditionally marginalises and denies First Nations peoples.

Our study provides ample evidence to stake the claim that the application of multiple and disparate accreditation standards does not provide efficiency or sustainability for Aboriginal PHC services. They are not fit-for-purpose. The ISO 9001:2015 QMS is a superior standard and is considered the gold standard for ACCOs as a better fit-for-purpose standard.

5.3.8 References

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6 ACCO Gift to Government

(Discussion)

[Online pictures. Author unknown]

Unlike 'Pandora's Box' the gift we give to the ACCO sector, the state and federal governments and other industry players is our research for all to read, review, digest and ponder on to make good social change.

These outcomes, presented in this chapter, are captured from the three results chapters. They are drawn from the conclusions appearing at the end of the five themes and assembled together as the discussion and integration of the results chapter. The depth and richness of the data captured from our interviewees and focus group participants produced a large dataset. We are grateful to each of them for their contribution to this new body of knowledge. We are thankful for the respective roles they hold contributing to the national accreditation landscape. We thank each and every one of our research participants who made this body of work possible. I am thankful for the support of the advisory team!

This research project and lens through which this body of work is viewed, conveyed and presented is an Indigenist gaze. The framework supporting this gaze is our Australian parallel experience of Brayboy's (2006) TribalCrit concepts. Personally, this research project is a labour of love and was undertaken to bring valid research results concerning the Australian accreditation industry standards operating in the primary care tier. We heard from a wide spectrum of people with results from those industry experts who brought their experiences, giving generously to this new body of knowledge for good social change. We believe the research tools and methods employed in this research project have provided legitimacy to each of our study participants.

The concepts of Knowledge, Power, Ownership provide overarching signposts to initiate robust discussions within each segment.

6.1 Knowledge

6.1.1 Gaps in the Australian PHC Tier Accreditation Landscape

The research results provide evidence for us to learn from and validate the following gaps in the Australian accreditation landscape:

1. The ACCO sector is overburdened with reporting, and multiple mandated prescriptive Australian-designed accreditation standards—up to 11 different frameworks—add to the overburden in reporting.
2. The GP health services are only required to apply one standard—RACGP.
3. Prescriptive standards do not provide holistic engagement in an iterative, continuous cycle of quality improvement for the businesses applying these types of accreditation frameworks.
4. No acknowledgement or review of the PHC tiers' engagement in the types of accreditation standards has been done until now (MP Consulting 2021) and these research results.
5. There is no systematic approach to how Australian accreditation frameworks (i) are developed and introduced to the market and(ii) no equity for the market mandated to apply them.
6. Prescriptive Australian accreditation-designed standards are not 'fit-for-purpose' for ACCO businesses, their model of care, service delivery or community.
7. Australian-mandated prescriptive frameworks are cultural constructs and, by design, are culturally deaf, which is a denial of the ACCO business model.
8. ACCOs desire one standard that will cover all their needs and allow for iterative, continuous quality improvement based on the maturity and rurality of their services.

9. Quality improvement is one pillar of the clinical governance framework most ACCOs apply for continuous innovative client-centred care. The communities require this level of care.

Table 6.1 and Table 6.2 list the traits of open and prescriptive frameworks to give language to the ACCO sector.

Table 6.1

Australian Industry-Designed Accreditation Standard Traits

Trait	Description
Trait 1	Standards are designed by specific industry players who own them.
Trait 2	Standards are prescriptive in design.
Trait 3	Closed in the design of their indicators.
Trait 4	Majority of indicators are linked to the KPIs in contractual agreements of funding agencies and appear in their standard. Duplication of reporting and criteria.
Trait 5	Their names dictate their design for a particular market, population health cohort or disease.
Trait 6	Their prescriptive design holds in silo, each accreditation standard with limited synchronicity.
Trait 7	Industry-designed standards are frequently reviewed & updated (in some instances yearly) eroding consistency and robustness.
Trait 8	There is no mutual recognition between the industry-designed standards.
Trait 9	Many industry-designed standards are now compulsory for ACCOs.

Table 6.2

ISO 9001:2015 Quality Management System Standard Traits

Trait	Description
Trait 1	ISO 9001:2015 QMS is a certification standard and is buttressed by a host of interlinking international standards to give it value.
Trait 2	The 9001 ISO series are purposely designed for service delivery—one standard designed for application across multiple industries—food to the Therapeutic Goods Association to airlines to International Bureau Of Meteorology to healthcare and everything in between.
Trait 3	The clauses are open to interpretation allowing businesses to meet the clauses based on the businesses' maturity and rurality.
Trait 4	The ISO Technical Committee are responsible for changes & host a number of member-country representatives who in 2021 reviewed this standard—now 8 years without changes.
Trait 5	Review / changes to ISO 9001:2015 are made between 5–7 years.
Trait 6	The certification standard is for the whole company from board governance down to the businesses service delivery.
Trait 7	The ISO 9001:2015 QMS purpose is to create business systems to carry a business. Not reliant on an individual.
Trait 8	ISO 9001:2015 guides, promotes, and applies a systems-thinking approach to businesses & value-adds to the business systems' robustness, stability and quality in alignment to the company's maturity and rurality.
Trait 9	ISO 9001:2015 QMS measures for consistency/reliability in their audits. The compulsory internal audit schedule are regular health checks on the business to monitor risk.

6.1.2 ACCO Reporting Overburden

Silburn et al. (2016) reported discrepancies in the vertical and horizontal levels of reporting for ACCOs in Victoria based on the three main ways ACCOs obtain funding: through state and federal government funding, Medicare and competitive tendering. The report identified that these arrangements require 409 reports against 46 funding arrangements, resulting in these types of reports: *53* annual reports, *52* half-yearly reports, *88* quarterly reports and *216* monthly reports (Silburn et al. 2016). In addition to these 409 reports per year is the burden of one ACCO operating seven accreditation standards within a three-year accreditation cycle. The reporting burden and preparation time increased exponentially to 21 additional reports. The total is approximately *430 reports* per annum outside of the regulator, tax and other legal reporting requirements to operate a business.

Over 14 years, the ACCO sector applied multiple disparate and mandated Australian accreditation standards without review, which is a liability for the Australian accreditation

industry and the federal government. These actions are disingenuous and cannot be justified by any measure.

6.1.3 Recommendations

1. Design of ACCO identified Medicare item numbers as a measure to reclaim the money spent on multiple and disparate accreditation standards with no real value or benefit to their businesses.
2. Reduce the number of accreditation standards to one for the ACCO sector, with ISO 9001:2015 being the preferred standard and fit-for-purpose based on our research findings. Table 6.2 outlines the benefits and traits.

6.2 Power

6.2.1 Systematic Approach to Monitoring and Review of PHC Tier Frameworks

There appears to be no systematic approach to how Australian accreditation standards are designed, as evidenced by the lack of synchronicity and mutual recognition between these standards. This was further affected by the lack of a systems approach to the market mandated to apply multiple prescriptive Australian accreditation standards. The evidence reports that GP health services apply only one standard—RACGP. In a recent report by the Australian Government (MP Consulting 2021), Allen and Clarke indicate that not many GP practices apply RACGP and believe it is not valuable to their business. Tables 6.1 and 6.2 show the identified traits for these accreditation frameworks operating at the primary tier of the Australian health system. The prescriptive nature of the indicators/criteria in Australian accreditation standards disables any systems thinking and systems development within businesses applying these standards because the criteria are predetermined. The prescriptive nature inhibits any form of iterative, continuous quality improvement within the businesses applying these standards. They are predominantly person reliant and devoid of systems thinking and systems development across the program area they are designed for.

Quality improvement is one pillar of the clinical governance framework. For over 50 years, the ACCO sector has had a reporting culture and engaged in clinical governance data to inform and innovate clinical care within the PHC area of their business and in some states and territories at the regional level. ACCOs operate with a direct responsibility to the communities they serve.

For the 14 years of the ACCO sectors' compliance to multiple prescriptive Australian accreditation standards, our observations and results confirm a flow of information in one direction to the certification body to validate compliance to the standard/s, with an accreditation certificate to authenticate compliance. It is not good practice to have all the data flowing one way without a corporate level of responsibility for the experience of mandated

framework compliance for ACCOs. Fourteen years of ACCO compliance with 11 frameworks should have produced cycle upon cycle from the framework owner's good quality improvement data for the ACCOs to use towards their clinical governance. We know Australian accreditation standards are reviewed annually. Therefore, there must be a level of corporate responsibility in the annual framework reviews for responsible data capture on the level of quality improvements seized through data for each of the ACCOs' participation.

Good quality improvement data outside of a certificate of compliance is the benefit ACCOs require from their participation in Australian accreditation-designed frameworks. This is the reciprocity the ACCO sector seeks as a level of corporate responsibility from the Australian accreditation industry players—a systems approach to the design and capture of quality improvement data to improve the personhood of each of their community members. Garnered off the applied exercise of the PDSA iterative cycle of continuous quality improvement in real-time practice is an ACCO priority from 14 years of continuous accreditation engagement.

6.2.2 Recommendations

1. Identify First Nations agencies to share responsibility for monitoring and reviewing the federal government legislation (of a national accreditation framework at the PHC tier) to ensure there are regular checks and balances in place so one market is never overburdened and marginalised.
2. Build equity into the accreditation system (at the PHC tier) with a review of the process of how Australian industry-designed standards are introduced into the marketplace.
3. Design Australian accreditation standards with a level of corporate responsibility on the data (collected cycle upon cycle) of good quality improvement data capture, returned to the ACCO sector as a measure for clinical governance.
4. Deliberate the legal and cultural considerations of Indigenous data sovereignty in the design of Australian accreditation standards.

6.3 Ownership

6.3.1 Taking Back What Belongs to Us Through Good Data

The business decision to engage in a framework that proves compliance with quality and safety is the desire of any company that believes in its services. The ACCO sector is passionate about this value and has proven its loyalty to applying multiple, mandated, prescriptive accreditation standards for 14 years without complaint or knowledge of the language to the various aspects of engagement in Australian accreditation standards and or review by the accreditation industry players.

The number of certification bodies exploded after 2010, and since then, there have been 141 registered CBs with JASANZ, the rise driven by demand for the number of Australian accreditation standards in the market. The accreditation market has become a siloed myriad of frameworks with no level of accountability to the people, market and businesses they are assigned and no level of synchronicity between them at the PHC tier.

The network of 145 ACCOs across Australia has been inundated with multiple disparate accreditation frameworks since 2010, when the federal government introduced ISO 9001:2008 to this sector as a second certification standard. Since 2010, many ACCOs have been grappling with the language of the various processes within the PHC tier of frameworks. ACCO staff are still trying to manually map the criteria across these multiple standards to develop one set of policies and procedures across the frameworks for compliance. After 14 years of compliance staff performing manual gap analyses between these disparate standards, their need—and rightly so: spoken loudly, multiple times, by our study participants—is for *one accreditation standard.*

The results are in, and this research gives the ACCO sector the evidence-based knowledge it requires to make some informed level of decision-making—sector wide. We know these results provide good data back to the accreditation industry on identified gaps and injustices inherent in the system. We know our evidenced-based research stands as robust cogent information for the federal government, state governments and other standard owners on their frameworks.

Based on the traits of the prescriptive Australian-designed accreditation standards, this research asserts that their prescriptive design is devoid of systems thinking and systems development in the frameworks of businesses that apply them. The underlying research assumption is that QMS improves ACCO service performance, and this research tests that.

6.3.2 Efficiency and Sustainability as Measures of Quality

Those who design accreditation standards assign ‘quality and safety’ as measures advertising their benefit to the market. This research focused on defining and examining efficiency and sustainability as traits of quality. Our second literature review adopted these definitions of efficiency and sustainability as they pertain to PHC. Thompson et al. (2015:145) define the sustainability of PHC as ‘the ability of a health service to provide ongoing access to appropriate quality care in a cost-efficient and health-effective manner’. Knippenberg et al. (1997:11) describe sustainability as ‘the production of health outputs and outcomes at optimised efficiency with uninterrupted inputs’. Sibthorpe et al. (2007:5) define efficiency as ‘the assessment of relationships between costs of organisational structures and processes, processes of care and intermediate outcomes’. Our recommendations based on these

definitions and their articulation with the PDSA cycle for iterative, continuous quality improvement in the application of accreditation standards are explored in this discussion chapter. Figure 6.1 shows the definitions of Knippenberg, Thompson and Sibthorpe combined in a working model of a QMS.

Figure 6.1 is a schematic of the model of QMS. The inner blue circles are a representation of the development of interlinking processes to create a systems approach to the development of a QMS. Resource management is a representation of *(Clause 6) Planning*, Management responsibility is *(Clauses 7 and 8) Support and Operation*, Measurement Analysis and Improvement is *(Clause 9) Performance Evaluation*, and Product Realisation is *(Clause 10) Improvement*. The inner cycle is *(Clause 5) Leadership.*[21]

This cycle is supported by an iterative, continuous quality improvement cycle known as the PDSA cycle, represented by the light blue squares. The PDSA cycle consists of different processes; only a certification standard, ISO 9001:2015, enables a systems approach to the implementation of this standard—processes like a project plan, management responsibility for the implementation of the standard, review committees established to monitor the internal changes, development of policies and procedures, designed audit schedules as risk mitigation and regular health checks on the internal areas. An audit register monitors the outcome of regular internal audits as potential information flows back to the client and business partners. The light blue squares in this model intersect with the implementation process in the centre, buttressed with client requirements and client satisfaction. This is the superiority of the ISO 9001:2015 standards in contrast to Australian prescriptive industry-designed accreditation standards.

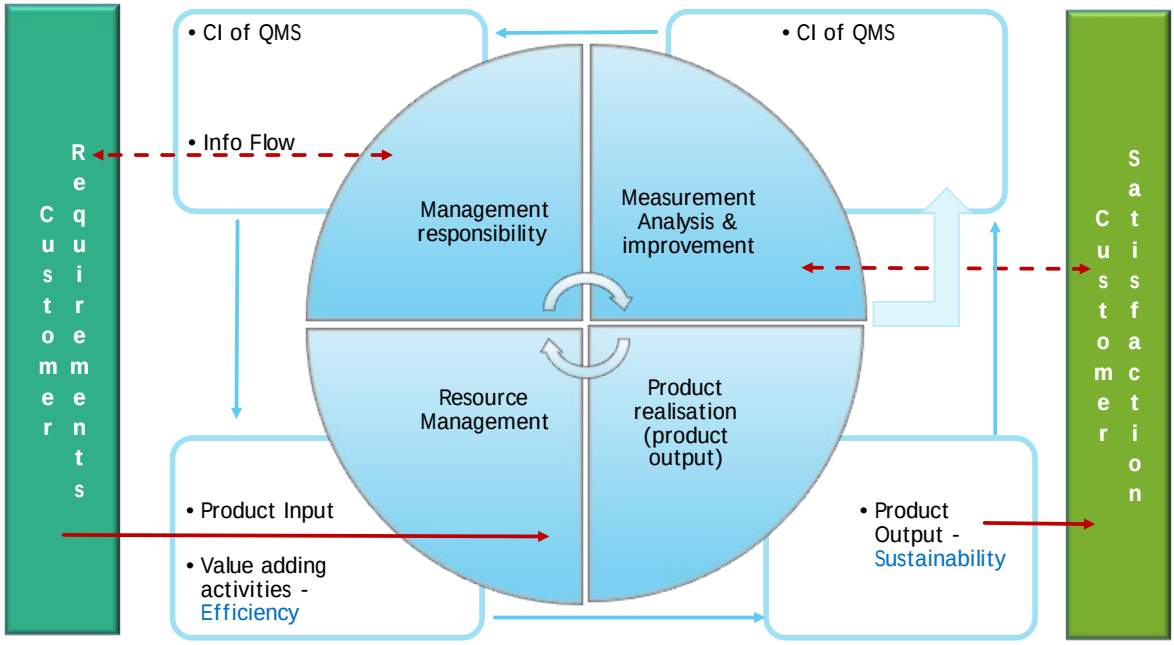
The clauses for the ISO 9001:2015 are 1. Clauses 1–3 Scope, Clause 4: Context of the organisation, Clause 5: Leadership, Clause 6: Planning, Clause 7: Support, Clause 8: Operation, Clause 9: Performance Evaluation, Clause 10: Improvement.[22]

The 7 ISO principles are (1) Customer focus, (2) Leadership, (3) Engagement of people, (4) Process approach, (5) Improvement, (6) Evidence-based decision-making, (7) Relationship management.[23]

[21] https://www.iso.org/standard/62085.html [accessed 24/4/2024]
[22] https://www.iso.org/standard/62085.html [accessed 24/4/2024]
[23] https://www.iso.org/standard/62085.html [accessed 24/4/2024]

Figure 6.1

Schematic of a Quality Management System



(source: adapted from ISO 9001:2008)

6.3.3 Research Assumption: QMS Improves ACCO Service Performance

This research tests the underlying assumption that QMS improves ACCO service performance. Applying standards should provide assurance that the standard is beneficial to the business. The standard measures are of a particular quality and safety to the business and clients. The ultimate outcome is it gives value to the business as a measure of continuous quality improvement undergirded by the development of a robust system dispersed throughout the program areas and the company.

There is no comparison between ISO 9001:2015 and Australian-designed prescriptive accreditation standards. They are opposites on the accreditation continuum in terms of their quality and safety, as supported in their table of traits. Engagement in a holistic QMS improves business service performance. The schematic model in Figure 6.2 explains the development of processes creating an interlinking network (of process from the clauses) for systems to be created within each business unit producing a universal company QMS.

Our evidenced-based research and sector knowledge from our study participants, on multiple occasions, identified the need for one accreditation standard for the ACCO sector to bring equity and reprieve. ISO 9001:2015 is the only standard that has an inherently inbuilt PDSA cycle, as indicated in Figure 6.2.

Figure 6.2

Schematic Representation of the Elements of a Single Process

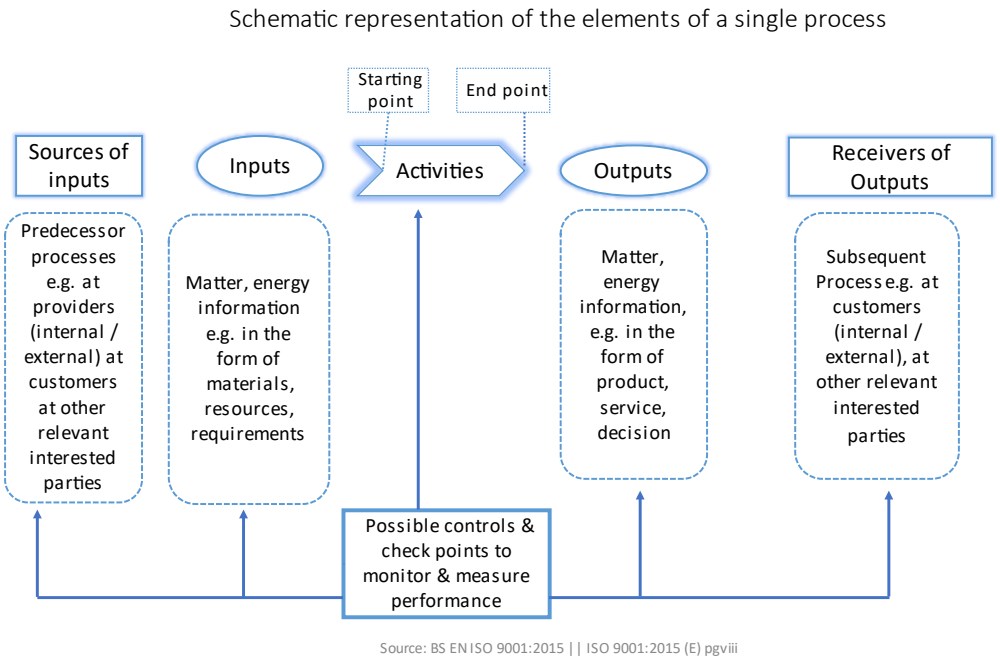


Figure 6.2's schematic representation of the elements of a single process shows the interaction of its elements with monitoring and measuring checkpoints. These are necessary for control and are specific to each process depending on the related risks.

As claimed in the ISO 9001:2015 standards, the potential benefits for the organisation applying this QMS based on this international standard are:

i) the ability to consistently provide products and services that meet customer and applicable statutory and regulatory requirements

ii) facilitation of opportunities to enhance customer satisfaction

iii) addressing of risks and opportunities associated with its context and objectives

iv) creation of the ability to demonstrate conformity to specified QMS requirements.[24]

Our proposed recommendation to the ACCO sector for one accreditation standard in your business (in testing our assumption) would be to apply ISO 9001:2015 QMS as a whole-of-organisation certification. This standard as an international standard is robust, with rigour and consistency to the clauses, is underpinned by other ISO standards and awards a certificate of compliance. The clauses are written to allow the business to identify their evidence based on the ACCO's maturity and rurality. ISO 9001:2015 creates systems thinking and systems design in the business. The Australian-designed accreditation standards are no match in terms of

[24] https://www.iso.org/standard/62085.html [accessed 24/4/2024]

quality and safety and cannot be compared with the international certification standard of ISO 9001:2015. They are situated at opposites of the certification/accreditation continuum.

The ACCO sector's contribution to the Australian PHC tier is unmatched in its business model, service delivery and business outputs to the most marginalised population in Australia—First Nations peoples, who are 3.8% of Australia. They deserve our applause for their engagement in frameworks that primarily work against the purpose of ACCOs.

Our research introduced the term 'culturally deaf' accreditation standards and the term 'colonial construct' as a reference to Australian-designed accreditation standards.

The overarching concepts of KNOWLEDGE, POWER, OWNERSHIP were the palpable tensions experienced from our study participants' stories. These concepts used by the accreditation industry players keep the business of accreditation locked in an industry whose primary goal is revenue as a replacement for quality and safety. Cultural deafness references the denial of Aboriginal and Torres Strait Islander people as the First People of our lands in what is known as Australia. Our history is central to who we are. Our Country is who we are. The design of Australian accreditation standards dismisses and does not consider these important areas of who we are in their holistic design. Colonial constructs are a reference to the controls and attempts of Australian-designed accreditation standards to standardise the business model, service delivery and model of holistic care that ACCOs provide to their communities. The design of colonial constructs (as mandated accreditation standards) is another attempt to force ACCOs into mainstream practices in ways that do not fit the needs of the community or the values of the community. Our ways of being, knowing and doing are transacted through relationality, respect and reciprocity.

The ACCO ways of doing business should be adopted into mainstream GP health services. Phillips et al.'s (2010) endorsement of the ACCHS model as a systems approach at an organisational level may lead to effective PHC regionally, a decrease in chronic disease and an efficient business model. Phillips et al.'s systematic research of clinical governance models positioned the ACCHS sector as a leader in clinical governance in Australia, with valuable lessons for primary care more broadly (Darr et al. 2021; Phillips et al. 2010). Perhaps the adoption of the ACCHS way of doing business should be a GP health service consideration. The ACCO sector has carried this unwarranted accreditation burden and requires reprieve.

6.4 Recommendation

1. The Australian owners of the frameworks, including the state and federal government agencies, develop mutual agreements between their standards. If an ACCO applies ISO 9001:2015, QMS will automatically be given accreditation to the mandated, multiple, disparate and prescriptive Australian-designed accreditation standards.

2. Return of the ACCO business's corporate and commercial-in-confidence information and service data are released from the CB back to every ACCO and deleted from the CB electronic storage.
3. Australian accreditation standards consider the principles of Indigenous data Sovereignty in their design in developing holistic indicators and criteria.
4. Repeal the process of ACCOs depositing their information into CB portals because this practice is draconian and is control dispensed on a grand scale towards the ACCO sector.

6.5 References

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7 Reciprocity in Action: The Gift That Keeps on Giving (Conclusions and Recommendations)

[Online pictures. Author unknown.]

The recommendations have transpired from the evidence-based research. We submit these recommendations with the knowledge that they will bring about relief to the ACCO industry, which has been overburdened for many years. Let this sector shine and be known as the PHC industry leader in Australia.

In this chapter, we present the main features of our research findings for the accreditation industry players to consider. We also circulate to the end users of this knowledge the network of ACCOs across Australia and the NACCHO.

7.1 Conclusion and Recommendations

These recommendations are designed for the Australian accreditation industry players. No one can deny the level of injustice apportioned to the ACCO sector based on the number of frameworks/mandated accreditation standards applied, year on year, for 14 years by the Australian accreditation industry. This situation is disingenuous in nature on a national scale, revealing that there are no or limited systems in place to monitor the release of frameworks into the market. This limitation forced one segment of the market (the ACCO sector) to be penalised on the basis of their business model, holistic service delivery and client co-morbidities.

The federal government EQIS funding ended in 2012 for ACCOs to support a second accreditation standard. Since 2012, the ACCO sector has held the financial burden of employing specialist staff and purchasing supportive resources and electronic infrastructure to monitor and manage up to 11 frameworks without review or cogent evidence.

The federal and state governments and other standard owners unleashed their dominance on an unknowing ACCO sector to engage in frameworks that were unfit for purpose. ACCOs have been held hostage by these Australian standards being made mandatory as a result of their holistic business model.

The ACCO network has 145 members nationally. Their business model provides holistic wraparound services for their communities and becomes a casual and unassuming target by the accreditation industry. Each of these frameworks is siloed and segments the ACCO service delivery accreditation compliance—frameworks like the RACGP standard for PHC, NDIS for disability services, HSQF for youth and community service programs, NSQHF for dental services and so on. The ACCO services provide health wellbeing services to 3.8% of the Australian population whose health demands are dire.

These recommendations are designed to fill the current gaps in the Australian accreditation industry at the PHC tier and remedy any future issues to remove the glut in accreditation standards the ACCO sector currently applies.

The lack of a systems approach to the application of accreditation standards by the accreditation industry is a void requiring a systems-wide remedy. The ACCO sector has paid a huge financial price for 14 years, one that would have remained unchecked had it not been for this body of research and new knowledge on the Australian accreditation industry.

Crocetti et al. (2023) highlight in their study ‘Aboriginal Led-Businesses Are the Defenders of Self-Determination With Practices of Cultural and Financial Empowerment at Their Heart’ a need for strong policy and regulation to mitigate harmful industry practices

while incentivising the potential positive impacts of the commercial activities on Aboriginal health and wellbeing.

To reiterate, we present these research recommendations in one place, housed under the three concepts of KNOWLEDGE, POWER, OWNERSHIP.

7.2 Recommendations

7.2.1 Knowledge—Whose Knowledge?

1. Design ACCO identified Medicare item numbers as a measure of cost recovery on the money spent on multiple and disparate accreditation standards with no real value or benefit to their businesses.
2. Reduce the number of accreditation standards to one for the ACCO sector with ISO 9001:2015 QMS being the preferred certification standard as the better fit-for-purpose standard based on our research findings. Tables 4.2 and 6.2 outlines the benefits and traits.

7.2.2 Power—Real or Perceived | Assumed and Asserted

1. Identify a First Nations agency to share responsibility for reviewing and monitoring the federal government legislation (of a national accreditation framework) at the PHC tier to install regular checks and balances and remain in place so one market (i.e. ACCOs) is never overburdened or marginalised.
2. To build equity (into the accreditation system) at the PHC tier, review the process of how Australian industry-designed standards are introduced into the marketplace.
3. Design Australian accreditation standards with a level of corporate responsibility in terms of the data collected, cycle upon cycle, from engagement with multiple frameworks for businesses. Certification body reciprocity through good data capture involving accreditation quality improvements (cycle upon cycle) returned to the ACCO sector. This level of data can be used in ACCOs for quality improvement, being one pillar and measure towards their clinical governance.

7.2.3 Ownership—Good Data Allows for Informed Changes to Happen

1. The Australian owners of the frameworks and the respective government agencies should develop mutual agreements. If an ACCO applies ISO 9001:2015, QMS will automatically be given a checked assessment of the mandated, multiple, disparate and prescriptive Australian-designed accreditation standards.
2. Return of the ACCO business's corporate and commercial-in-confidence information and service data should be handed from the certification body to the respective ACCOs and deleted from the CB electronic system.

3. Australian accreditation standards, in their review, should consider the principles of Indigenous data sovereignty in their design.
4. Repeal the process of ACCOs depositing their commercial-in-confidence information and service data into certification body portals. This practice is draconian, and is control dispensed on a grand scale towards the ACCO sector.

Our priority recommendation is for *one holistic* (as in a whole-of-business) certification standard. ISO 9001:2015 QMS is a more efficient and sustainable fit-for-purpose framework that holistically benefits ACCOs. The application of ISO 9001:2015 QMS, when supported by accreditation management software, produces solid, nuanced data for ACCOs as clinical governance performance measures. These evidence-based recommendations, when considered and applied, will fill the identified gaps in the Australian accreditation industry at the PHC tier for Aboriginal Primary Health Care services in Australia.

7.3 References

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