



HealthWorkforce
AUSTRALIA



Environmental Scan: Version 7.0 - FINAL

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Table of abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation (also used interchangeably with "AMS" – Aboriginal and Torres Strait Islander Medical Service)
ACT	Australian Capital Territory
AHMAC	Australian Health Ministers' Advisory Council
AHW	Aboriginal Health Worker
AMS	Aboriginal Medical Service (also used interchangeably with "ACCHO" – Aboriginal and Torres Strait Islander Community Controlled Health Organisation)
ANZCO	Australian and New Zealand Standard Classification of Occupations
ASGC	Australian Standard Geographical Classification
ATSIHRTONN	Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network
COAG	Australian Council of Australian Governments
CEREC	Curtin Educational Research and Evaluation Consortium
CIRC	Curtin Indigenous Research Centre
CS&HISC	Community Services and Health Industry Skills Council
CVD	Cardiovascular Disease
DALY	Disability-Adjusted Life Year
DEEWR	Australian Government Department of Education, Employment and Workplace Relations
DoHA	Australian Government Department of Health and Ageing
ERG	Expert Reference Group (for this project)
JPG	Jurisdictional Planning Group (for this project)
HLO	Hospital Liaison Officer
HREOC	Human Rights and Equal Opportunities Commission
HWA	Health Workforce Australia
IOW	Indigenous Outreach Worker
MBS	Medicare Benefits Schedule

NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSIHC	National Aboriginal and Torres Strait Islander Health Council
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NATSIHWA	National Aboriginal and Torres Strait Islander Health Workers Association
NRAS	National Registration and Accreditation Scheme
NSW	New South Wales
NT	Northern Territory
OATSIH	Office of Aboriginal and Torres Strait Islander Health
PHC	Primary Health Care
QLD	Queensland
QAIHC	Queensland Aboriginal and Islander Health Council
RTO	Registered Training Organisation
SA	South Australia
SAMIS	QLD Secure AMS Information System
SIDS	Sudden Infant Death Syndrome
Tas.	Tasmania
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VET	Vocational Education and Training
Vic.	Victoria
WA	Western Australia
YLD	Years Lived with Disabilities
YLL	Years of Life Lost

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1. Executive Summary

The overarching aim of Health Workforce Australia's Aboriginal and Torres Strait Islander Health Worker project (the 'project') is to inform the development of policies and strategies which will greatly strengthen and sustain the Aboriginal and Torres Strait Islander Health Worker (Health Worker) workforce into the future.

The outputs of the project will also inform the requirements for national registration and accreditation of Aboriginal and/or Torres Strait Islander Health Practitioners which is due to occur on 1 July 2012.

The Environmental Scan forms one part of this project.

Overview

The objective of the Environmental Scan is to document and synthesise the wide range of information and data (e.g. policies, practices and research studies) which are relevant to the development of the Health Worker workforce. In so doing, the Environmental Scan:

- Provides a national, cross-sector picture of what is already known
- Identifies gaps in the knowledge base for further investigation
- Informs the framework to guide the information collection phases of this project.

The Environmental Scan focuses on two broad areas:

- High level considerations which influence the design of and demand for the Health Worker role including: Historical, cultural and policy context (Chapter 2); health needs of Aboriginal and Torres Strait Islander peoples (Chapter 3); and the availability and accessibility of health services (Chapter 4)
- Health Worker specific issues including: Definition, scope of practice and role (Chapter 5); distribution and demographics of the Health Worker workforce (Chapter 6); quality and safety mechanisms (Chapter 7); career pathways (Chapter 8); education and training (Chapter 9); and recruitment and retention (Chapter 10).

The Environmental Scan is not intended to be an exhaustive literature review. Rather, it is a working resource for the project which summarises the key themes arising from a range of sources identified through desktop research, key informant interviews¹ and feedback from the Jurisdictional Planning Group (JPG) and Expert Reference Group (ERG).

The Scan Methodology included:

- Invitations to ERG and JPG members to input on the structure of the Environmental Scan and provide documentation for inclusion
- Key informant interviews with representatives from Aboriginal Community Controlled Health Organisations (ACCHOs), relevant government departments and agencies, and education providers

¹ including representatives from Aboriginal Community Controlled Health Organisations (ACCHOs), relevant government departments and agencies, and education providers

- Review and feedback from ERG members on early and subsequent drafts of the Scan
- Review and feedback from Shannon Consulting Services during the planning, drafting and reviewing phases of the Scan.

Note, all works drawn upon have been cited in the body of this report.

Findings

Overview

There has been substantial research into the Health Worker workforce by a variety of organisations. Areas that have been particularly well developed previously include:

- Comprehensive national burden of disease information, and some understanding of access barriers – which provides a foundation for Health Worker workforce development and evidenced based models of care
- Significant work to define the scope of practice of Health Workers and in the development of a nationally consistent Health Worker qualification framework, introduced in 2007 by the Community Services & Health Industry Skills Council
- Assessment of training and education requirements through training needs analysis for the Aboriginal Community Controlled Health sector workforce.

However, the workforce development approach for this profession has a diverse heritage. Consequently, when viewed against a national landscape the existing body of information appears to be somewhat fragmented. For example, some of the work that has previously been undertaken occurs within the context of a single jurisdiction; other work is restricted to a particular sector. For example, targeting the Health Worker workforce that is employed exclusively by Government health services, or exclusively by the Aboriginal Community Controlled Health Services. While a number of reviews of the workforce have been conducted which provide recommendations on how to improve the workforce, few of these may be considered to be supported by sufficient national evidentiary base.

Specific findings

Policy context

In December 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Aboriginal and Torres Strait Islander communities to achieve the target of closing the gap in Aboriginal and Torres Strait Islander disadvantage covering a range of health, education and employment outcomes (Council of Australian Governments, 2009). The objectives of the Health Worker project are aligned with all aspects of this major government initiative. This is important considering that the cultural context (discussed below) highlights that Aboriginal and Torres Strait Islander health outcomes are a result of a range of environmental and community factors. Areas of Aboriginal and Torres Strait Islander disadvantage are closely interlinked and should not be addressed in isolation. The Closing the Gap initiative recognises the need for a holistic response which considers the social and physical determinants of health but also indicates that the response must extend beyond health sector organisations and be truly cross-sector.

The National Registration and Accreditation Scheme (NRAS) will also be assisted by this project. The project will inform the process of national registration. For example, it will provide information on the jurisdictional differences that will need to be navigated. Similarly, it will highlight potential issues that will need to be managed during the national registration process to minimise any potential negative impacts on the existing Health Worker workforce.

Historical and cultural context

The historical and cultural context in relation to Aboriginal and Torres Strait Islander people and the Health Worker role is important because these experiences have impacted the mental and physical health of Aboriginal and Torres Strait Islander peoples, and the way in which Aboriginal and Torres Strait Islanders interact with health services and institutions.

Further, to Aboriginal and Torres Strait Islander peoples, the concept of 'health' incorporates total physical, emotional, and mental wellbeing. Improving wellbeing therefore includes considerations of the physical environment, of dignity, of community, of self esteem, and of justice. Community health is therefore not only about Health Workers; it is very much about the totality of what Aboriginal and Torres Strait Islander people experience in their lives each day. Accordingly, health is everybody's business.

Burden of disease

The top five contributors to the burden of disease of Aboriginal and Torres Strait Islander peoples include cardiovascular disease, mental disorders, chronic respiratory disease, diabetes and injury. The risk of developing the majority of these diseases is exacerbated by lifestyle choices including smoking, drinking, substance abuse, physical inactivity, poor diet and domestic violence.

Therefore, a key strategy to reducing the disease burden is through a preventative, holistic approach to health care. Health education and promotion activities provide an opportunity to affect behavioural choices that contribute to the incidence of disease.

This information helps to provide a foundation for determining Health Worker workforce development needs and designing evidenced based models of care.

However, more work is required to pinpoint where specific gaps exist between health and access needs and Health Worker capability and capacity. Further, particular variables (such as location, unique health and cultural needs of local population, employing organisation or service delivery model) affect the scope of practice, role and the manner in which Health workers respond to the health needs of communities.

Health service availability and accessibility

Health services need to be both available and culturally accessible. These are separate and distinct concepts. Certain barriers can render available health services inaccessible to Aboriginal and Torres Strait Islander peoples.

An individual's fear of racial discrimination might be overcome through a Health Worker-first approach, whereby the Aboriginal or Torres Strait Islander Health Worker is the first point of contact in a health service for Aboriginal and Torres Strait Islander clients. This can assist in establishing trusting, respectful and understanding relationships between the client and other non-Aboriginal or non-Torres Strait Islander health professionals.

Therefore, it cannot be assumed that health service availability equates to accessibility. Data has shown that some Aboriginal and Torres Strait Islanders in non-remote areas

actually have a higher level of unmet need than those living in remote areas. This is despite the fact that health services are more densely concentrated, and therefore more available, in non-remote areas. One hypothesis explaining this phenomenon is that the increased concentration of Health Workers in remote areas has a positive effect on health service accessibility for Aboriginal and Torres Strait Islander peoples. Regardless, it is clear that health services must be “culturally safe” to be accessible for Aboriginal and Torres Strait Islander communities.

Scope of practice

Significant work has been undertaken to define the scope of practice of Health Workers, although a lot of variation exists across the different jurisdictions. The Health Worker role is inevitably, and necessarily, shaped by varying contextual demands and unique community needs.

According to available literature, it seems that there are certain core aspects of the Health Worker role, in particular its focus on a comprehensive primary health model of care. Unique to the Health Worker scope of practice is the provision of comprehensive primary health care within a culturally appropriate and culturally safe environment. The Health Worker assists in brokering culturally safe health care through direct client interaction, supporting and developing other health professionals' cultural awareness, and working to develop and foster the community's wellbeing.

An area of particular difference across Australia is in relation to the level of clinical responsibility involved in the role of a Health Worker. Depending on a variety of contextual factors, it may be viewed as more or less appropriate for the Health Worker to perform a clinical role. For example, in remote locations, such as the Northern Territory and Western Australia, Health Workers tend to have much broader clinical scopes of practice.

There are also a variety of different models of care in use involving Health Workers, including the “Health Worker-first” model, integration of Health Workers within the Multi-disciplinary team, or including Health Workers as a separate team within a health service. There is a limited evidence base to show which models of care and team structures are most effective.

Distribution and demographics

Australia does not have a clear national picture of the Health Worker workforce at this point in time. The data that are available have many limitations. For example, there is no clear definition of Aboriginal and Torres Strait Islander Health Workers used across Australia to define the data set.

However, using the best available data, certain key points are clear:

- The distribution of the total Health Worker workforce does not align to the distribution of the Aboriginal and Torres Strait Islander population – 48% of the Health Worker workforce is located in remote or very remote areas of Australia (Australian Bureau of Statistics, 2006c), whilst only 24% of the Aboriginal and Torres Strait Islander population is located in these areas (Australian Bureau of Statistics, 2006d).
- The majority of Health Workers are female (70%)(Australian Bureau of Statistics, 2006c)

- These findings raise some important considerations for the future development of the Health Worker workforce such as the development of a workforce with greater gender balance and appropriate geographic distribution.

Quality and Safety

There is limited discussion in the literature about quality and safety processes in place in relation to Health Worker services. Regulation, supervision and performance monitoring mechanisms help to both ensure service quality and also provide sufficient support to Health Workers.

The gaps in the information available regarding Health Worker regulation can be explained by the fact that the Northern Territory is currently the only jurisdiction with a formal Health Worker registration system. The limited information relating to Health Worker supervision and performance monitoring practices does not indicate that these quality and safety mechanisms do not exist; only that little is documented about appropriate processes in place. Quality and safety is therefore a key area for further investigation during the Community Mapping phase of this project.

Career Pathways

A significant body of work has already been undertaken in relation to the career pathways of Aboriginal and Torres Strait Islander Health Workers. Every effort should be made to contribute to this evidence base, rather than duplicate past work.

However, the majority of past efforts have been confined to particular jurisdictions. Furthermore, most have been restricted in focus to Health Workers who are employed by the Government, or those who are employed by the Aboriginal and Torres Strait Islander Community Controlled sector.

Nevertheless, from the available literature several key themes have emerged. These include the variation between entry-level requirements to become a Health Worker across the country; opportunities for career progression are limited by a variety of factors; and nationally recognisable and transferable skill sets are crucial.

There is limited information on the articulation pathways of Health Workers into other health professions. In addition, there has been no systematic evaluation of successful recruitment and retention strategies specific to the entire Health Worker workforce.

Therefore, although highly valuable and informative studies have already been undertaken in the past in relation to career pathways, this project represents an important opportunity to synthesise and build upon this knowledge base.

Education and training

A nationally consistent Health Worker qualification framework was introduced in 2007 by the Community Services & Health Industry Skills Council (CS&HISC). The CS&HISC developed a national Health Training Package HLT07, promoting nationally consistent Health Worker training standards (Community Services & Health Industry Skills Council, 2008b). This established opportunities for Health Worker to choose between Clinical Practice and Community Care streams of education, and identified training parameters for each level of qualification. In addition, there has recently been an assessment of training and education requirements through a training needs analysis for the Aboriginal Community Controlled Health sector.

Nevertheless, the entry-level qualification and requirements for Health Workers is still variable with a range of vocational certificate levels and qualifications in existence. In

addition, there has been no evaluation of whether the number and type of educational opportunities available for Health Workers are sufficient to meet future potential workforce demands.

Significantly, there are also a number of areas where the lack of data and evidence is substantial. For example, at its most fundamental, a robust national data set does not exist on the size and distribution of the Health Worker workforce, which is key to taking a strategic approach to workforce planning and development.

Recruitment and Retention

Although Health Worker recruitment and retention has been the focus of a number of past reviews, far more is documented about the barriers for recruitment and retention than the drivers of this profession. Barriers include financial, geographic, family commitments, and lack of culturally appropriate educational format and delivery. Low literacy and numeracy of some potential candidates has also been identified as an issue. There is a significant body of information discussing recruitment and retention strategies that can be utilised going forward.

The consultation phases of this project provide a good opportunity to gain a more nuanced understanding of what motivates Health Workers. Moreover, these activities may identify other success stories that have not yet been canvassed in the literature.

Key to recruitment and retention will be the supporting infrastructures in place, such as professional and cultural mentoring and peer support (e.g. through regional or national networking opportunities). Consultations will contribute to knowledge on these topics, considering that only a small quantity of information is currently available. Supporting infrastructure will therefore be further canvassed in the Interim Report.

Project data collection framework

The paragraphs above summarise the existing body of knowledge relevant to the reform of the Aboriginal and Torres Strait Islander Health Worker workforce. As demonstrated, there are certain key areas requiring additional information in order to develop an informed national picture of the Health Worker workforce.

The gaps identified have contributed to the development of a data collection framework for this project. The data collection framework comprises a series of questions that guide a number of information gathering activities, including Health Worker and Manager surveys and interviews with Health Workers, Managers and other health professionals.

The key project questions emerging from the Environmental Scan to guide this data collection process are outlined below. They are structured in accordance with the underlying objectives of the first two phases of the project: to first gain a national understanding of the existing workforce; and then identify evidence-based options for its future development. The key project questions will continue to be refined in light of new findings as they emerge.

Key project questions: Understanding the current Health Worker workforce

1. What is the current definition, scope of practice and role of the Health Worker workforce across Australia?
2. How does the Health Worker workforce contribute to the broader health system and the availability/accessibility of health services for Aboriginal and Torres Strait Islander peoples?
3. What evidence is there demonstrating how the Health Worker workforce responds to the known burden and distribution of disease experienced by Aboriginal and Torres Strait Islander peoples?
4. What quality and safety processes currently exist in relation to services provided by Health Workers?
5. What career pathways, opportunities and barriers exist for Health Workers?
6. What education and training requirements, opportunities and barriers exist for Health Workers?
7. What recruitment and retention strategies and barriers exist in relation to the Health Worker workforce?

Key project questions: Informing future Health Worker workforce developments

8. What are the opportunities, challenges and views on the development of a nationally consistent Health Worker definition, scope of practice and role?
9. Is there any evidence to suggest that the Health Worker workforce could contribute to the broader health system in a different way?
10. Is there any evidence to suggest that the Health Worker role or scope of practice should change to better meet the health and service needs of Aboriginal and Torres Strait Islander communities?
11. What evidence is there highlighting appropriate quality and safety mechanisms for Health Worker services in future?
12. Is there any evidence to suggest that Health Worker career pathways should change, and if so in what way?
13. Is there any evidence to suggest that Health Worker education and training requirements and opportunities should change, and if so in what way?
14. Is there any evidence in relation to effective recruitment and retention strategies that can be used to strengthen the Health Worker workforce in future?

Conclusion

This is a major project for Health Workforce Australia.

The Environmental Scan provides a compendium of previous workforce development initiatives across jurisdictions and sectors, drawing the grey and published literature into a single document.

A comprehensive evidence base to inform the process moving forward remains absent. Further effort into workforce development is required around a range of issues and the development of options in these areas will be the remit for the remainder of this project.

2. Introduction

The introductory chapter gives a brief overview of the HWA Aboriginal and Torres Strait Islander Health Worker project in order to provide some context to the Environmental Scan. This section also details the objectives and scope of the Environmental Scan, recognising that it is one of a series of project outputs.

The objective of the Environmental Scan is to document and synthesise the wide range of information and data (e.g. policies, practices and research studies) which are relevant to the development of the Health Worker workforce. This document does not aim to provide answers for the project; instead, it seeks to identify gaps in existing knowledge, thereby framing the set of questions that will guide the remaining information collection activities throughout the project. The chapter concludes by outlining the structure of the remainder of the Environmental Scan.

2.1 The Health Workforce Australia Aboriginal and Torres Strait Islander Health Worker Project

2.1.1 Project objective

The overarching objective of the Aboriginal and Torres Strait Islander Health Worker project is to inform the development of policies and strategies that will strengthen and sustain the Health Worker workforce. The reform of the Health Worker workforce will better position it to respond to the unique health and service needs of Aboriginal and Torres Strait Islander communities, contributing to efforts to improve their health outcomes.

The outputs of the project will also inform the requirements for national registration and accreditation of Aboriginal and/or Torres Strait Islander Health Practitioners, which is due to occur on 1 July 2012.

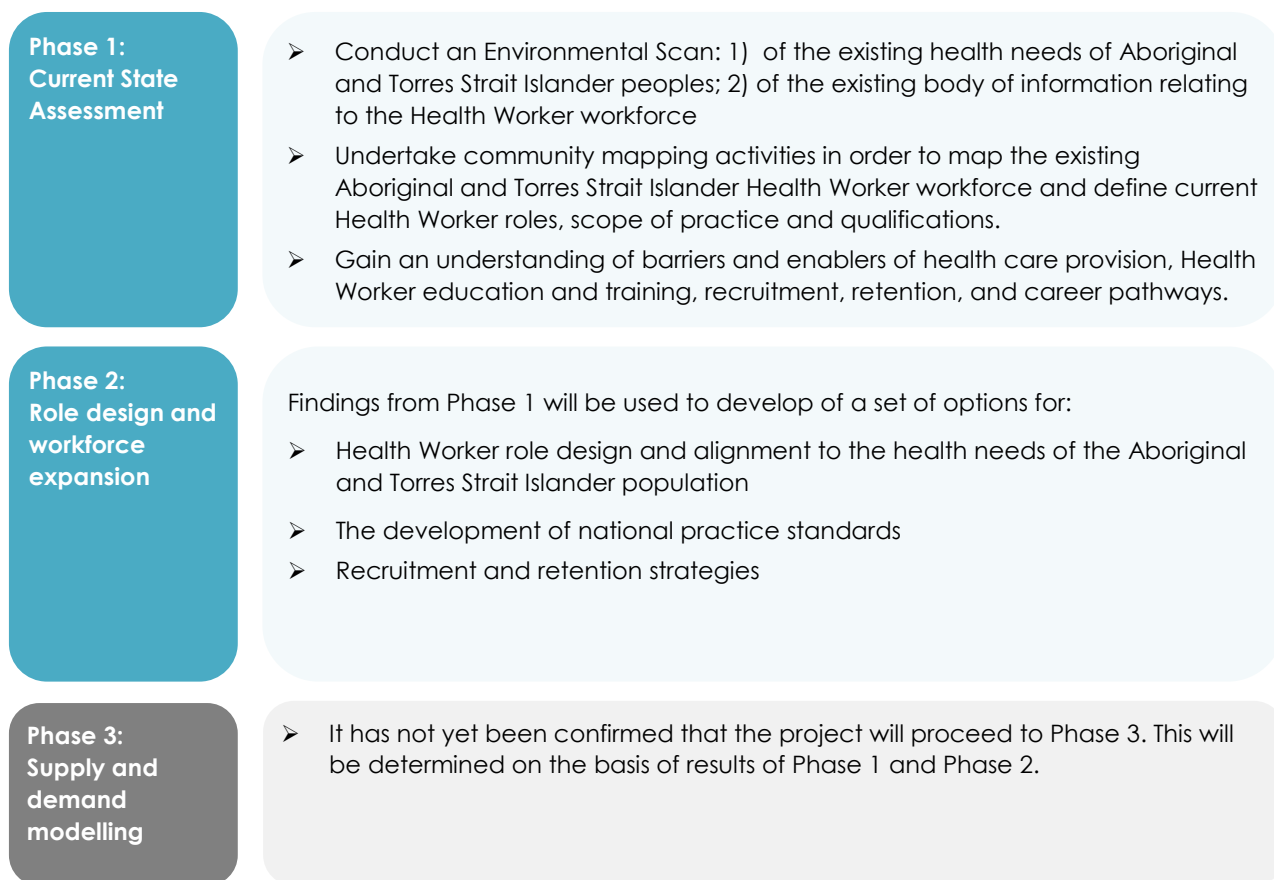
2.1.2 Project phases

In order to achieve the project objective, three project phases have been designed. The aims of these three phases are to:

Phase 1	Establish a clear understanding of the existing Aboriginal and Torres Strait Islander Health Worker workforce and the health status of Aboriginal and Torres Strait Islander peoples.
Phase 2	Develop a set of options for the future workforce design, roles and educational requirements to submit to governments for consideration.
Phase 3	Use supply and demand data to model the future Health Worker workforce.

The activities that will take place in each project phase are summarised below in Figure 1, providing the project context for this Environmental Scan. (For more detail on the project activities and the planned project timeline, see Appendix B).

Figure 1 - The Aboriginal and Torres Strait Islander Project Phases²



2.2 The Environmental Scan

2.2.1 Objectives

The overarching objective of the Environmental Scan is to document and synthesise the wide range of information and data (e.g. policies, practices and research studies) which are relevant to the development of the Health Worker workforce.

In so doing, the Environmental Scan aims to:

- Provide a national, cross-sector picture of what is already known
- Identify gaps in the knowledge base for further investigation
- Inform the framework to guide the information collection phases of this project.

The Environmental Scan focuses on two broad areas:

- High level considerations which influence the design of and demand for the Health Worker role including: Historical, cultural and policy context (Chapter 2); health

² Note that implementation of the third phase of the project is dependent upon the outcomes of the first two phases.

needs of Aboriginal and Torres Strait Islander peoples (Chapter 3); and the availability and accessibility of health services (Chapter 4)

- Health Worker specific issues including: Definition, scope of practice and role (Chapter 5); distribution and demographics of the Health Worker workforce (Chapter 6); quality and safety mechanisms (Chapter 7); career pathways (Chapter 8); education and training (Chapter 9); and recruitment and retention (Chapter 10).

2.2.2 The scope of the Environmental Scan

The scope of the Environmental Scan is not to provide the answers but to highlight the key questions for this project. These questions guide the collection of information during other project activities, including the key informant interviews, community mapping activities and survey of Health Workers and their managers.

The Environmental Scan is just one of several key project outputs. The Environmental Scan will be followed by an Interim Report and a Final Report which are described briefly below.

Interim Report

The Interim Report aims to provide a comprehensive body of evidence outlining the current “As-is” scenario with regard to the Health Worker workforce. This report will synthesise information presented in the Environmental Scan with information collected during the Community Mapping activities. It aims to address gaps in the evidence identified via the Environmental Scan using data collected in the field.

Final Report

The Final Report will focus on the “To-be” scenario, defining a set of options for consideration by stakeholders in relation to the future development of the Health Worker workforce. These options will be supported by the evidence base collected via Phase 1 of the project.

2.2.3 Environmental Scan methodology

The methodology used to develop this Environmental Scan was deliberately iterative in nature. This enabled the net to be cast as wide as possible to identify relevant information, including: peer reviewed journal articles, Government and Aboriginal Community Controlled sector policy documents, grey literature and project reports from studies in Australia and internationally.

The following steps contributed to this iterative process:

- An initial desk top review was conducted. The search terms, journal databases and websites that were used during this desk top review are depicted below in Table 1. This first search for information provided a strong foundation for the Environmental Scan structure and preliminary draft versions. However, it was recognised that much of the existing information would not necessarily be available online given the nature of this project. Subsequent steps therefore aimed to provide key stakeholders with an opportunity to contribute additional information to develop a more comprehensive national picture
- The Expert Reference Group (ERG) and Jurisdictional Planning Group (JPG) were invited to give input on the preliminary Environmental Scan structure and provide additional documentation for inclusion

- A series of key informant interviews were conducted with representatives from ACCHOs, relevant government departments and agencies, and education providers. Information for inclusion was provided by these stakeholders
- The structure of Draft Version 1.0, including the draft Health Needs chapter and existing reference list, was submitted to the ERG for review and feedback at the ERG meeting on 20 September 2010. A second opportunity was provided to ERG members to identify documents for inclusion
- The emerging knowledge gaps identified in Draft Version 1.0 were used to inform the development of the Information Collection Framework. This framework, which guides the Community Mapping activities, was also presented to the ERG for feedback and validation
- Documents received from JPG members, ERG members, key informants and initial stages of Community Mapping were incorporated into the Environmental Scan to form Draft Version 2.0.
- Draft Versions 2.0 and 3.0 underwent review and feedback iterations, resulting in Version 4.0.
- Draft Version 4.0 was submitted to the ERG for feedback on 1 December 2010.
- Finalisation of the Environmental Scan following input from the ERG.

In addition, Shannon Consulting Services collaborated with the project team and provided valuable input during the planning, drafting and reviewing phases of the Environmental Scan.

The nature of the majority of the information available for inclusion in the Environmental Scan is either grey literature and/or policy documents. This type of literature generally does not include control trials or formal evaluations of programs. Therefore, the available information does not lend itself well to a detailed scientific analysis of the quality and level of evidence provided. Instead, an assessment of the weight of evidence is provided throughout the Environmental Scan where relevant.

Accordingly, the Environmental Scan is not intended to be an exhaustive literature review. Rather, it is a working resource for the project which summarises the key themes arising from a range of sources identified through desktop research, key informant interviews and feedback from the JPG and ERG.

Table 1 - Environmental Scan desk top review search methodology

Search terms	<p>Aboriginal and Torres Strait Islander* Health Worker; Aboriginal and Torres Strait Islander health; Aboriginal and Torres Strait Islander burden of disease; Aboriginal and Torres Strait Islander primary health care; Aboriginal and Torres Strait Islander DALY's; Aboriginal and Torres Strait Islander health outcomes; Aboriginal and Torres Strait Islander morbidity / mortality; Aboriginal and Torres Strait Islander health risk factors; Aboriginal and Torres Strait Islander health professionals; Aboriginal and Torres Strait Islander health workforce; Aboriginal and Torres Strait Islander Policy; Close the Gap; Aboriginal and Torres Strait Islander education; Aboriginal and Torres Strait Islander employment; Aboriginal and Torres Strait Islander Community Controlled Health Organisations/Medical Services; Aboriginal and Torres Strait Islander population; health services availability; health service accessibility; Aboriginal and Torres Strait Islander health / traditional beliefs; Aboriginal and Torres Strait Islander Health Worker scope of practice; Hospital Liaison Officers; Indigenous Outreach Workers;</p> <p><i>*Note: For each search term that contains "Aboriginal and Torres Strait Islander", the same search was conducted using "Indigenous" and "Aboriginal" as a substitute for "Aboriginal and Torres Strait Islander" to address possible discrepancies in language used in literature.</i></p>
Databases	<p>Medline Cinahl AMED: Allied and Complementary Medicine PubMed Web of Science Scopus ATSI Health RURAL: Rural and remote health database Health & Society Database Australian Indigenous HealthinfoNet Apais-Health Cochrane Library Informit Online Expanded Academic Index ASAP Embase Proquest</p>

Websites	<p>Aboriginal HealthinfoNet: www.healthinfo.net.ecu.edu.au</p> <p>Australian Bureau of Statistics: http://www.abs.gov.au/</p> <p>Australian Institute of Health and Welfare: www.aihw.gov.au</p> <p>Community Services & Health Industry Skills Council: www.cshisc.com.au</p> <p>Google: www.google.au</p> <p>Websites of Aboriginal and Torres Strait Islander Community Controlled Health organisations, peak bodies and councils: http://www.naccho.org.au/, http://www.vaccho.org.au/, www.ahmrc.org.au, www.ahcwa.org.au, www.amsant.org.au, www.natsihwa.org.au, www.quaihc.com.au, http://www.ahcsa.org.au/</p> <p>VET and Tertiary education provider websites: http://www.atsihrtonn.org.au, www.csu.edu.au,</p> <p>Relevant Federal, State and Territory governmental department websites: http://www.health.gov.au/, www.fachsia.gov.au, http://www.deewr.gov.au/Pages/default.aspx</p> <p>World Health Organisation: www.who.int</p>
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2.2.4 Roadmap to the Environmental Scan

The balance of the Environmental Scan is structured as follows:

- **Chapter 3:** Provides an overview of the historical, cultural and policy context in relation to Aboriginal and Torres Strait Islander peoples and the Health Worker role
- **Chapter 4:** Outlines demographic and burden of diseases data for Aboriginal and Torres Strait Islander peoples
- **Chapter 5:** Discusses currently available health service access and utilisation data is provided, noting the importance of health service availability and accessibility
- **Chapter 6:** Gives an overview of previous work undertaken to define the Health Worker workforce and their roles, scopes of practice and models of care
- **Chapter 7:** Considers the known numbers, geographic location and sector distribution of the Aboriginal and/or Torres Strait Islander Health Worker workforce
- **Chapter 8:** Discusses the documented literature relating to quality and safety mechanisms surrounding the Health Worker workforce
- **Chapter 9:** Provides an overview of the career pathways available to Health Workers, and the work that has already gone into strengthening these pathways
- **Chapter 10:** Details the extensive work already undertaken to review Health Worker training needs and availability and the development of a nationally consistent training package for the workforce in 2007
- **Chapter 11:** Documents past reviews of recruitment and retention of the Health Worker workforce, noting existing barriers.

3. Contextual overview

The HWA Aboriginal and Torres Strait Islander Health Worker Project is one part of an ongoing effort to better respond to the health needs of Aboriginal and Torres Strait Islander peoples and strengthen the Health Worker workforce. The complex historical, cultural and policy context to this project must be understood in order to design a workforce response which is both appropriate and effective. This chapter provides the relevant contextual background by giving an overview of each of these three areas.

The chapter emphasises that:

- Australia's post-colonial history has had a profound impact on the health status and service needs of Aboriginal and Torres Strait Islander peoples
- Health services need to be culturally relevant, safe and appropriate to adequately meet the health needs of Aboriginal and Torres Strait Islander peoples

3.1 The historical context

The social impact of Australia's post-colonial history upon Aboriginal and Torres Strait Islander peoples is now widely recognised. Experiences of neglect, abuse and social exclusion have had serious implications for the mental and physical health, education, and employment status of Aboriginal and Torres Strait Islander peoples today.

An understanding of this historical context is significant to this project for three key reasons:

- a) Historical experiences have impacted upon the mental and physical health needs of Aboriginal and Torres Strait Islander peoples
- b) Historical experiences have impacted upon the way in which Aboriginal and Torres Strait Islander peoples interact with health services and institutions, thereby influencing the type of roles performed by Health Workers
- c) The history highlights the value placed upon Aboriginal and Torres Strait Islander self-determination, community control and leadership in today's context, including within the Aboriginal and Torres Strait Islander health sector.

With this in mind, a brief overview of the historical context and its significance to this project is provided below.

3.1.1 Summary of the historical context

The history of Australia post-colonisation is the focus of an extensive body of literature. Although it is not possible, nor appropriate, to provide a comprehensive discussion of the available literature in this document, it is crucial to acknowledge the nation's past.

The traditional Aboriginal and Torres Strait Islander owners of the land experienced significant injustice and mistreatment post-colonisation. Colonisation brought about widespread possession of Aboriginal and Torres Strait Islander land by white settlers, the introduction of disease and alcohol, inter-racial violence and localised massacres of Aboriginal and Torres Strait Islander peoples.

Australia's history was formally acknowledged by Federal Parliament in the apology presented by Prime Minister Kevin Rudd to Indigenous Australians on 13 February 2008 (Senate Hansard, 2008). On this day, the former Prime Minister apologised on behalf of Federal Parliament 'for the laws and policies of successive Parliaments and governments that have inflicted profound grief, suffering and loss on these our fellow Australians' (Senate Hansard, 2008). This apology acknowledged the evolving historical experience of Aboriginal and Torres Strait Islander peoples post-colonisation, which is summarised in chronological order below (Korff, 2010).

White settlement

During the initial period following white settlement of Australia in 1788, relations between Aboriginal and Torres Strait Islander peoples and colonists were largely combative. Ongoing conflicts caused many Aboriginal and Torres Strait Islander deaths, and racial segregation was generally enforced. The introduction of diseases and alcohol contributed to a decline in Aboriginal and Torres Strait Islander health and mortality.

Protection and control policy

Protection and control policies dominated the latter half of the 19th Century. During this period, there was clear racial segregation between Aboriginal and Torres Strait Islander peoples and the colonists. Australia's first inhabitants were not recognised as citizens or deemed eligible to vote. The presence of church missions and reserves for Aboriginal and Torres Strait Islander peoples expanded and distanced vast numbers of Aboriginal and Torres Strait Islander people from their traditional way of life. Furthermore, child protection legislation was passed at both the Federal and State Government levels, instigating a period that was later described as the Stolen Generation.

The Stolen Generation

The Stolen Generation refers to children of Aboriginal or Torres Strait Islander descent who were forcibly removed from their families by the Australian Federal and State government agencies and church missions. It is estimated that approximately 100,000 children were forcibly separated from their families in the period between approximately 1869 and 1969 (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children From Their Families, 1997). As documented in the *Bringing Them Home* report, government policies destroyed many family and cultural ties, contributing to profound experiences of grief and loss for many Aboriginal and Torres Strait Islander individuals and families (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children From Their Families, 1997).

Assimilation policy

In 1937, partway through the Stolen Generation years, the Aboriginal Welfare Conference of Commonwealth and State Authorities determined that the official policy for some Aboriginal people would be one of assimilation. The government authorities decided that Aboriginal people who were of mixed descent were to be assimilated into white society. This was to be achieved through the education of selected groups of Aboriginal and Torres Strait Islander peoples. Segregationist practices continued in many public places, including hospitals where separate wards were created.

Integration policy

The assimilation policy was replaced by integration policy in 1965. The principles underlying this policy represented a step away from the paternalism that had dominated since colonisation, aiming to give Aboriginal and Torres Strait Islander

peoples more control over their lives and society. However, in reality, it took some time to change paternalistic attitudes and practices and restore community control to the hands of Aboriginal and Torres Strait Islander peoples. It was not until 1967 that Australians voted to change the Constitution so that Aboriginal and Torres Strait Islander people would be legally counted in the Australian census, and be provided with the Commonwealth vote. It was just four decades ago, in 1969, that laws specific to Aboriginal and Torres Strait Islander people permitting the forcible removal of children from their families were formally repealed in every State and Territory.

Self-determination policy

In the 1970s, the integration policy evolved to give the opportunity for more genuine Aboriginal and Torres Strait Islander self-determination. The growing Aboriginal and Torres Strait Islander rights movement saw community control and self-management practices continue to expand and strengthen (NAHS, 1989). During this period, significant quantities of land were returned to its traditional owners via native title legislation. Importantly, many Aboriginal Community Controlled Health Services began to emerge across the nation. The first Aboriginal Medical Service was established in Redfern in the early 1970s, operating without government funding and staffed solely by volunteers (Dwyer et al., 2007). Over time, the number of Aboriginal and Torres Strait Islander Community Controlled Medical Services expanded to the 169 that exist today (National Aboriginal Community Controlled Health Organisation, 2010a).

Reconciliation policy

Towards the end of the 20th Century, Australian federal, state and territory governments moved towards reconciliation with Aboriginal and Torres Strait Islander peoples. The *Bringing Them Home* report into the Stolen Generation served as an important catalyst for change. The report concluded that the forcible removal of children was an act of genocide that was against the United Nations Convention on Genocide, which was ratified by Australia in 1949 (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children From Their Families, 1997). This report not only formally documented the mistreatment of Aboriginal and Torres Strait Islander peoples in Australia's past, but also served as a high profile call to action to change their story for the future.

Shared responsibility policy

Today, the shared responsibility of both governments and Aboriginal and Torres Strait Islander communities to Close the Gap is widely supported. The government commitment to address Aboriginal and Torres Strait Islander inequality and disadvantage was symbolised by Prime Minister Kevin Rudd's apology, and supported in practice by a series of national initiatives (outlined in more detail in Section 3.3).

Most importantly, Aboriginal and Torres Strait Islander leaders and communities are today empowered to change the future for themselves and for their families. These leaders play a crucial role in improving the lives of many Aboriginal and Torres Strait Islander peoples, working both independently and in collaboration with government and non-government agencies.

3.1.2 The significance of the historical context for this project

Most readers of this document will agree that the history briefly outlined above is not new to them. However, the purpose of including a short historical overview in this paper is to highlight the importance of the historical context to this project. There are three key ways in which the historical context is pertinent to this project.

Firstly, historical experiences have impacted upon the contemporary health needs of Aboriginal and Torres Strait Islander peoples. Experiences of trauma, grief, abuse, neglect and inequality have made a significant contribution to the burden of disease and mental illness experienced by Aboriginal and Torres Strait Islander peoples today. The social impact of these experiences is felt by the individuals that experienced them directly, and has also been transferred to other family members and subsequent generations. Past experiences are therefore a crucial factor contributing to the health needs of Aboriginal and Torres Strait Islander peoples.

Secondly, historical experiences have impacted upon the way in which Aboriginal and Torres Strait Islanders interact with health services and institutions today. For some, mainstream health services may have negative connotations associated with the history of racial segregation, institutional neglect, and the Stolen Generations. Consideration of the role of Aboriginal and Torres Strait Islander Health Workers in improving access to health care must therefore be cognisant of this historical background.

Thirdly, the historical journey highlights the continued movement of Aboriginal and Torres Strait Islander people to self-determination, community control and leadership. It is argued that previous failures by Government to adequately address Aboriginal and Torres Strait Islander health are the result of a lack of partnership with Aboriginal and Torres Strait Islander communities and a loss of self-determination (Townsend, 2008). The importance of Aboriginal and Torres Strait Islander leadership and empowerment therefore cannot be understated. The Health Worker workforce is a key element in Aboriginal and Torres Strait Islander empowerment and through this workforce engagement in improving the health status of Aboriginal and Torres Strait Islander peoples.

These three key points demonstrate the importance of understanding the historical context of this project in order to better inform the future direction of the Aboriginal and Torres Strait Islander Health Worker workforce.

3.2 The cultural context: why a focus on culturally appropriate health services is needed

An understanding of the cultural context is equally important. Differences between the culture of Aboriginal and Torres Strait Islander peoples and mainstream Australian culture can influence the accessibility of health care services. Furthermore, cultural and linguistic differences may affect the understanding of Western medical practices and the success rates of Western medical treatments and care plans for Aboriginal and Torres Strait Islander peoples. Failure to understand and accommodate the diverse cultural beliefs of Aboriginal and Torres Strait Islander communities is likely to result in inappropriate responses to their health care needs.

3.2.1 Overview of the cultural context

Aboriginal and Torres Strait Islander peoples are culturally, linguistically and ethnically diverse. There is a danger in making generalisations about the cultural beliefs of Aboriginal and Torres Strait Islander peoples, as they do not acknowledge the cultural differences between many Aboriginal and Torres Strait Islander communities and families.

However, certain core beliefs relating to “health” are common to many Aboriginal and Torres Strait Islander peoples. There are fundamental differences between these core

traditional beliefs and Western medicine beliefs. This is outlined in the excerpt below, which was drawn from the preface to the National Aboriginal Health Strategy published in 1989:

'Aboriginal culture is the very antithesis of Western ideology. The accent on individual commitment, the concept of linear time, the switch in focus from spiritual to worldly, the emphasis on possession and the pricing of goods and services, the rape of the environment and, above all, the devaluing of relationships between people, both within families and within the whole community, as the determinant of social behaviour, are totally at variance with the fundamental belief system of Aboriginal people.'

"Health" to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.

... In contemporary terms Aboriginal people are more concerned about the "quality of life". Traditional Aboriginal social systems include a three-dimensional model that provides a blue-print for living. Such a social system is based on inter-relationships between people and land, people and creator beings, and between people, which ideally stipulates inter-dependence within and between a set of relationships.'

(NAHS, 1989)

The excerpt above provides some insights into the differences in the belief systems of Aboriginal and Torres Strait Islander peoples and other Australians. Although this report does not intend to enter into in-depth discussion about these cultural differences, it is pertinent to consider several key points of difference.

Firstly, the concept of "health" for Aboriginal and Torres Strait Islander peoples is a more holistic concept than the Western understanding of health. It is not limited to the clinical domain. Instead, many Aboriginal and Torres Strait Islander peoples understand the concept of health to refer to physical, mental, emotional, environmental and spiritual wellbeing (Devanesen and Maher, 2003).

Secondly, it is important to recognise the value that Aboriginal and Torres Strait Islander peoples place upon interpersonal relationships (NAHS, 1989, Devanesen and Maher, 2003). This includes relationships within/between families and communities, and also extends to relationships with health care professionals. The level of engagement an Aboriginal or Torres Strait Islander individual has with health services may therefore depend upon the nature of their relationship with Aboriginal and Torres Strait Islander Health Workers and other health professionals employed there.

The value that Aboriginal and Torres Strait Islander peoples place upon holistic healthcare provision and interpersonal relationships is exemplified by a study conducted in Arnhem Land with the Yolgnu people (Harrington et al., 2006). The research found that the provision of nurturing, holistic health care was an important determinant of compliance with rheumatic fever prophylaxis. According to the results, the development of trusted relationships with health care professionals in a holistic service delivery setting were more important determinants of treatment compliance than the patient's biomedical understanding of their condition (Harrington et al., 2006).

Thirdly, traditional Aboriginal and Torres Strait Islander beliefs emphasise the interconnected causal factors of ill health (Maher, 1999). For some Aboriginal and Torres Strait Islander peoples, *'individual wellbeing is always contingent upon the effective discharge of obligations to society and the land itself'* (Maher, 1999, Morgan et al., 1997). For this reason, an Aboriginal or Torres Strait Islander individual may prioritise

their social responsibilities and obligations instead of their own health (Maher, 1999, Devanesen and Maher, 2003). According to the beliefs of some Aboriginal and Torres Strait Islander peoples, the causes of illness may also be attributed to supernatural intervention or sorcery (Maher, 1999, Devanesen and Maher, 2003). In other words, scientific explanations of the causes of disease may not carry as much weight for clients who have a different belief system than the one underpinning Western medical science. This may contribute to a lack of “compliance” with medical treatment plans developed by medical practitioners (McConnel, 2003, Humphery and Weeramanthri, 2001).

Fourthly, there are clear divisions between men's business and women's business in the traditional cultural beliefs of Aboriginal and Torres Strait Islander peoples. Any breach of gender divisions in the provision of health care is likely to cause great distress and 'shame' for Aboriginal or Torres Strait Islander individuals (Maher, 1999, Spencer and Schlemmer, 1997). This is relevant when considering the needs of Aboriginal or Torres Strait Islander patients, in addition to the needs of Aboriginal or Torres Strait Islander Health Workers from their place of employment.

The above points provide a simplified summary of long-standing and complex cultural beliefs. However, they highlight several key differences between the cultural belief system underpinning Aboriginal and Torres Strait Islander peoples' conceptualisation of health, and the cultural belief system that dominates mainstream health services. The purpose of highlighting these differences is not to suggest that one belief system is more legitimate than another. Rather, it emphasises the importance of appropriately navigating the intersection between Western medical practices and the cultural beliefs of Aboriginal and Torres Strait Islander peoples (Devanesen and Maher, 2003). Health care for Aboriginal and Torres Strait Islander communities needs to be culturally appropriate to generate better health outcomes (Standing Committee on Aboriginal and Torres Strait Islander Health, 2002). What works in mainstream health services is not always going to effectively meet the health and cultural needs of Aboriginal and Torres Strait Islander peoples.

3.2.2 The significance of the cultural context for this project

The importance of understanding the cultural needs of Aboriginal and Torres Strait Islander peoples when considering the Aboriginal and Torres Strait Islander Health Worker role and scope of practice cannot be overestimated. As outlined in more detail in Section 6.1, part of the Health Worker role is to contribute to the provision of culturally appropriate health care. This might involve performing a cultural brokerage and advocacy role for the client; an education and support role for health services and colleagues of Health Workers; or a community development and wellbeing role. The community mapping phase of this project should seek to understand the importance of these roles to improving the health status of Aboriginal and Torres Strait Islander peoples. In so doing, certain service delivery models involving Health Workers may be identified as being particularly effective in ensuring the cultural safety of their clients.

Cultural considerations are also relevant to the investigation of Health Workers in their own work environment, particularly in relation to team structures, supervisory practices and working relationships with other health professionals. Furthermore, the cultural context has implications for the development/maintenance of appropriate educational and career pathways for Health Workers. These issues are explored in more depth in Sections 4 and 5 respectively.

3.3 The national policy context

The above pages have demonstrated the significance of the historical and cultural context of this project. It is equally important to consider the national policy context.

This project is part of a number of steps towards addressing the inequality in health status between Aboriginal and Torres Strait Islander peoples and the broader population of Australia.

With this in mind, this section identifies some of the key policy initiatives that have shaped the current environment.

3.3.1 National Aboriginal Health Strategy (1989)

The National Aboriginal Health Strategy (NAHS), first published in 1989, represented a critical step forward in Australian Government policy relating to the health status of Aboriginal and Torres Strait Islander peoples (NAHS, 1989). Federal, State and Territory Governments collaborated with a Working Party comprising Aboriginal and Torres Strait Islander representatives and relevant experts.

The strategy paved the way for a collaborative, partnership-based approach to improving health outcomes for Aboriginal and Torres Strait Islander peoples. Emphasis was placed upon the importance of Aboriginal Community Controlled Health Organisations, which at the time were collectively the largest employer of Health Workers (NAHS, 1989).

NAHS advocated a holistic approach to health that recognised that Aboriginal people perceive health to encompass "all aspects of their life, including control over their physical environment, of dignity, of community self esteem, and of justice" (Anderson et al., 2000, Townsend, 2008).

The principles underlying NAHS have continued to influence future policies and reviews, including the Aboriginal and Torres Strait Islander Health Workforce National Framework (Standing Committee on Aboriginal and Torres Strait Islander Health, 2002).

3.3.2 National Aboriginal and Torres Strait Islander Health Worker Training Review (1999)

The Commonwealth Office for Aboriginal and Torres Strait Islander Health (OATSIH) commissioned a National Review of Training for Aboriginal and Torres Strait Islander Health Workers in 1999. This Review was undertaken by a collaborative partnership that included the Curtin Indigenous Research Centre (CIRC), Curtin Educational Research and Evaluation Consortium (CEREC), and Jojara and Associates.

The National Health Worker Training Review focused on issues pertaining to Health Worker training within the following five areas:

- The Role of the Health Worker;
- Planning;
- Coordination;
- Flexible Training Service Delivery; and
- Quality Issues.

The Review found that it was difficult to determine a national definition of Health Workers and their roles. A number of strategies were recommended to overcome this

issue, including ‘the introduction of the beginner/advanced practitioner model into clinical practice situations, and the clarification of core, extended and advanced roles’ (Curtin Indigenous Research Centre with Centre for Educational Research and Evaluation Consortium and Jojara & Associates, 2000). The Review also identified the need to clarify training and education pathways, develop greater incentives to study for the Health Worker role, and make training opportunities more accessible, flexible, and culturally appropriate (Curtin Indigenous Research Centre with Centre for Educational Research and Evaluation Consortium and Jojara & Associates, 2000).

3.3.3 Aboriginal and Torres Strait Islander Health Workforce National Framework (2002)

Informed by the recommendations of the National Aboriginal and Torres Strait Islander Health Worker Training Review, the Aboriginal and Torres Strait Islander Health Workforce National Framework was published in 2002. This Framework was developed by the Standing Committee on Aboriginal and Torres Strait Islander Health on behalf of the Australian Health Ministers’ Advisory Council (AHMAC) (Standing Committee on Aboriginal and Torres Strait Islander Health, 2002). The Framework reflected the principles set out in the 1989 National Aboriginal Health Strategy, and was informed by widespread consultations with stakeholders.

Also referred to as “The Yellow Book”, this document outlined strategies to achieve five objectives in relation to the Aboriginal and Torres Strait Islander Health Workforce, including:

Objective 1	Increase the number of Aboriginal and Torres Strait Islander people working across all the health professions
Objective 2	Improve the clarity of roles, regulation and recognition of Aboriginal and Torres Strait Islander Health Workers as a key component of the health workforce, and improve vocational education and training sector support for training for Aboriginal and Torres Strait Islander Health Workers
Objective 3	Address the role and development needs of other health workforce groups contributing to Aboriginal and Torres Strait Islander health
Objective 4	Improve the effectiveness of training, recruitment and retention measures targeting both non-Indigenous Australian and Indigenous Australian health staff working within Aboriginal primary health services
Objective 5	Include clear accountability for government programs to quantify and achieve these objectives and support for Aboriginal and Torres Strait Islander organisations and people to drive the process

The objectives and strategies outlined in the Yellow Book are being implemented at both the State/Territory and National levels. They will continue to have relevance to the reform process of the Health Worker workforce moving forward.

3.3.4 The Cultural Respect Framework 2004 – 2009 (2004)

The Cultural Respect Framework was developed on behalf of the Australian Health Minister’s Advisory Council (AHMAC) by the AHMAC Standing Subcommittee Aboriginal and Torres Strait Islander Health Working Party (Australian Health Ministers’ Advisory Council, 2004).

The Cultural Respect Framework has been developed as a guiding principle in policy construction and service delivery for utilisation by jurisdictions as they implement initiatives to address their own needs, in particular mechanisms to strengthen relationships between the health care system and Aboriginal and Torres Strait Islander peoples.

In the framework Cultural respect is defined as *“recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples.”*

The Cultural Respect Framework recognises that it is important to have strategies and initiatives across the range of dimensions including knowledge and awareness, skilled practice and behaviour, strong (customer and community) relationships, and equity of outcomes.

3.3.5 The Social Justice Report (2005)

The Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma, and the Human Rights and Equal Opportunities Council (HREOC), published the Social Justice Report in 2005. Although this report addressed broader issues of social justice, one of its primary focuses was the improvement of the health status of Aboriginal and Torres Strait Islander peoples.

The Social Justice Report called upon the Australian Government to work towards health status equality between Aboriginal and Torres Strait Islander peoples and other Australians within a generation (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005).

This report had a significant influence upon the subsequent agreement forged by the Council of Australian Governments (COAG) in 2008.

3.3.6 Council of Australian Governments National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (2008-2012)

Following the Social Justice Report, on 20 December 2007, the Council of Australian Governments agreed to establish a partnership between all levels of governments to work with Aboriginal and Torres Strait Islanders to close the gap in health status. This agreement was outlined in the *Statement of Intent*, which was signed by the Prime Minister and key Aboriginal and Torres Strait Islander and other Australian stakeholders on 20 March 2008. Parties to the *Statement of Intent* agreed to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander people and other Australians by the year 2030 (Council of Australian Governments (COAG), 2009).

On 29 November 2008, COAG signed the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* and committed \$1.57 billion over four years to improve Aboriginal health and wellbeing.

The COAG National Partnership Agreement on Closing the Gap includes five initiatives to improve health outcomes for Aboriginal and Torres Strait Islander peoples, as depicted in Figure 2 below.

Figure 2 - Initiatives of the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*

Initiative	Expected outcomes for Aboriginal and/or Torres Strait Islander peoples
1. Tackle smoking	Reduced smoking rate; and Reduced burden of tobacco related disease for Aboriginal and Torres Strait Islander communities.
2. Healthy transition to adulthood	Increased sense of social and emotional wellbeing; Reduced uptake of alcohol, tobacco and illicit drugs; Reduced rates of sexually transmissible infections; Reduced hospitalisations for violence and injury; and Reduced excess mortality and morbidity among Aboriginal and Torres Strait Islander men.
3. Making Indigenous health everyone's business	Improved multi-agency, multi-programme and inter-sectoral collaboration and coordination to meet the needs of Aboriginal and Torres Strait Islander families and communities; Improved access to targeted early detection and intervention programs by high need Aboriginal and Torres Strait Islander families; Reduced waiting times for health services; and Reduction in early mortality.
4. Primary health care services that can deliver	Implementation of national best practice standards and accreditation processes for Aboriginal and Torres Strait Islander health services delivering primary health care. Increased uptake of MBS-funded primary health care services by Aboriginal and Torres Strait Islander people; Improved access to quality primary health care through improved coordination across the care continuum, particularly for people with chronic diseases and/or complex needs; and Provision of improved cultural security in services, and increased cultural competence of the primary health care workforce.
5. Fixing the gaps and improving the patient journey	Reduced average length of stay in the long term; Improved level of engagement between Aboriginal and Torres Strait Islander patients, referred care providers and primary level providers (private or public) to deliver better follow up and referral processes; Improved long term stability in primary provider choice; Improved patient satisfaction with the care and patient journey (based on domains of concern to patients); and Reduced admissions and incomplete treatments for Aboriginal and Torres Strait Islander patients.

Australia is currently in the process of implementing the National Partnership Agreement. This process is being informed by the Commonwealth Implementation Plan (Council of Australian Governments (COAG), 2009).

A series of national reforms have been outlined in the Implementation Plan (Council of Australian Governments (COAG), 2009). These reforms represent system-level changes

to support combined efforts to close the gap in Aboriginal and Torres Strait Islander health outcomes, including:

1. National minimum service standards for all organisations providing primary health care services to Aboriginal and Torres Strait Islander populations
2. Improved quality of Aboriginal and Torres Strait Islander identification in demographic, health outcomes and administrative datasets
3. Infrastructures to support care transitions and linked records of Aboriginal and Torres Strait Islander patients between primary, in-patient and specialist services
4. Workforce: increase the number of Aboriginal and Torres Strait Islander people in the health workforce, and reform and improve the supply of the health workforce generally including the adoption of complementary workplace reforms
5. Cultural Security: Improved cultural security in health service delivery in all organisations providing care to Aboriginal and Torres Strait Islander people.

In an effort to close the health status gap, COAG has also funded a number of other Aboriginal and Torres Strait Islander health workforce initiatives. These include:

- Aboriginal and Torres Strait Islander Outreach Workers within the Divisions of General Practice (Australian Government Department of Health and Ageing, 2010b)
- A national network of Tackling Smoking and Healthy Lifestyle Workers to conduct anti-smoking campaigns in Aboriginal and Torres Strait Islander communities in 57 regions (Australian Government Department of Health and Ageing, 2010c).

A well as the continuation of the Healthy for Life Program targeting the burden of disease in Aboriginal and Torres Strait Islander mothers, babies and children; and in clients developing a chronic disease such as diabetes and heart disease (Winnunga Nimmityjah Aboriginal Health Service, 2007).

These initiatives may have several implications for the development of the Health Worker workforce. For example, people who might otherwise consider becoming a Health Worker may instead choose to become an Outreach Worker or a Healthy Lifestyle Worker. It is likely that the possibility of this occurring will be influenced by different qualification requirements, career pathway opportunities and relative salaries. These implications are discussed further in Section 11.1.

3.3.7 Council of Australian Governments agreement on Closing the Gap in Employment and Education (2008-2012)

The COAG Closing the Gap agreement does not only relate to health – it adopts a holistic approach to addressing Aboriginal and Torres Strait Islander disadvantage in Australia. For this reason, closing the gap in areas such as employment and education are equally important components of the COAG agreement.

The COAG National Indigenous Reform Agreement states that 'Individuals and communities should have the opportunity to benefit from the mainstream economy – real jobs, business opportunities, economic independence and wealth creation' (Council of Australian Governments, 2008). It also emphasises the importance of supporting Aboriginal and Torres Strait Islander peoples' transition pathways 'into schooling and into to work, post school education and training' (Council of Australian Governments, 2008).

The reform of the Health Worker workforce therefore aligns to the broader COAG commitment to close the gap in health, employment, and education. It will aim to provide better education and employment opportunities for Aboriginal and Torres Strait Islander peoples, enabling a strengthened response to Aboriginal and Torres Strait Islander peoples' health needs. As recognised by COAG, a holistic, integrated approach is required to have a real impact upon Aboriginal and Torres Strait Islander disadvantage.

3.3.8 National Primary Health Care Strategy

Australia's first national primary health care strategy was released in May 2010 by the Australian Government Department of Health and Ageing. *Building a 21st Century Primary Health Care System (Commonwealth of Australia)* provides the roadmap to primary health care reform and the establishment of Medicare Locals. Aboriginal Community Controlled Health Organisations are seen as important partners in this reform process. The strategy has four key priority areas for change:

1. Improving access and reducing inequity
2. Better management of chronic conditions
3. Increasing the focus on prevention
4. Improving quality, safety and performance.

All four areas are extremely pertinent for primary health care provided to Aboriginal and Torres Strait Islander people. The strategy provides particular emphasis on improving Aboriginal and Torres Strait Islander peoples' access to primary health care, particularly in relation to chronic disease management and early childhood development. The strategy proposes five building blocks to primary health care reform.

5. Regional integration
6. Information and technology including eHealth
7. Skilled workforce
8. infrastructure
9. Financing and system performance.

The supporting report to the strategy, *Primary Health Care Reform in Australia* provided a definition of primary health care for the Australian context (Australian Government Department of Health and Ageing, 2009):

"Primary health care is the socially appropriate, universally accessible scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes

*health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation"*³

The *Primary Health Care Reform in Australia* report emphasised the importance of comprehensive primary health care, as outlined in the definition above, to improving the health outcomes for Aboriginal and Torres Strait Islander people. It noted the valuable contribution of Aboriginal Health Workers in the delivery of comprehensive primary health care.

3.3.9 National Registration and Accreditation Scheme

The reform of the Aboriginal and Torres Strait Islander Health Worker workforce is occurring alongside a broader National Registration and Accreditation Scheme (NRAS) to regulate health practitioners and health students. In 2009, the Health Practitioner Regulation National Law Bill was passed. The key purpose of this policy is 'to protect the public by establishing a national scheme for the regulation of health practitioners and students' (Health Practitioner Regulation National Law Bill as enacted in participating jurisdictions).

The Bill outlined six objectives for NRAS, including:

1. to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
2. to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction;
3. to facilitate the provision of high quality education and training of health practitioners;
4. to facilitate the rigorous and responsive assessment of overseas-trained health practitioners;
5. to facilitate access to services provided by health practitioners in accordance with the public interest; and
6. to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

The regulation of ten health professions was consolidated under the National Registration and Accreditation Scheme (NRAS) on 1 July 2010. In addition, the Bill outlines plans for four partially regulated professions to be included within NRAS by 1 July 2012. These four partially regulated professions include:

- Aboriginal and Torres Strait Islander health practice
- Chinese medicine
- Medical radiation practice
- Occupational therapy

³ Definition developed by the Australian Health Care Research Institute for the ADGP Primary Health care Position Statement 2005, cited in Commonwealth of Australia, 2009, *Primary Health Care Reform in Australia*.

Some Aboriginal and Torres Strait Health Workers will be registered as Aboriginal and/or Torres Strait Islander Health Practitioners under the national scheme from 1 July 2012. In accordance with the principal purpose of the Health Practitioner Regulation National Law Bill 2009, it is likely that registration will only apply to Health Workers who perform services that carry a risk to public safety.

For the registration of Health Workers to occur, a number of crucial steps must first be undertaken. For example, the group of Health Workers that will be registered needs to be determined; national practice standards must be defined; and a regulatory body must be established. Although it is not the role of this Project to determine these requirements for national registration, the body of evidence that it will generate will inform the steps toward registration of Aboriginal and Torres Strait Islander Health Practitioners in July 2012.

3.4 Section summary

An understanding of the historical, cultural and policy context must be incorporated into any Health Worker workforce response to the health needs of Aboriginal and Torres Strait Islander peoples.

The post-colonial historical experiences of Aboriginal and Torres Strait Islander peoples have impacted upon their mental and physical health status, and also affected the way in which they interact with health services and institutions. Furthermore, the cultural distance between Aboriginal and Torres Strait Islander peoples and mainstream health services can influence the accessibility and appropriateness of health care.

The contribution that the Health Worker workforce makes to the delivery of culturally appropriate health services is therefore important. Health Workers are in a position to understand the lived experience of Aboriginal and Torres Strait Islander peoples, and provide a 'brokerage' or conduit relationship on behalf of the communities they serve and to the wider health system. Recent policy directions to close the health disparity gap, along with the current Aboriginal and Torres Strait Islander project, provide valuable opportunities to strengthen the roles of Health Workers within this contextual environment.

The role of Aboriginal and Torres Strait Islander Health Worker workforce delivering comprehensive primary health care within this historical, cultural and policy context will be explored further as part of the data collection and community mapping phases of the project.

Specifically, the data collection phase of the project will seek to explore:

- What is the role of the Health Worker in ensuring the cultural safety of Aboriginal and Torres Strait Islander people receiving health care services?
- How much importance does the Aboriginal and Torres Strait Islander community place on the cultural safety role performed by Health Workers?
- Do particular variables such as location (urban, regional, remote), unique health and cultural needs of local population, employing organisation or service delivery model effect this role and the importance placed on cultural safety?

The following section highlights the population distribution, burden of disease and health needs of Aboriginal and Torres Strait Islander people.

4. Health needs of Aboriginal and Torres Strait Islander peoples

One of the fundamental objectives of reforming the Health Worker workforce is to better respond to the health needs of Aboriginal and Torres Strait Islander peoples. The reform process must therefore be informed by a sound understanding of the population demographics and their unique health needs.

This section first outlines the demographic profile of the Aboriginal and Torres Strait Islander population. It highlights the young population structure and the fact that only one-quarter of the population live in remote or very remote locations.

The health status of Aboriginal and Torres Strait Islander peoples is also explored, drawing upon a considerable body of burden of disease and injury data. Although the wider Australian population enjoys some of the highest standards of health of any population around the world, the health status of Aboriginal and Torres Strait Islander peoples is comparatively very poor. Aboriginal and Torres Strait Islander peoples have a much higher disease profile than other Australians in relation to chronic disease, injury, social and mental wellbeing, and infant morbidity and mortality.

A significant proportion of this disease burden can be reduced by minimising risk factors such as smoking, drinking, drug use, physical inactivity, poor diet and domestic violence. The alignment of the Health Worker role to these needs is likely to contribute to closing the health status gap.

4.1 Demographic profile of the population

The demographic profile of the Aboriginal and Torres Strait Islander population in Australia is important to the process of understanding their health needs. The pattern of demand for Aboriginal and Torres Strait Islander health services across Australia is influenced by the size and geographic distribution of the population. Areas with a high concentration of Aboriginal and Torres Strait Islander peoples may have a higher level of demand for Health Worker services. Similarly, there are distinct needs for Health Workers in communities that are geographically isolated which have limited access to mainstream health services. An understanding of the key demographic characteristics, such as the age and gender break-down of the population, also informs health service planning.

The primary data source for this information is the Australian Bureau of Statistics (ABS). The most recent ABS Population Census was conducted in 2006. Any population statistics relating to years after 2006 are drawn from ABS population projections, given that the next Census is not due until 2011. These ABS data have been used to develop the demographic profile presented in this section.

4.1.1 Size of the population

The ABS estimates that there were 550,818 Aboriginal and Torres Strait Islander people living in Australia at 30 June 2009 (Australian Bureau of Statistics, 2009). This represents 2.5% of the total Australian population.

Of the Aboriginal and Torres Strait Islander population:

- 90% are Aboriginal;

- 6% are Torres Strait Islanders; and,
- 4% are of both Aboriginal and Torres Strait Islander descent.

In 2009, NSW had the largest Aboriginal and Torres Strait Islander population with 161,910 people (29%), followed by QLD with (28%), WA (14%) and the Northern Territory (12%). Victoria, Tasmania and South Australia had less than 7% of the Aboriginal and Torres Strait Islander population in each State; and less than 1% of the population lived in the ACT (Australian Bureau of Statistics, 2009).

These statistics are presented in Table 2 - Aboriginal and Torres Strait Islander Population in Australia at 30 June 2009, by jurisdiction (Table 2) below. Table 2 also provides information on the proportion of the total population in each jurisdiction that are Aboriginal and Torres Strait Islanders. Although just 12% of the Aboriginal and Torres Strait Islander population live in NT, this group constitutes 30% of the entire population in this State - a significantly high proportion in comparison to other Australian States and Territories.

Table 2 - Aboriginal and Torres Strait Islander Population in Australia at 30 June 2009, by jurisdiction

Jurisdiction	Aboriginal and Torres Strait Islander population	Proportion of the total Aboriginal and Torres Strait Islander population residing in jurisdiction (%)	Proportion of the total jurisdictional population that are of Aboriginal and Torres Strait Islander descent (%)
NSW	161,910	29.4	2.3
Qld	156,454	28.4	3.6
WA	74,859	13.6	3.4
NT	67,441	12.3	30.2
Vic	35,894	6.5	0.7
SA	29,775	5.4	1.8
Tas	19,641	3.6	3.9
ACT	4,599	0.8	1.3
Total	550,818	100.0	2.5

Source: ABS Experimental estimates and projections - Aboriginal and Torres Strait Islander Australians 1991 to 2021. Canberra, 2009

4.1.2 Geographic distribution of the population

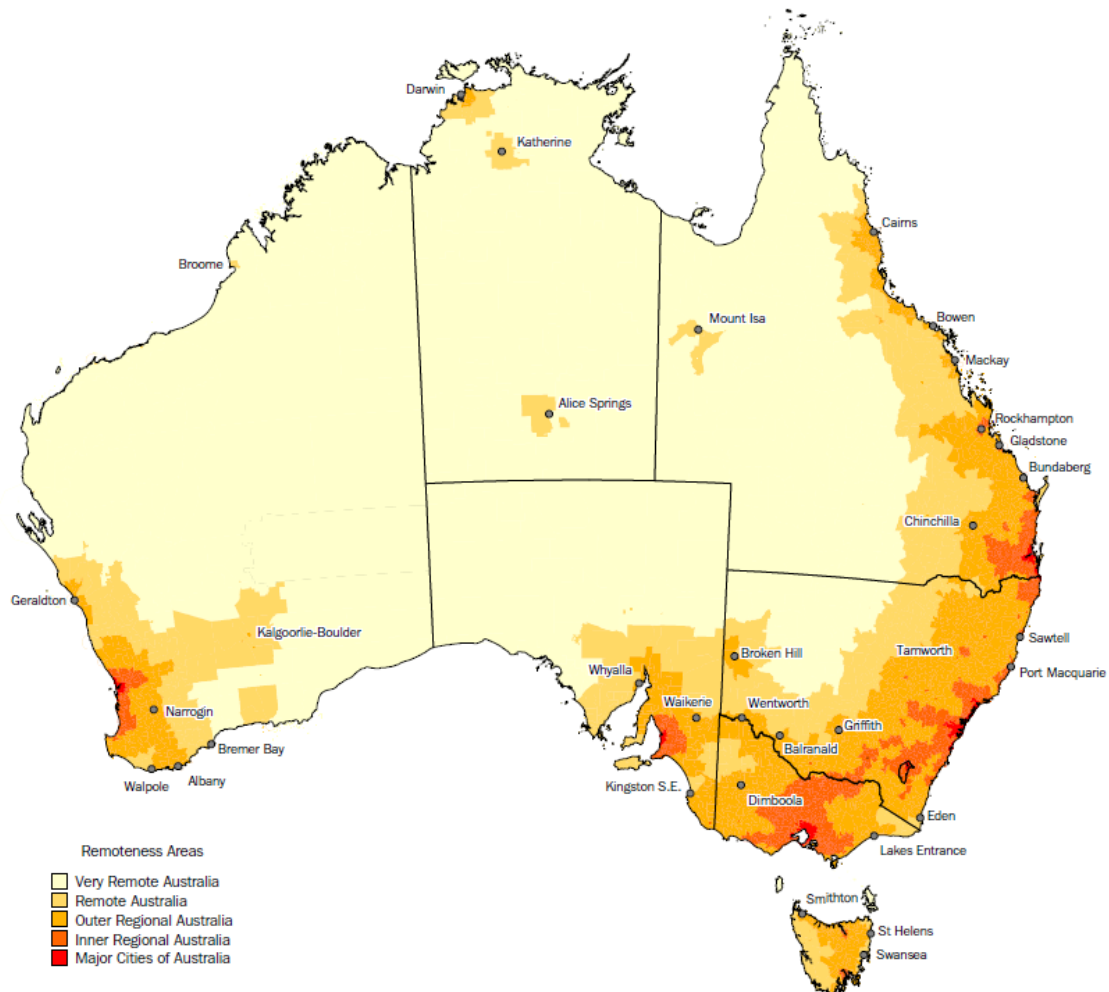
The geographic distribution of the population is highly relevant to the process of Health Worker workforce planning. There is significant variation between the health service needs of Aboriginal and Torres Strait Islander peoples living in urban centres in comparison to those living in remote communities. Some of the reasons for this variation may include the level of isolation from mainstream health services, the availability of health professionals, and the cultural appropriateness of the care provided.

The Australian Bureau of Statistics developed a system for classifying geographic locations by level of remoteness which is useful to population data analysis. The Australian Standard Geographical Classification (ASGC) includes five categories of remoteness, including:

1. Major Cities (e.g. Sydney, Brisbane, Melbourne, Adelaide)
2. Inner regional areas (e.g. Hobart, Port Macquarie)
3. Outer regional areas (e.g. Darwin, Tamworth)
4. Remote (e.g. Alice Springs, Broome)
5. Very remote (e.g. Torres Strait Islands)

The ASGC areas of remoteness are represented on the map of Australia below (Figure 3).

Figure 3 – Australia by areas of remoteness, ASGC Classification

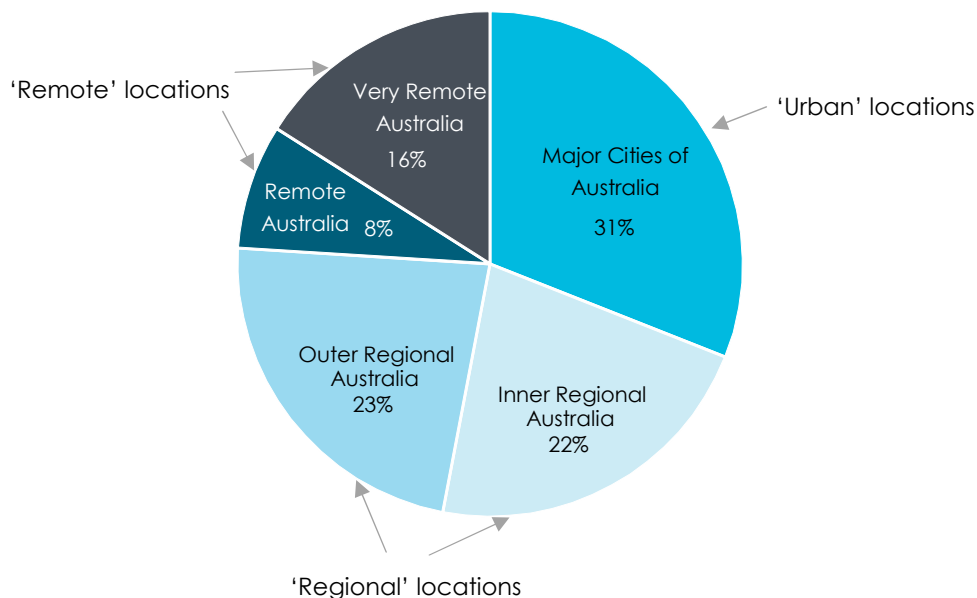


Source: ABS Census Paper 03/01, ASGC Remoteness Classification: Purpose and Use. Canberra.

The ASGC provides a useful framework for understanding the distribution of the Aboriginal and Torres Strait Islander population across Australia. ABS population data relating to ASGC classification is represented below in Figure 4. However, in parts of this Environmental Scan, the ASGC categories have been consolidated into three groups of remoteness for simplification purposes: urban, regional and remote. Locations that fall within the ASGC Category 1 are referred to as “urban” areas; locations within ASGC Categories 2 and 3 are referred to as “regional” areas; and locations within ASGC Categories 4 and 5 are referred to as “remote” areas.

According to the 2006 ABS Census, one third of the Aboriginal and Torres Strait Islander population has a usual place of residence in urban areas, such as Sydney, Melbourne or Brisbane. 45% of the population stated that their usual place of residence was in regional areas, and about one-quarter in remote or very remote parts of Australia. Half of Australia’s total population living in very remote areas are of Aboriginal and Torres Strait Islander descent (Australian Bureau of Statistics, 2006d).

Figure 4 – Distribution of Aboriginal and Torres Strait Islander population by ASGC remoteness classification in 2006.



Source: Population Distribution, Aboriginal and Torres Strait Islander Australians, 2006

*Note: Grey arrows indicate the consolidated classification group used in the context of this Project.

In the context of this Project, it must be recognised that the demand for services from Health Workers varies across Australia. The specific attributes or complexities associated with the delivery of services in an urban, regional or remote area are likely to influence the type of role performed by a Health Worker. For example, the role performed by a Health Worker in remote areas is likely to be affected by the specific health service needs of a low density, widely dispersed population that might be isolated from other health services.

In comparison, Health Workers located in urban areas are likely to have a different set of demands placed upon them. The proportion of the total population that is of Aboriginal or Torres Strait Islander descent is much lower in urban areas than in remote areas. There is a risk that Aboriginal and Torres Strait Islanders are less visible in the health system in urban areas. Therefore, although there may be a higher number of health services available to the urban population, it is not possible to assume that these services are appropriately designed to meet the unique health and cultural needs of Aboriginal and Torres Strait Islander peoples.

These types of demographic considerations are likely to affect the kind of role demanded of health workers in urban, regional and remote areas, and the model of care that is appropriate for a particular location. This will be explored in greater depth in Section 6.1.

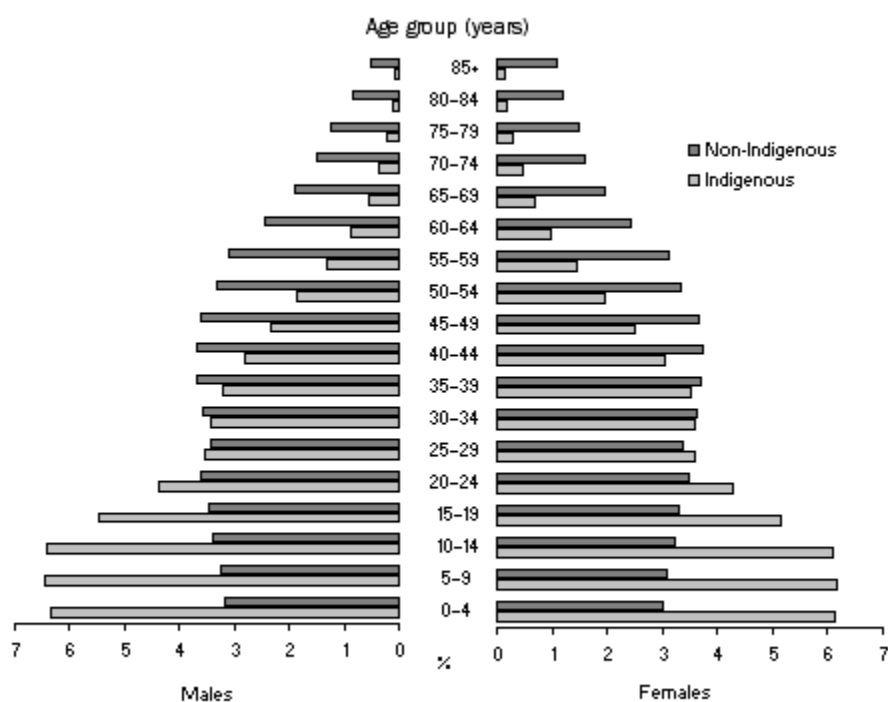
4.1.3 Population structure

The age and gender structure of the Aboriginal and Torres Strait Islander population varies significantly in comparison to that of the total Australian population.

Figure 5 demonstrates that the curve of the population age structure is visibly distinct for each population group (Australian Bureau of Statistics, 2006d). Clearly, there is a much younger distribution of the Aboriginal and Torres Strait Islander population than for mainstream Australia, with a large proportion of this population group aged between 0-24 years. This is in part a reflection of the lower life-expectancy of Aboriginal and Torres Strait Islander peoples. In comparison, the highest proportion of other Australians falls between the ages of 35-60 years. This can be partially attributed to a peak in birth rates after World War II, otherwise referred to as the Baby Boomer generation.

In general, the age structure of a population is a critical part of the process of understanding the health care needs of the population and in planning healthcare services. Typically, a health service that is designed to address the health needs of a younger population would focus upon disease prevention and treatment of acute illness. Alternatively, a health service targeting the needs of an older population would typically focus more upon the management of chronic illness. The age structure of the Aboriginal and Torres Strait Islander population must certainly be taken into account when designing health services that specifically target this population group. However, given the unique health needs of the Aboriginal and Torres Strait Islander population group, the age structure may have different implications than it does for the design of mainstream Australian health services.

Figure 5 – Population distribution: comparison of Aboriginal and Torres Strait Islander and other Australians, 2006



Source: Population Distribution, Aboriginal and Torres Strait Islander Australians, 2006

With regard to gender, there is not a large difference between Aboriginal and Torres Strait Islander population and the total Australian population. In 2006, 49.8% of the Aboriginal and Torres Strait Islander population was male, and 50.2% was female. These figures are similar for the non-Aboriginal or Torres Strait Islander population. The

difference only becomes significant in the 65+ age group, where there are much higher numbers of women than men in the Aboriginal and Torres Strait Islander population.

4.2 Health status of the Aboriginal and Torres Strait Islander population

The gap between the health status of Aboriginal and Torres Strait Islander peoples and the total Australian population is well-recognised. In order to determine the role of the Health Worker workforce in responding to the health status gap, it is necessary to understand the unique disease and injury burden of the Aboriginal and Torres Strait Islander population.

This section of the Environmental Scan provides an overview of the health status of Aboriginal and Torres Strait Islander peoples based on the learnings gained from existing research. It is divided into five segments – the first segment provides a discussion on the measurement of health needs, including a description of some of the key data limitations; the remaining four segments respectively focus on the disability-adjusted life years, mortality rates, causes of morbidity, and health risk factors of this population group.

4.2.1 Measuring health needs

Information on health needs and demand for health services forms a crucial platform for workforce planning. It is important to use an appropriate framework for measuring health needs to gain an accurate understanding of the causes and distribution of disease, injury and mortality within any population group. Ideally, valid mortality and burden of disease data is collected on a consistent and regular basis to highlight changes in health needs and predict future trends.

However, the process of measuring health needs is not straightforward and regularly depends upon the use of fragmented data sets. Some useful frameworks have been established to bring consistency to this process. The Disability-Adjusted Life Year (DALY) is one metric that is commonly used throughout the world to measure health outcomes. This metric, which was introduced in 1990 in the first Global Burden of Disease and Injury study, quantifies the burden of diseases, injuries and risk factors in a population (Murray and Lopez, 1996). One DALY can be thought of as one lost year of "healthy" life. The sum of DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability (World Health Organisation, 2010). The DALY metric enables consistent and comparable health data to be collected across the globe.

In the context of Aboriginal and Torres Strait Islander health, DALY data is not collected on a consistent or regular basis. The first and only comprehensive study of the burden of disease and injury in Aboriginal and Torres Strait Islander peoples was undertaken in 2003 (Vos et al., 2003). This study estimated the fatal and non-fatal burden of disease in the Aboriginal and Torres Strait Islander population, and also highlighted the key risks to health for this population group. The DALYs of Aboriginal and Torres Strait Islander peoples were assessed by comparing the findings from the study with estimates for the total Australian population from the same year (Begg et al., 2003). The results from both studies were quantified using the same measure with comparable methods. In so doing, it was possible to gain an evidence-based understanding of the gap between the health outcomes of Aboriginal and Torres Strait Islander peoples and other Australians for the first time.

The 2003 data provide the most detailed burden of disease study using the DALY method published to date. The study found that, in 2003, the Aboriginal and Torres Strait Islander population had a total burden of disease and injury that was two-and-a-half times that of the general Australian population (Vos et al., 2003). As yet the study has not been repeated using the same methodology.

Other studies of the Aboriginal and Torres Strait Islander health status indicate that the health gap persists today. For example, the Australian Institute of Health and Welfare (AIHW) publishes biennial reports on Australian Health (Australian Institute of Health and Welfare, 2010b). One section of these reports focuses on the health of Aboriginal and Torres Strait Islander peoples. Relevant information is also collected by the Australian Bureau of Statistics (ABS) in its census and population data and the ABS National Aboriginal and Torres Strait Islander Health Survey. A summary of available data from a range of sources was also published by the Australian Indigenous Health Infonet in 2009 – the *Overview of Australian Indigenous health* (Australian Indigenous Health Infonet, 2009). However, it is not possible to directly compare the findings of Vos et al.'s 2003 study with more recent data in order to identify changing trends because each study used different research methods and data sets.

The information on the health needs of Aboriginal and Torres Strait Islander people presented in this Environmental Scan is drawn from existing research, relying particularly on the sources outlined above. Although all available literature on the burden of disease and injury of Aboriginal and Torres Strait Islander peoples has been consulted, greater emphasis is placed upon sources that have adopted more robust research methodologies.

Data quality and limitations

There are some limitations in the quality of existing data relating to the burden and distribution of disease and injury in Aboriginal and Torres Strait Islander peoples. This has been acknowledged by those responsible for the research cited in this section, including the AIHW and the ABS (Australian Institute of Health and Welfare and Australian Bureau of Statistics, 2008).

The central issues relating to data quality that have been identified include:

- Under-identification of Aboriginal and Torres Strait Islander persons in health service records and death registrations;
- Statistical and practical challenges of surveying a population that is relatively small—2.5% of the total population—and one-quarter of whom (24%) live in remote or very remote areas.

These issues highlight the inevitable limitations of the data used for the purposes of this Environmental Scan.

However, there is an expectation that the quality of data relating to Aboriginal and Torres Strait Islander health will improve with time as a result of the COAG National Indigenous Reform Agreement (Council of Australian Governments, 2008). This agreement emphasises the need to improve data quality across a number of sectors including Aboriginal and Torres Strait Islander health.

The National Indigenous Reform Agreement: performance indicators for measuring health outcomes

The COAG partnership on Closing the Gap acknowledged the data limitations outlined above, which made it difficult to determine what progress was being made against the Close the Gap targets. Consequently, a framework for measuring progress was established under the National Indigenous Reform Agreement (Council of Australian

Governments, 2008). This framework includes certain performance indicators that specifically relate to the health outcomes of Aboriginal and Torres Strait Islander peoples. Figure 6 outlines the COAG performance indicators that are relevant to this Project. A more detailed explanation of the level of reporting, data source and baseline data to be used for each indicator is provided in the full COAG Reform Agreement.

Figure 6 – COAG Closing the Gap targets and performance indicators for improving health outcomes

Closing the Gap Target	Performance Indicators
Close the life expectancy gap within a generation	<ul style="list-style-type: none"> (a) Estimated life expectancy at birth (b) Mortality rate (and excess deaths) by leading causes (c) Hospitalisation rates by principal diagnosis (d) Rates of current daily smokers (e) Average daily alcohol consumption and associated risk levels; rates of alcohol consumption at long term risky to high risk levels (f) Levels of obesity – Body Mass Index (g) Level of Physical Activity (h) Access to health care compared to need <ul style="list-style-type: none"> – Percentage who accessed health care by type of service – Level of need for a health care service, by type
Halve the gap in mortality rates for Indigenous children under five within a decade	<ul style="list-style-type: none"> (a) Child under 5 mortality rate (and excess deaths) (b) Mortality rates (and excess) deaths by leading causes <ul style="list-style-type: none"> – Perinatal; – Infant; – 1-4 years; – 0-4 years; (c) Child under 5 hospitalisation rates by principal diagnosis (d) Proportion of babies born of low birthweight; (e) Tobacco smoking during pregnancy (f) Antenatal care <ul style="list-style-type: none"> – Proportion of mothers with antenatal care in first trimester – Proportion of mothers attending 5 or more antenatal care sessions

Source: Council of Australian Governments 2008. National Indigenous Reform Agreement.

In the context of the overall reform agenda, it is essential to consider these parameters throughout the development of the Health Worker workforce. The underlying purpose of strengthening the Health Worker workforce is to enable it to better respond to the health needs of Aboriginal and Torres Strait Islander peoples, thereby improving health

outcomes. Progress towards this goal will be partially assessed using the COAG performance indicators outlined above.

4.2.2 Overview of disability-adjusted life year (DALY) analysis

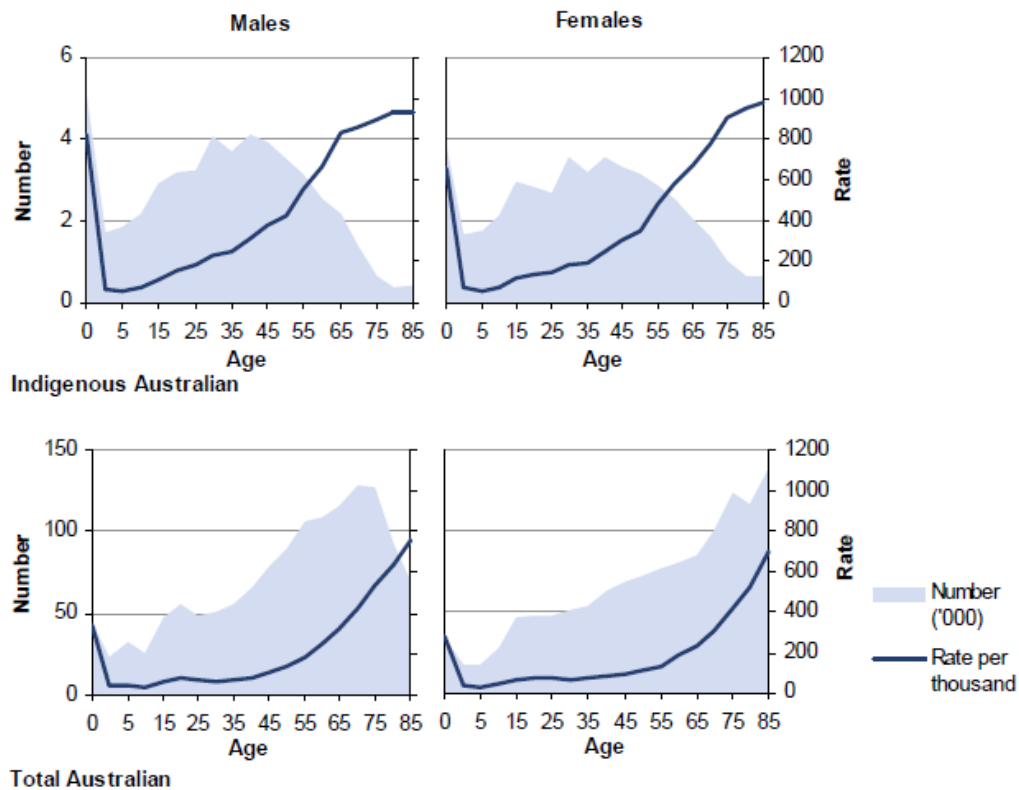
The Aboriginal and Torres Strait Islander population carries a disproportionate burden of disease in comparison to the total Australian population. One of the key findings from the Burden of Disease study conducted by Vos *et al.* was that, although Aboriginal and Torres Strait Islanders made up just 2.4% of the total Australian population in 2003, this group carried 3.6% of the burden of disease of the total Australian population (Vos *et al.*, 2003).

This study used the DALY metric to establish that:

- The majority of the absolute burden (number of DALYs) for Aboriginal and Torres Strait Islanders occurred in the middle-aged population
- There was a significant peak also occurring in the very young segment of the Aboriginal and Torres Strait Islander population
- In the Aboriginal and Torres Strait Islander population, the rate of burden increased at a much younger age than for the total Australian population. It also occurred at a considerably higher rate at each age for Aboriginal and Torres Strait Islander peoples than for the total Australian population
- A greater proportion of the Aboriginal and Torres Strait Islander peoples' health burden was due to premature mortality compared with the total Australian population.

These findings are represented in Figure 7 below.

Figure 7 – DALYs by age and sex expressed as rates and numbers, Aboriginal and Torres Strait Islander population (Indigenous Australian) and total Australian populations, 2003

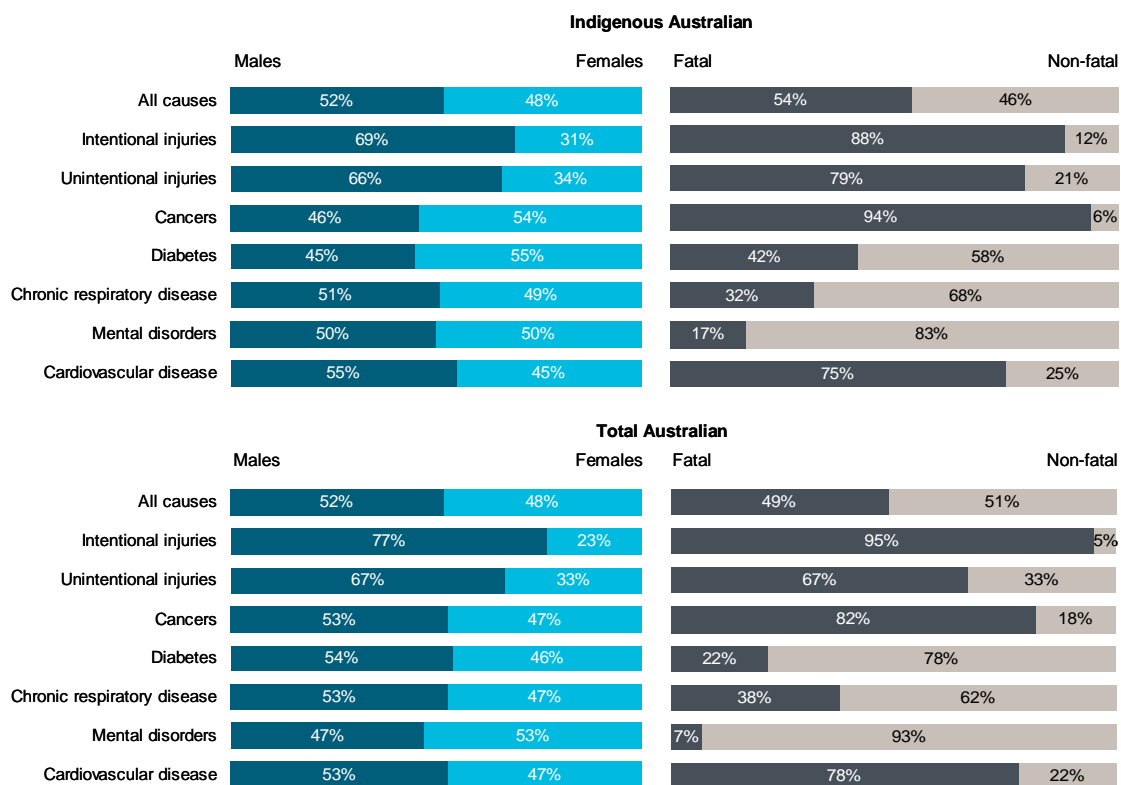


Source: Vos, T., et al. 2003. *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples*, Brisbane, School of Population Health, The University of Queensland.

The study identified that a greater proportion of the Aboriginal and Torres Strait Islander population's burden of disease resulted from premature mortality when compared with the total Australian population (as can be seen from Figure 8). Furthermore, the largest differentials in disease burden rates were for cardiovascular disease, diabetes mellitus, and intentional injuries in both males and females (Figure 9).

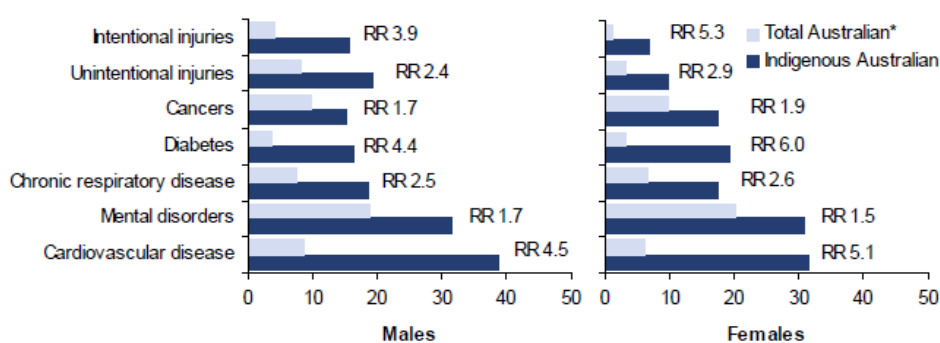
These findings are discussed further in the next three segments, which provide more detail in relation to mortality rates, the leading causes of death, and the factors contributing to disease and injury.

Figure 8 – DALYs by broad cause group expressed as proportions by sex, and proportions due to fatal and non-fatal outcomes, Indigenous Australian and total Australian populations, 2003



Source: Vos, T., et al. 2003. *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples*, Brisbane, School of Population Health, The University of Queensland.

Figure 9 – DALY rate per 1,000 and rate ratios for the leading broad cause groups by sex, Indigenous Australian and total Australian populations, 2003



* Age standardised to the total Indigenous Australian population, 2003
RR Indigenous Australian to total Australian rate ratio

Source: Vos, T., et al. 2003. *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples*, Brisbane, School of Population Health, The University of Queensland.

4.2.3 Mortality rates in the Aboriginal and Torres Strait Islander population

Adult mortality rates

The Aboriginal and Torres Strait Islander population has a much higher rate of mortality and a much lower life expectancy than the total Australian population. In 2003, the probability of dying between the ages of 15 and 60 was 33% and 23% for Aboriginal and Torres Strait Islander males and females, respectively. In comparison, the rates for the total Australian population were 10% and 6% (Vos *et al.*, 2003). Using these rates, Vos *et al.* estimated that the life expectancy at birth for Aboriginal and Torres Strait Islanders born between 1996 and 2001 was 64 years for males and 69 years for females.

More recent estimates from the ABS for those born between 2005 and 2007 indicate that Aboriginal and Torres Strait Islander males could be expected to live to 69.9 years, and females 72.6 years (Australian Bureau of Statistics, 2010). This is approximately 12 years less than other male Australians, and 10 years less than other female Australians.

However, it is important to note that although the ABS estimates are more recent, they should not be compared with the Vos *et al.* estimates because different methodologies were used. As mentioned earlier, there has not been a repeat of the study conducted by Vos *et al.*, and as such accurate trend data is not available.

In 2008, there were 2,472 deaths registered to people who were identified as being of (Australian Bureau of Statistics, 2010). However, many Aboriginal and Torres Strait Islander deaths are incorrectly identified as “non-Indigenous”. ABS data is drawn from the number of deaths that are registered for persons identified as being of Aboriginal and Torres Strait Islander descent. This is collected via State and Territory death registration processes. The completeness of the identification of Aboriginal and Torres Strait Islander Australians in these registration systems varies significantly across States and Territories. Because of this variation, care is required in making comparisons on the data. In recognition of this, the ABS estimates that the actual number of Aboriginal and Torres Strait Islander deaths is likely to be closer to 4,000 (Australian Bureau of Statistics, 2010).

Infant and childhood mortality rates

Despite the continuing high rate of Aboriginal and Torres Strait Islander infant mortality, the gap compared with other infants is narrowing. During the period between 1991 and 2005, a significant decline occurred in infant mortality for both Aboriginal and Torres Strait Islander infants and infants in the total Australian population Western Australia, South Australia and the Northern Territory (Australian Institute of Health and Welfare, 2008). Both the absolute and relative difference in mortality rates between Aboriginal and Torres Strait Islander and other infants declined significantly over this period. The rate of difference declined by 54% between 1991 and 2005 (from 19 per 1,000 births to 9 per 1,000 births over this period); and the ratio declined by approximately 30% from 4.3 in 1991 to 3.0 in 2005 (Australian Institute of Health and Welfare, 2008).

One of the most comprehensive studies into the mortality of Aboriginal and Torres Strait Islander infants, children and young people was undertaken in Western Australia in the period between 1980-2002 (Freemantle *et al.*, 2007). The first report published on this research focuses on measuring disparities in the trends of mortality of Aboriginal and Torres Strait Islander infants, children and young people in comparison with their non-Aboriginal peers.

The Report found that (Freemantle *et al.*, 2007):

- Of the total 3,713 infant deaths in WA that occurred between 1980 and 2002, 17% were of Aboriginal or Torres Strait Islander descent (629) (Freemantle *et al.*, 2007).

- Of the 629 Aboriginal or Torres Strait Islander infant deaths, 55% of were male and 45% were female; 47% were neonatal and 53% were postneonatal
- Teenage pregnancies were associated with high mortality rates, with 29% of Aboriginal births being to teenage mothers
- The main causes of mortality among Aboriginal and Torres Strait Islander infants were infection (29%), SIDS (27%), prematurity (16%) and birth defects (15%)
- In the most recent years included in the study, the relative risk compared with non-Aboriginal infants of death due to infection was 9 times higher, the risk of SIDS was nearly 8 times higher and there was an increase in the Cardio Magnetic Resonance due to the sequelae of prematurity
- Of deaths attributable to SIDS, 73% of Aboriginal infants were identified as co-sleeping at the time of death
- Aboriginal infants living in remote locations are significantly more likely to die due to birth defects and infection compared with Aboriginal infants in metropolitan locations
- 51% of Aboriginal mothers smoked, and in 60% of infant deaths mothers smoked during pregnancy.

The same Report also published a number of findings in relation to childhood mortality, referring to infant survivors that died before reaching their 23rd birthday. These findings include the following (Freemantle et al., 2007):

- 17% of the total 1,535 childhood deaths were Aboriginal
- The main cause of death among Aboriginal children – infection – is preventable
- The risk of death due to infection was 5 ½ times higher for Aboriginal and Torres Strait Islander male children than non-Aboriginal male children, and 6 ½ times more likely for female children
- Aboriginal and Torres Strait Islander young people aged between 13 and 23 years were over five times more likely than non Aboriginal to commit suicide.

Although this Report was not undertaken at the national scale, it does provide findings that are pertinent to the national understanding of the health needs of Aboriginal and Torres Strait Islander infants, children and young people. In particular, it is clear that a significant number of Aboriginal and Torres Strait Islander people under the age of 23 are dying from preventable causes. Importantly, there is an opportunity to influence the behavioural choices being made by some mothers in order to improve infant and childhood mortality rates.

4.2.4 Morbidity in the Aboriginal and Torres Strait Islander population

The diseases that cause the higher rates of mortality in the Aboriginal and Torres Strait Islander population must be understood to overcome the life expectancy gap. According to the 2003 study, the leading causes of disease in the adult Aboriginal and Torres Strait Islander population include (Vos et al., 2003):

1. Cardiovascular disease
2. Mental Disorders
3. Chronic Respiratory Disease
4. Diabetes
5. Intentional and unintentional injuries

Collectively, these five leading broad cause categories account for 63.7% of the total disease burden experienced by the Aboriginal and Torres Strait Islander population, as demonstrated in Figure 10 below (Vos et al., 2003). Considering that cancers also contribute to 8.1% of the disease burden, the top six cause categories account for over 70% of the total burden of disease. In order to improve health outcomes for Aboriginal and Torres Strait Islander peoples, it is essential to target these leading causes of disease. The top five diseases are discussed further below to gain a more detailed understanding of the impact that they have upon the population.

Figure 10 - Years Lived with Disabilities (YLD), Years of Life Lost (YLL) and Disability-Adjusted Life Years (DALYs) for top ten broad cause groups, Indigenous Australian population, 2003

Rank	Cause	YLD	Per cent of total	YLL	Per cent of total	DALY	Percent of total
	All causes	44,501	100.0	51,475	100.0	95,976	100.0
1	Cardiovascular disease	4,214	9.5	12,573	24.4	16,786	17.5
2	Mental disorders	12,335	27.7	2,525	4.9	14,860	15.5
3	Chronic respiratory disease	5,816	13.1	2,771	5.4	8,587	8.9
4	Diabetes	4,946	11.1	3,552	6.9	8,498	8.9
5	Cancers	466	1.0	7,351	14.3	7,817	8.1
6	Unintentional injuries	1,464	3.3	5,524	10.7	6,989	7.3
7	Intentional injuries	622	1.4	4,774	9.3	5,395	5.6
8	Nervous system and sense organ disorders	2,629	5.9	1,485	2.9	4,114	4.3
9	Neonatal causes	1,668	3.7	2,379	4.6	4,047	4.2
10	Infectious and parasitic diseases	1,682	3.8	2,114	4.1	3,796	4.0
	Other	8,660	19.5	6,427	12.5	15,087	15.7

Source: Vos, T., et al. 2003. *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples*, Brisbane, School of Population Health, The University of Queensland.

Cardiovascular Disease (CVD)

Cardiovascular disease (CVD) is omnipresent in the Aboriginal and Torres Strait Islander population. The most recent source of information on the occurrence of CVD in the Aboriginal and Torres Strait Islander population is the National Aboriginal and Torres Strait Islander Health Survey conducted in 2004-2005 by the ABS (Australian Bureau of Statistics, 2006e). Almost one-in-eight Aboriginal and Torres Strait Islander people reported having a long-term heart or related condition, with the proportion being slightly higher for those living in remote areas (14%) than in non-remote areas (11%)

(Australian Bureau of Statistics, 2006e). These proportions represent a slight, but not statistically significant, increase from those reported in the ABS National Health Survey in 2001.

After adjusting for differences in the age structures of the Aboriginal and Torres Strait Islander population and other Australians, heart and circulatory problems/diseases were approximately 1.3 times more common for Aboriginal and Torres Strait Islander than for other Australians (Australian Indigenous Health Infonet, 2009). Hypertensive disease was 1.5 times more common for Aboriginal and Torres Strait Islander people than for non-Indigenous Australians, and other diseases of the heart and circulatory system 1.2 times more common (Australian Indigenous Health Infonet, 2009).

When considering the difference between Torres Strait Islanders and Aboriginals, it was found that a lower proportion of Torres Strait Islander (9%) than Aboriginal people (12%) reported having a heart and circulatory problem/diseases. For Torres Strait Islanders living in the Torres Strait area, the proportion was 11% (Australian Indigenous Health Infonet, 2009).

Injuries

Injury from a variety of sources presents a significant burden of ill-health among Aboriginal and Torres Strait Islander people. However, assessing the total impact of injury is difficult. The vast majority of injuries do not result in hospitalisation or death and there are few systematic data on them other than those collected as part of population surveys, such as the ABS National Health Surveys. As a result, they may not be brought to the attention of health policy-makers and program managers (Australian Indigenous Health Infonet, 2009).

Understanding of the proximal factors contributing to most types of injury among Aboriginal and Torres Strait Islander peoples is limited, but the levels and types of injury need to be seen within a broad context including: disruption to cultural, environmental, and lifestyle variables; socioeconomic disadvantage; geographical isolation; increased road usage; exposure to hazardous environment(s); substance abuse; violence; social and familial dysfunction; risky behaviour; risky home environments; and limited access to health and social support services (Australian Indigenous Health Infonet, 2009).

In 2007-08, injuries were responsible for 19,919 hospital separations for Aboriginal and Torres Strait Islander people living in Qld, WA, SA, and the NT. Assault was the most frequent external cause of the hospitalisation of Aboriginal and Torres Strait Islander people for injury Australia-wide in the two year period July 2004 to June 2006, being responsible for 22% of Aboriginal and Torres Strait Islander male admissions for injury and for 32% of Aboriginal and Torres Strait Islander female admissions (Australian Indigenous Health Infonet, 2009). The numbers of admissions of Aboriginal and Torres Strait Islander people for assault were very much higher than the numbers expected from the rates of other Australians – 8 times higher for males and 35 times higher for females. Over the seven year period from 1998/99 to 2005/06, however, there was a significant decline in the hospitalisation rates for assault among Aboriginal and Torres Strait Islanders - a reduction of 16% for males and 9% for females (Australian Indigenous Health Infonet, 2009).

Diabetes

Type 2 diabetes represents a serious public health problem for Aboriginal and Torres Strait Islander people. Type 2 diabetes occurs at a much higher prevalence rate for Aboriginal and Torres Strait Islanders than in the non-Aboriginal and Torres Strait Islander Australian population, and with a much earlier age of onset of the disease and its micro- and macro vascular complications.

It is likely that diabetes is an important contributor to the considerably higher circulatory disease mortality rate among Aboriginal and Torres Strait Islander Australians at young ages (9–10 times higher in Aboriginal and Torres Strait Islander men aged 25–44 years, and 12–13 times higher in Aboriginal and Torres Strait Islander women aged 35–54 years). Thus, diabetes imposes significant financial and human costs on Australian society, which are disproportionately borne by Aboriginal and Torres Strait Islander individuals, families and communities (O'Dea et al., 2007).

Table 3 shows a comparison of Aboriginal and Torres Strait Islander people and other Australians reporting diabetes as a long-term health issue (Australian Bureau of Statistics, 2006e). From this information, it is clear that Aboriginal and Torres Strait Islanders aged between 25–34 years report 7.2 times the rate of high-sugar levels than other Australians in the same age group. Furthermore, 32% of Aboriginal and Torres Strait Islanders aged over 55 have high sugar levels, as do 21% of those aged 45–54 years. These figures are significantly higher than for the other Australian population.

Table 3 – Percentage of people reporting high sugar levels in Australia (ABS Census 2006)

Age group (years)	Aboriginal and Torres Strait Islander people	Other Australians	Ratio
15-24	1.0	0.5	2.0
25-34	4.3	0.6	7.2
35-44	10.0	2.0	5.0
45-54	20.7	4.0	5.2
55+	32.1	11.6	2.8

Mental Disorders

Despite the cultural importance of mental health to the wellbeing of Aboriginal and Torres Strait Islander communities, there are glaring deficiencies in our knowledge about mental health disorders in Aboriginal and Torres Strait Islander peoples. The deficiencies in knowledge are exacerbated by the complexity of the general area of mental health, in which diverse views exist and where terms are used in different ways (Australian Indigenous Health Infonet, 2009).

On the other hand, what we do know suggests that mental health presents a significant problem for the Aboriginal and Torres Strait Islander population, accounting for 15.5% of the total disease burden (Vos et al., 2003). The details of the mental health burden on this population group were poorly documented up until the 2004–2005 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) (Australian Indigenous Health Infonet, 2009). This survey included a module capturing eight aspects of social and emotional wellbeing (Australian Bureau of Statistics, 2006e). In so doing, it attempted to capture an Aboriginal and Torres Strait Islander holistic and whole-of-life view of social and emotional wellbeing, which includes mental health in addition to the impact of other factors on emotional wellbeing (Australian Indigenous Health Infonet, 2009).

According to the 2004–2005 General Social Survey conducted by the ABS, 77% of Aboriginal and Torres Strait Islander people experienced one or more significant stressors in the previous 12 months (Australian Bureau of Statistics, 2007). In comparison,

59% of the total Australian population reported one or more significant stressors in the 12 months preceding 2006 (Australian Bureau of Statistics, 2007). These comparisons are presented in Table 4 below (Australian Indigenous Health Infonet, 2009).

The findings clearly demonstrate that the Aboriginal and Torres Strait Islander population is under a substantial amount of stress. The proportion of the Aboriginal and Torres Strait Islander population that experienced the death of a family member or friend (42%) was almost twice that of the total Australian population. A third of the Aboriginal and Torres Strait Islander population has a serious illness or disability. One quarter experience an alcohol or drug related problem, which is almost three times the proportion of the total Australian population (8.6%). The proportion that have witnessed violence, had trouble with police or been subjected to discrimination is approximately four times higher for Aboriginal and Torres Strait Islander peoples than for the broader Australian population. These stressors have a significant impact upon the mental health and wellbeing of the Aboriginal and Torres Strait Islander population

Table 4 - Proportion (%) of stressors reported in previous 12 months, by Indigenous status, year and stressor type, Australia, 2004-2005 and 2006

Type of stressor	Aboriginal and Torres Strait Islander (2004-05)	Total population (2006)
Death of a family member or friend	42	23
Serious illness or disability	28	30
Not able to get a job	17	13
Alcohol or drug related problem	25	8.6
Overcrowding at home	17	-
Member of family sent to jail/in jail	19	-
Witness to violence	14	3.9
Trouble with police	16	3.9
Discrimination/racism	12	-
Any stressor	77	59

Note: The total population proportion for 'serious illness or disability' data has been estimated by adding proportions for the two sub-components, so may slightly overstate the true proportion.

Source: ABS 2007. *General social survey: summary results, Australia, 2006*. Canberra.

Respiratory Disease

Respiratory diseases represent a significant burden of ill-health and hospitalisation among Aboriginal and Torres Strait Islander people, particularly among very young and older people. The development of respiratory diseases is dependent on a number of contributing factors, including poor environmental conditions, socioeconomic disadvantage, risky behaviour (such as nicotine smoking), and previous medical condition.

Disease of the respiratory system was reported by 27% of Aboriginal and Torres Strait Islander people who participated in the 2004-2005 NATSIHS (Australian Bureau of Statistics, 2006e). These problems were reported more frequently by Aboriginal and Torres Strait Islander people living in non-remote areas (30%) than by those living in remote areas (17%). The proportions represent a slight decrease from those reported to the 2001 National Health Survey. With 15% of Aboriginal and Torres Strait Islander people reporting having asthma, it was the most commonly reported respiratory condition among Aboriginal and Torres Strait Islander people, and the second most commonly reported health condition. Asthma was reported more frequently by Aboriginal and Torres Strait Islander people living in non-remote areas (17%) than by those living in remote areas (9%) (Chang and Couzos, 2007).

Tuberculosis is found within the Aboriginal and Torres Strait Islander population largely due to overcrowded housing conditions, poor nutrition and poverty levels. Of the 885 notifications of tuberculosis among Australian-born people in Australia in 2002-2006, 174 (20%) were identified as being Aboriginal and Torres Strait Islander (Australian Indigenous Health Infonet, 2009). Almost one-half of the new cases occurring in people of Aboriginal and Torres Strait Islander descent were reported by the Northern Territory (83 cases), and around one-quarter by Queensland (45 cases) (Australian Indigenous Health Infonet, 2009). The Australia-wide crude incidence rate of 7.2 cases per 100,000 people in the Aboriginal and Torres Strait Islander population was almost 10 times the rate of 0.7 per 100,000 for other Australians. The crude incidence rate was highest for the Northern Territory (28 cases per 100,000 population) (Australian Indigenous Health Infonet, 2009).

Morbidity found in Aboriginal and Torres Strait Islander children

The health and wellbeing of Aboriginal and Torres Strait Islander children is one of Australia's most important priorities. Reflecting this, the Closing the Gap agreement emphasised the need to improve mortality and morbidity rates for Aboriginal and Torres Strait Islander children under five years old. However, limited data is available in relation to this population group specifically.

The data that is available sends a very clear message: Aboriginal and Torres Strait Islander children experience very high rates of preventable morbidity, which is not typical in a first world country. This is demonstrated in a study that was conducted in two remote Aboriginal communities in the Northern Territory. A retrospective review of clinical records was undertaken for the period between January 2002 and September 2005, which included 7,273 patient files (Clucas et al., 2008).

The top five reasons that children visited the two clinics are presented in Table 5. Respiratory Tract Infections are the main reason that children were presenting to the clinics, accounting for 43% of the total presentations. 18% of the presentations were due to skin sores and/or scabies, and 14% had diarrhoea. These causes of morbidity in Aboriginal and Torres Strait Islander children are inconsistent with the health conditions of a typical first world country, and they are also easily preventable. Therefore, the health outcomes of Aboriginal and Torres Strait Islander children can be significantly improved by undertaking prevention activities for these diseases.

Table 5 – Top five reasons for attendance for children in 2 remote NT clinics

Reason for Presentation	Number of Presentations	Percentage of Total Presentations
Respiratory Tract Infections (Upper and Lower)	3,092	43%
Skin Sores and/or Scabies	1,328	18%
Ear Disease	1,288	18%
Febrile Illness	1,082	15%
Diarrhoea	1,021	14%
Total overall Presentations*	7,273	

*(includes other morbidities not listed)

Source: CLUCAS, D., et al. Disease burden and health-care clinic attendances for young children in remote Aboriginal communities of northern Australia. Bull World Health Organ.

Note: Upper and Lower Respiratory Tract Infections for the purpose of this report as classified together as clinical differential is often difficult and is very susceptible to clinical error.

4.2.5 Key health risk factors in the Aboriginal and Torres Strait Islander population

The physical and social environments in which Aboriginal and Torres Strait Islander people live may affect their opportunities to live productive lives relatively free of serious illness. Some of this population group live in conditions of social and economic disadvantage. This fact, alongside other geographic, environmental and cultural factors, contributes to the poor health status outlined above (Productivity Commission, 2008).

More importantly, a number of distinct risk factors have been identified by the 2003 Burden of Disease study as having a causal correlation to the burden of disease experienced by Aboriginal and Torres Strait Islanders (Vos et al., 2003). 11 risk factors explained 37% of the total burden of disease experienced by this population group.

The 11 selected risks to health identified by Vos et al. include:

- Tobacco Use
- High body Mass
- Physical inactivity
- High blood cholesterol
- Alcohol
- High Blood Pressure
- Low fruit and vegetable intake
- Illicit drugs
- Intimate partner violence
- Child sexual abuse
- Unsafe sex

The DALYs that are attributable to these risk factors by broad cause group are presented in Table 6 (Vos et al., 2003). From this table, it is possible to see that eight of the risk factors were associated with Cancer, which explained 48.5% of the total Cancer burden. Ten risk factors are associated with Cardiovascular Disease, and explain 68.9% of the total burden of Cardiovascular Disease. Three risk factors are associated with Diabetes, and contribute to 68.8% of the Diabetes burden.

This research presents an opportunity to reduce the burden of disease by targeting common risk factors to prevent disease.

Table 6 – Individual and joint DALYs attributable to 11 selected risk factors by broad cause group, Indigenous Australian population, 2003

Cause	Cancer	CVD	Mental	Neurological	Injury	Diabetes	Other	All causes
Total burden	7,817	16,786	14,860	4,114	12,384	8,498	31,517	95,976
Attributable burden (%)^(a)								
Tobacco	34.6	33.0		-0.3	0.7		10.5	12.1
High body mass	3.2	31.3				63.2	0.1	11.4
Physical inactivity	4.7	29.9				31.2		8.4
High blood cholesterol		31.3						5.5
Alcohol								
Harmful effects	6.3	1.6	16.3		22.2		0.2	6.2
Beneficial effects		-4.8					>-0.1	-0.8
Net effects	6.3	-3.2	16.3		22.2		0.2	5.4
High blood pressure		26.3						4.6
Low fruit and vegetable intake	4.2	18.0						3.5
Illicit drugs		<0.1	12.9		3.6		2.8	3.4
Intimate partner violence	2.4	2.4	4.5	<0.1	7.5		0.9	2.6
Child sexual abuse	0.2	<0.1	6.7		2.7		0.1	1.4
Unsafe sex	4.5						2.6	1.2
11 risk factors combined^(b)	48.5	68.9	37.4	-0.3	32.6	68.8	16.2	37.4

Source: Vos, T., et al. 2003. *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples*, Brisbane, School of Population Health, The University of Queensland.

4.3 Section summary

The statistics on the burden of disease and health needs of Aboriginal and Torres Strait Islander people highlighted in this chapter are as stark as they are compelling. According to the most recent burden of disease study, although Aboriginal and Torres Strait Islanders make up just 2.4% of the total Australian population, they carry 3.6% of the burden of disease of the total Australian population (Vos et al., 2003).

The top five contributors to the burden of disease include cardiovascular disease, mental disorders, chronic respiratory disease, diabetes and injury. The risk of contracting the majority of these diseases is exacerbated by lifestyle choices including smoking, drinking, substance abuse, physical inactivity, poor diet and domestic violence.

Therefore, the incidence of a large proportion of the Aboriginal and Torres Strait Islander disease burden can be reduced through preventative, holistic approaches to health care. Health education and promotion activities provide an opportunity to affect behavioural choices that contribute to the incidence of disease. The alignment of the Health Worker role to these has clear potential to improve the health outcomes of Aboriginal and Torres Strait Islander peoples.

Demographic data also highlight the geographic population areas where the demand for Aboriginal and Torres Strait Islander health services is concentrated. When coupled with an understanding of the geographic distribution of health services (provided in the following chapter), this information paints the picture of where and how the Health Worker workforce should be distributed to best respond to the needs of the Aboriginal and Torres Strait Islander population.

Through key informant interviews, health worker/health manager surveys and community mapping activities, this project seeks to confirm the manner in which the Aboriginal and Torres Strait Islander Health worker workforce responds to the needs identified in this chapter.

In particular, these data collections methods will seek to provide further evidence to answer the following questions from a national perspective:

- How does the Health Worker scope of practice and role align to the health needs of Aboriginal and Torres Strait Islander peoples?
- How does the Health Worker workforce respond to the health service needs of Aboriginal and Torres Strait Islander peoples?
- Do particular variables (such as location, unique health and cultural needs of local population, employing organisation or service delivery model) affect the scope of practice, role and the manner in which Health workers respond to the health needs of communities?

5. Availability and accessibility of health services

When considering how the Health Worker workforce can better respond to the health needs of Aboriginal and Torres Strait Islander peoples, it is necessary to understand its contribution as one element of a broader health system. This approach better positions the Health Worker workforce to contribute to health service gaps and improve the accessibility of health services to Aboriginal and Torres Strait Islander peoples.

This section discusses the availability and accessibility of health services as two distinct concepts. Health service availability refers to the level and type of health services available and their geographic distribution. Aboriginal Community Controlled Health Services predominately deliver primary health care services, whilst mainstream health services are available at the primary, secondary and tertiary levels across the country.

However, just because a service is available does not mean it is accessible to Aboriginal and Torres Strait Islander peoples. A number of barriers may impede access, including issues of cultural safety, racial discrimination, access to transport and the costs of health care. The Health Worker role is integral to the process of reducing these access barriers.

5.1 The availability of health services

Discussion of the availability of health services must take into consideration both the level and type of health services available to Aboriginal and Torres Strait Islander peoples.

5.1.1 Level of health services available

It is important to be aware of the different levels of health services available in the health system because each level is crucial to improving health outcomes for Aboriginal and Torres Strait Islander peoples. Comprehensive primary health care, secondary and specialist care, and tertiary hospitals each contribute to the continuum of health care services. Aboriginal and Torres Strait Islander Health Workers may perform different roles at each of these different levels of the health care system.

Comprehensive primary health care

Comprehensive primary health care approaches are particularly important given the high burden of chronic disease in Aboriginal and Torres Strait Islander communities (Dwyer et al., 2007).

As defined in a report conducted by the Cooperative Research Centre for Aboriginal Health, for the purposes of Aboriginal and Torres Strait Islander health, comprehensive primary health care includes:

- Clinical care – including emergency care, treatment of acute illness and management of chronic conditions
- Population health programs – e.g. immunisation, screening programs for early detection of disease, specific health promotion activities
- Facilitation of access to secondary and tertiary care – including the improvement of linkages across a range of services that would otherwise be inaccessible to Aboriginal and Torres Strait Islander people, such as specialist medical care

- Client/community assistance and advocacy – including an advocacy role where health risk factors and health determinants fall outside the direct ambit of the health system (Dwyer et al., 2007, Shannon and Longbottom, 2004).

Considering the high incidence of chronic disease in Aboriginal and Torres Strait Islander communities, primary health care is a critical factor in improving health outcomes. Where the availability of primary health care is compromised, “people are more likely to present for care at a later stage when they are significantly sicker” (Dwyer et al., 2007). Later presentations reduce the likelihood of successful medical intervention in chronic diseases. This contributes to the incidence of mortality from chronic diseases which may have been prevented by earlier clinical intervention.

Primary health care services therefore provide a range of interconnected health services and also facilitate access to secondary and specialist health care services, enabling collaboration between the health sector and other sectors (Victorian Advisory Council on Koori Health, 2009). Cross-sector collaboration provides a more holistic approach to client needs, and can contribute to health education and promotion, community development and wellbeing.

Secondary and tertiary services

There is a very limited body of evidence available in relation to the role of an Aboriginal and Torres Strait Islander Health Worker workforce in the secondary and tertiary health care setting. Some hospitals use Hospital Liaison Officers and Indigenous Outreach Workers, but there is limited investigation of these roles specifically in the literature.

5.1.2 Benefits of a comprehensive primary health care system

The report supporting Australia’s first national primary healthcare strategy emphasises the benefits of comprehensive person-centred primary care. The health promoting influence of this model of care is particularly relevant for Aboriginal and Torres Strait Islander people. The World Health Report cited in *Primary Health Care Reform in Australia* (WHO, 2008, cited in 2009, Commonwealth of Australia) outlined key elements in person-centred primary care and compared these to conventional ambulatory medical care. These include:

- Focus on health needs - versus a focus on illness and cure alone
- Enduring personal relationships – versus a relationship limited to the period of consultation
- Comprehensive, continuous and person centred care - versus episodic curative care
- Responsibility for the health of all in the community along the life cycle & responsibility for tackling the determinants of ill health – versus a responsibility limited to safe and effective advice to the patient at the time of consultation
- People as partners in managing their own health and that of their community – versus users as consumers of the care they purchase.

Aboriginal and Torres Strait Islander representatives contributing to the consultation process during the development of the National Primary Health Care Strategy universally supported a holistic approach to primary health care for Aboriginal and Torres Strait Islander people. Submissions highlighted the greatest barrier to health care access as the availability of effective, culturally safe and timely services.

Griew et al. (2008) provided an analysis of the current research related to the link between primary health care and health outcomes for Aboriginal and Torres Strait

Islander Australians (Robert Griew Consulting, 2008). While noting the limited definitive data in the Australian context, Griew highlighted the evidence from overseas, specifically the large cross country study by the John Hopkins University, which highlight strong primary health care systems as being significantly associated with lowered infant mortality, improved infant birth weights and lower overall national health costs. Evidence for the United States and New Zealand suggests primary health care as a positive contributor to the narrowing of the life expectancy gap between indigenous and non-indigenous peoples in those countries, with poorer primary health care as being associated with a widening life expectancy gap.

A study of mortality and chronic disease trends of Aboriginal people in the Northern Territory (Robert Griew Consulting, 2008, Thomas and Condon, 2006) showed a related death rates as slowing and even for some conditions beginning to fall with these improvements being attributed to improved primary and specialist medical care.

5.1.3 Types of health services available

The types of health services that are available to Aboriginal and Torres Strait Islander peoples are often considered through two lenses: “mainstream” health services, which are available to the mainstream Australian population; and “Aboriginal and Torres Strait Islander Community Controlled” health services, which specifically target Aboriginal and Torres Strait Islander peoples. The distinction between mainstream and Community-Controlled health services is outlined below

Aboriginal Community Controlled Health Services

Most Aboriginal Community Controlled Health Organisations (ACCHOs) adopt a holistic approach to primary health care in their service delivery models. Aboriginal and Torres Strait Islander Community Controlled services are described by the National Community Controlled Health Organisation (NACCHO) as providing:

“...essential, integrated care based upon practical, scientifically sound and socially accepted procedures and technology made accessible to communities as close as possible to where they live through their full participation in the spirit of self reliance and self determination”

(National Aboriginal Community Controlled Health Organisation, 2008b).

The *Primary Health Care Reform in Australia* supported a greater emphasis on the role of Aboriginal Health Workers in the delivery of holistic primary healthcare, particularly within the Community Controlled Health Sector (Australian Government Department of Health and Ageing, 2009).

An example of the broad service offering of ACCHOs is provided by the Winnunga Nimmityjah Aboriginal Health Service in Canberra which delivers the following services (Winnunga Nimmityjah Aboriginal Health Service, 2007):

- GP services
- Psychiatric and psychology services
- Otitis Media
- Aboriginal Midwifery Access Program
- Dental Services
- Social Health (including programs such as: Bringing Them Home, Substance Misuse, Dual Diagnosis, Youth Detox, Child and Adolescent Mental Health, Carer Support, Alcohol and Other Drug Use, Social and Emotional Wellbeing, No More Bundah, Oz

Tag Touch Football, Indigenous Drug Action Week, Needle Syringe Program, Women's Gathering, Parenting Program, Grief and Loss Program, Home Maintenance Program)

- Healthy for Life
- Health Promotion
- The Opiate Project.

The large number and breadth of services offered by Winnunga Health Service is a feature of many ACCHOs across Australia. Alternatively, some ACCHOs focus on specific areas of health care or health promotion (Dwyer et al., 2007).

A search was conducted for information on the geographical distribution of Aboriginal Community Controlled health services in order to understand their availability of health services. The National Aboriginal Community Controlled Health Organisation (NACCHO) provides data on the number of member organisations connected with each of their state and territory affiliates. As shown in Table 7, in 2007 there were 169 member organisations recorded in 2007 (National Aboriginal Community Controlled Health Organisation, 2008a).

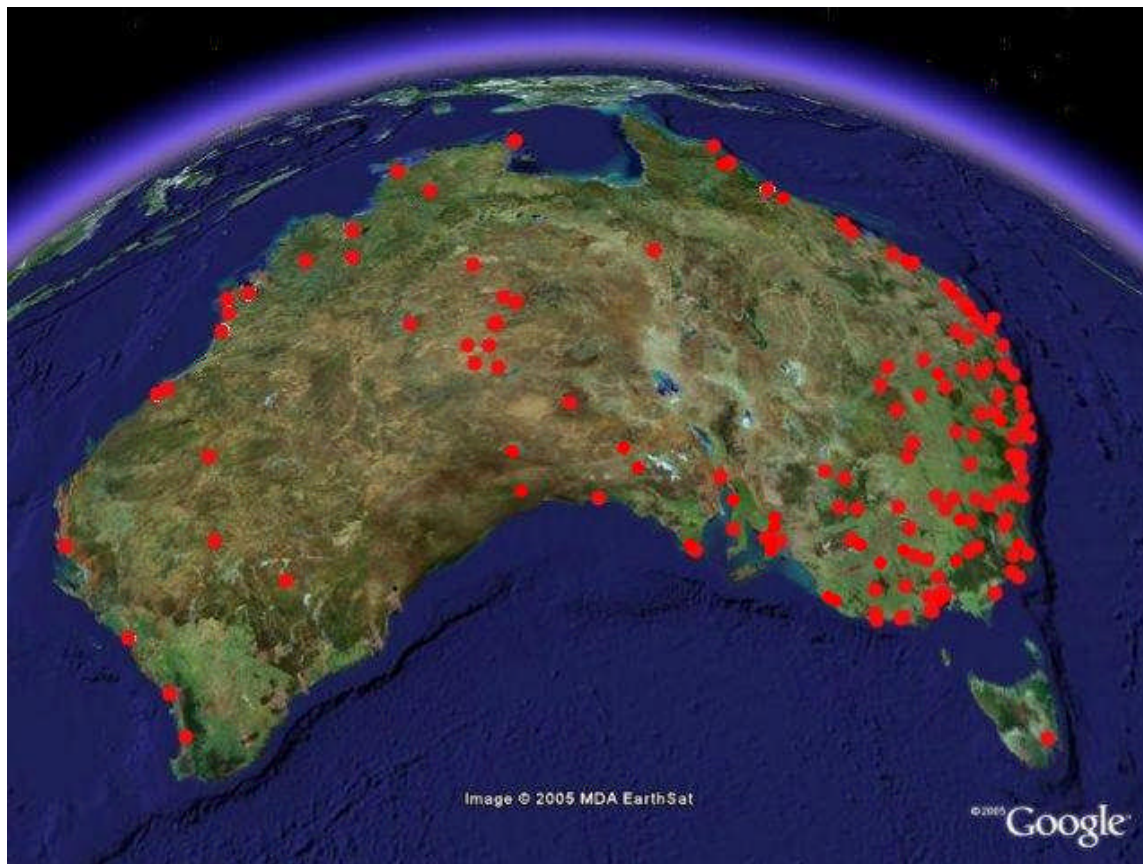
NACCHO also provides a map of the geographic distribution of these member organisations, as depicted Figure 11. This table and figure show that 35% of the Aboriginal Community Controlled Health Organisations in Australia are located in NSW; about 15% are in Northern Territory, and a further 15% in Victoria; approximately 12% are based in WA, SA and QLD; and the NACCHO affiliate organisations in the ACT and Tasmania do not have any additional members (National Aboriginal Community Controlled Health Organisation, 2008a).

Table 7 – Number of Aboriginal Community Controlled Health Organisations reported by NACCHO

NACCHO State and Territory affiliate organisation	State	Number of Community Controlled Health Services reported as members
Victorian Aboriginal Community Controlled Health Organisation (VACCHO) (Victorian Aboriginal Community Controlled Health Organisation, 2010b)	Vic.	24
Aboriginal Health & Medical Research Council of NSW (Aboriginal Health and Medical Research Council of New South Wales)	NSW	60
Queensland Aboriginal & Islander Health Council (QAIHC) (Queensland Aboriginal and Islander Health Council, 2010)	QLD	21
Aboriginal Health Council of Western Australia (AHCWA) (Aboriginal Health Council of Western Australia, 2010)	WA	19
Aboriginal Medical Services Alliance Northern Territory (AMSANT) (Aboriginal Medical Services Alliance Northern Territory, 2010)	NT	26
Aboriginal Health Council of SA Inc. (Aboriginal Health Council of SA Inc., 2010)	SA	19
Tasmanian Aboriginal Health Service (TAHS) (National Aboriginal Community Controlled Health Organisation, 2010b)	Tas.	0
Winnunga Nimmityjah Aboriginal Health Service	ACT	0
TOTAL		169

Source: NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION. 2008. *National Aboriginal Community Controlled Health Organisation: About Us* [Online]. Available: <http://www.naccho.org.au/aboutus/aboutus.html> [Accessed 23 June 2010].

Figure 11 – Map of Australia showing the geographical location of over 140 ACCHS – Members of NACCHO as of September 2007



Source: NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION. 2010. NACCHO: Our membership [Online]. Available: <http://www.naccho.org.au/aboutus/membership.html> [Accessed 14 November 2010].

A comparable map of Aboriginal Medical Services in Australia is also available from Health Infonet (Health Infonet, 2009). This distribution also aligns to the OATSIH records of health services funded in 2008-09, as presented in the OATSIH Services Reporting data (Australian Institute of Health and Welfare, 2010a).

Mainstream health services

Mainstream health care services are offered at different levels of the health care system.

Mainstream primary health care services include community clinics and GP clinics. These refer to both government and non-government run services, and comprehensive primary care services provided by some hospitals.

Many specialist health services are mainstream services; as are most (if not all) public and private hospitals. Given that Aboriginal and Torres Strait Islander Community Controlled Health Services are usually primary health care centres, Aboriginal and Torres Strait Islander peoples must inevitably use mainstream services for their specialist, secondary and tertiary care. Therefore, in considering the Health Worker role, it is important to be aware of the different contexts and demands placed upon them at different levels of the health care system.

There is a much higher quantity of information available in relation to the number and distribution of mainstream health services. This is provided on State and Territory Government websites, and also on the websites of Area Health Services at a more detailed level. A lot of this information is compiled for easy access on the Australian Health Map (ABC Health & Wellbeing, 2010).

The number of mainstream health services available in a given geographic location is influenced by its degree of remoteness. According to the Australian Institute of Health and Welfare, in 2002 there were 281 medical practitioners per 100,000 population employed in 'remote and very remote' areas compared with 312 per 100,000 in major cities (Australian Institute of Health and Welfare, 2006a). The most significant shortage of health professionals in 'remote and very remote' areas is of specialist clinicians where there were only 29 per 100,000 compared to 114 per 100,000 in major cities (Australian Institute of Health and Welfare, 2006a).

With regard to discrete Aboriginal and Torres Strait Islander communities, in 2001, 78% were located more than 50km from the nearest hospital, and 50% were located more than 25km from the nearest community health centre (Australian Institute of Health and Welfare, 2006a). Therefore the level of remoteness does have implications for the availability of mainstream health services.

However, just because mainstream health services are available to Aboriginal and Torres Strait Islander peoples does not mean that they are necessarily accessible. This concept is discussed in the following section.

Medical Specialist Outreach Assistance Program and Urban Specialist Outreach Assistance Program

Two key Australian Government Department of Health and Ageing initiatives to increase access to medical specialist services for Aboriginal and Torres Strait Islander peoples are the Medical Specialist Outreach Assistance Program (MSOAP) and the Urban Specialist Outreach Assistance Program (USOAP).

MSOAP was introduced in 2000 by the Australian Government Department of Health and Ageing to improve the access of rural and remote communities to medical specialist services (Australian Government Department of Health and Ageing, 2010d). MSOAP was designed to complement outreach medical specialist services provided by jurisdictional governments.

The COAG National Partnership Agreement on Closing the Gap in Indigenous Health in 2008, resulted in the MSOAP program receiving a significant funding increase to expand its programs. As part of the Indigenous Chronic Disease Package emerging from this agreement, \$54 million was allocated to MSOAP over a four year period. This has enabled MSOAP to expand to introduce multidisciplinary teams "to better manage complex and chronic health conditions in rural and remote Aboriginal and Torres Strait Islander communities" (Australian Government Department of Health and Ageing, 2010d).

USOAP was introduced to complement the expansion of MSOAP after the 2008 agreement. Whilst MSOAP focuses on rural and remote areas, USOAP focuses on urban areas. The USOAP program aims to:

- "Provide assistance to establish new and expand existing medical specialist outreach services that focus primarily on management and treatment of chronic disease, for Indigenous Australians in urban areas; and

- Provide and increase access to specialist medical care in primary settings that are culturally sensitive to the needs of Aboriginal and Torres Strait Islander peoples." (Australian Government Department of Health and Ageing, 2010a)

5.2 The accessibility of health services

Difficulty in measuring access to health services is not unique to Aboriginal and Torres Strait Islander peoples – it is a common issue faced by all health services. Research has indicated that there is currently no 'gold standard' to measuring access, with new approaches constantly being developed to reflect the changes in the delivery of services (Whitmore, 1997). According to the definition already mentioned above, access refers to 'the extent to which individuals receive necessary medical care, determined by the rates of persons who use specific services in the population' (Manitoba Centre for Health Policy). This definition has guided the discussion presented in this segment.

The access to mainstream health programs and funding streams of Aboriginal and Torres Strait Islander people has been the basis of a number of studies. The 2006 Urbis Keys Young report on the utilisation of the MBS and PBS as measures of health access demonstrated despite a large number of reforms and initiatives since 1997 few Indigenous Australians obtain the full appropriate benefits of the schemes. The report noted further work was required to enhance voluntary identification, increase utilisation of the enhanced primary care Medicare items and truly measure primary care and medical specialist (Urbis, Keys, Young, Indigenous Access – Final Report, 2006)

In order to gain insights into the degree to which the health needs of Aboriginal and Torres Strait Islander peoples are met by available health services, several different data sets have been considered and compared where appropriate. These data have been collected from the following sources:

- *Australian Bureau of Statistics – Population and Housing Census 2006.* This source provides data in relation to:
 - a) the population distribution of Aboriginal and Torres Strait Islander peoples
 - b) the geographic distribution of the Aboriginal and Torres Strait Islander Health Worker workforce
 - c) the level of unmet need for health services, as referred to by COAG in their 2010 National Healthcare Agreement baseline report (Australian Bureau of Statistics, 2006b, Council of Australian Governments Reform Council, 2010)
- *Australian Institute of Health and Welfare – Health and Community Services Labour Force 2006 Online data tables.* This source provides data in relation to the distribution of the health workforce. Note that the AIHW sourced their data from the ABS prior to undertaking AIHW analysis (Australian Institute of Health and Welfare, 2006b).
- *OATSIH Services Reporting data from 2008-09.* This information relates to the service activity of Aboriginal and Torres Strait Islander health services funded by OATSIH (Australian Institute of Health and Welfare, 2010a).
- *Medicare Benefits Schedule data.* This information provides some insights into the number of health services claimed on MBS (Medicare Australia, 2010).

The most recent available data has been considered. In some cases, such as the ABS / AIHW information, the most recent data is from 2006. There are therefore some limitations with respect to the currency of some of the data.

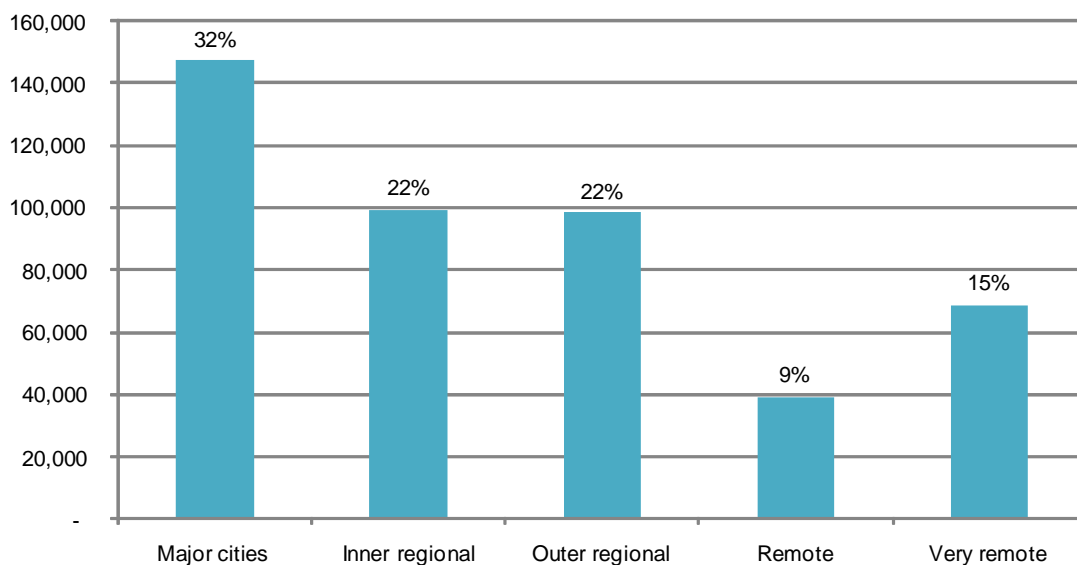
When considering these data, it was useful to compare accessibility across areas of remoteness and also by jurisdiction, given the vast contextual differences that exist. Where possible, both types of analysis have been performed on available data. However, some sources did not provide data by area of remoteness and have been therefore only been considered from a jurisdictional perspective.

5.2.1 Primary health care accessibility by area of remoteness

This section analyses data relating to primary health care accessibility by area of remoteness⁴. One of the key findings is that, although the *availability* of mainstream health care services increases in urban areas, there is a *higher level of unmet need* for Aboriginal and Torres Strait Islander peoples in the same areas. More importantly, there is a higher concentration of Aboriginal and Torres Strait Islander people in urban or regional areas where the level of unmet need is greatest. These findings have implications for the future allocation of health services targeting Aboriginal and Torres Strait Islander peoples and the Health Workers workforce.

Below is the population distribution as reported by the ABS in the 2006 Census of Population and Housing.

Figure 12 - Aboriginal and Torres Strait Islander population distribution: usual address reported by area of remoteness



Data source: Australian Bureau of Statistics 2006. Census of Population and Housing. Canberra.

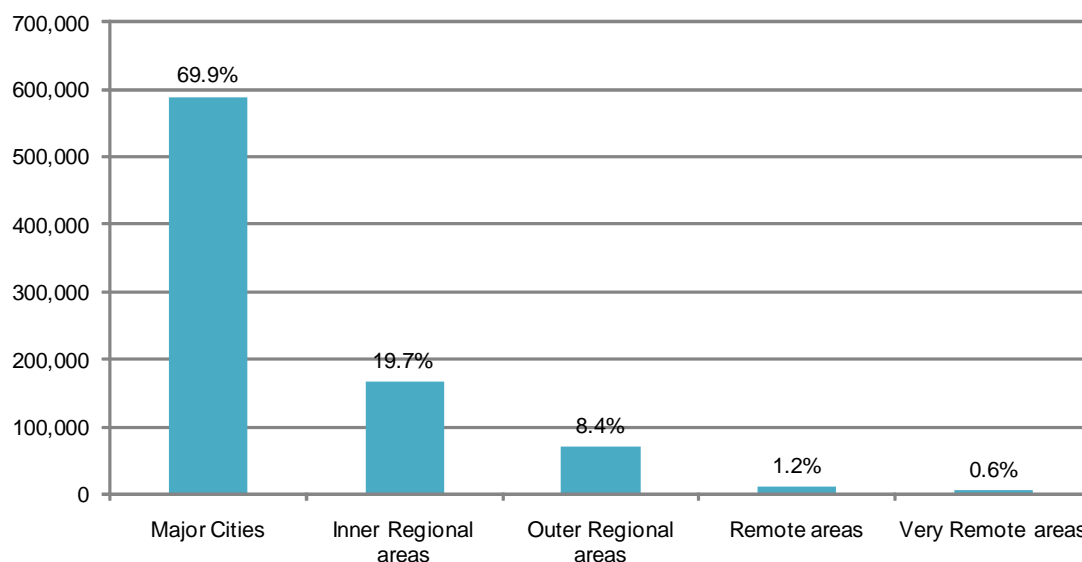
Note: Aboriginal and Torres Strait Islander persons that reported their housing status as 'migratory' or as having 'no usual address' are excluded from this graph, representing 0.03% and 0.32% of the total population respectively.

Comparing this with data on health service availability shows that mainstream services have a higher level of availability the closer they are to metropolitan areas. This pattern

⁴ The ABS Australian Standard Geographic Classifications are used throughout this data (ASGC). The ASGC classification defines remoteness using five categories: major cities, inner regional, outer regional, remote and very remote.

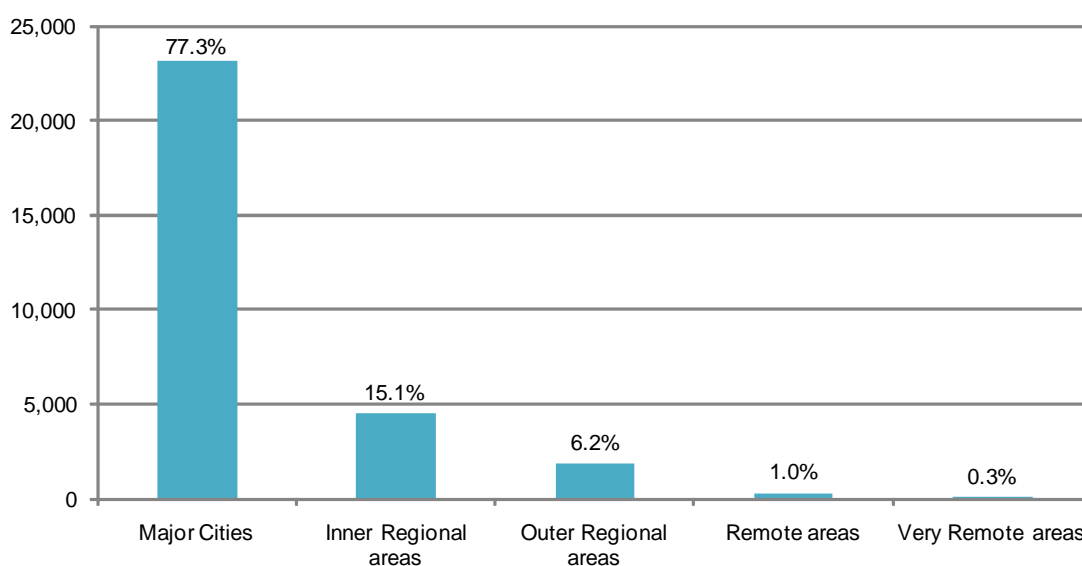
is reflected in data relating to the distribution of the overall health and community services workforce (Figure 13), in addition to the specific professions of general practitioners (Figure 14) and midwifery and nursing (Figure 15).

Figure 13 - Distribution of Health and Community Services Occupations in 2006: by area of remoteness



Data source: AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE. 2006. *Health and Community Services Labour Force 2006: Online data tables* [Online]. Available: http://www.aihw.gov.au/publications/index.cfm/title/10677#detailed_tables [Accessed 13 December 2010]. (NB. AIHW data sourced from: Australian Bureau of Statistics 2006. *Census of Population and Housing*. Canberra).

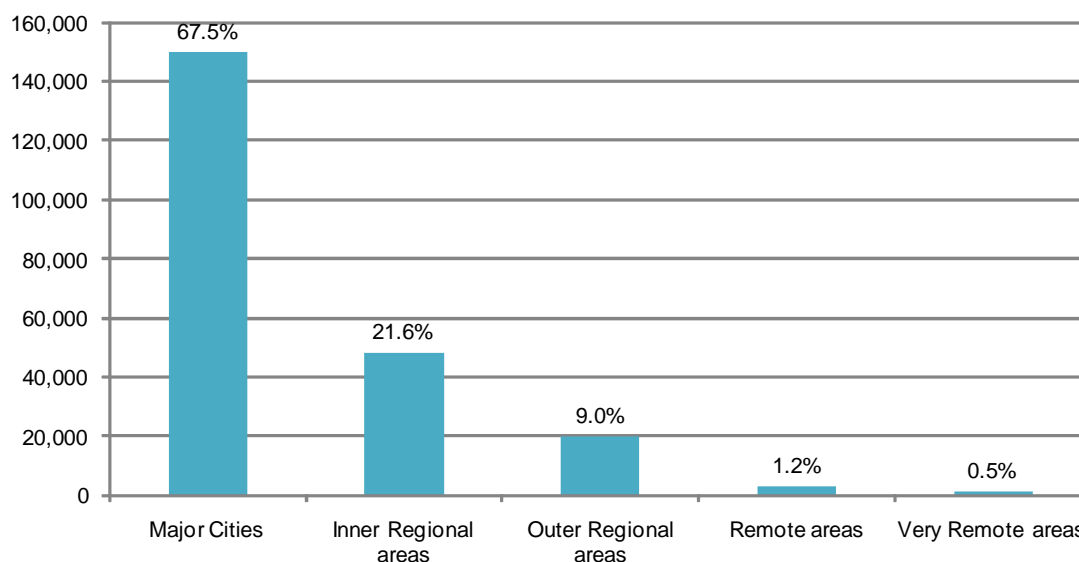
Figure 14 - Distribution of General Medical Practitioners in 2006: by area of remoteness



Data source: AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE. 2006. *Health and Community Services Labour Force 2006: Online data tables* [Online]. Available:

http://www.aihw.gov.au/publications/index.cfm/title/10677#detailed_tables [Accessed 13 December 2010].
(NB. AIHW data sourced from: Australian Bureau of Statistics 2006. Census of Population and Housing. Canberra).

Figure 15 - Distribution of midwifery and nursing professions in 2006: by area of remoteness



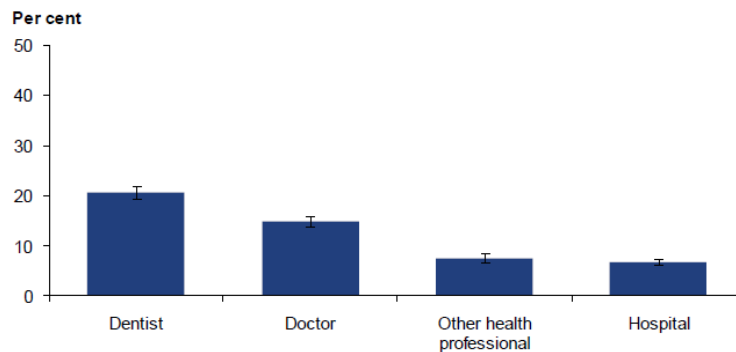
Data source: AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE. 2006. *Health and Community Services Labour Force 2006: Online data tables* [Online]. Available: http://www.aihw.gov.au/publications/index.cfm/title/10677#detailed_tables [Accessed 13 December 2010].
(NB. AIHW data sourced from: Australian Bureau of Statistics 2006. Census of Population and Housing. Canberra).

However, consideration of reported levels of unmet need contrasts with this pattern of health service availability. An investigation in relation to health service accessibility for Aboriginal and Torres Strait Islander peoples, drawing from ABS data, was conducted as part of the COAG Baseline Performance Report for the National Healthcare Agreement (Council of Australian Governments Reform Council, 2010). In this report, the level of unmet need in the Aboriginal and Torres Strait Islander population was assessed by comparing health service activity with health needs.

The findings demonstrate that a high proportion of Aboriginal and Torres Strait Islanders were not receiving the medical care they needed in 2006 (Council of Australian Governments Reform Council, 2010). The data reported were based on self-assessed need, which may under- or over-represent the actual health need of an individual. As depicted in Figure 16 below, the report found that:

- 21% of Aboriginal and Torres Strait Islander Australians reported not seeing a dentist when needed
- 15% per cent did not see a doctor when needed
- 8% per cent did not see another health professional when needed
- 7% per cent did not go to the hospital when needed (Council of Australian Governments Reform Council, 2010).

Figure 16 - Proportion of Aboriginal and Torres Strait Islander Australians with unmet need for healthcare services, by type of service, 2004-05

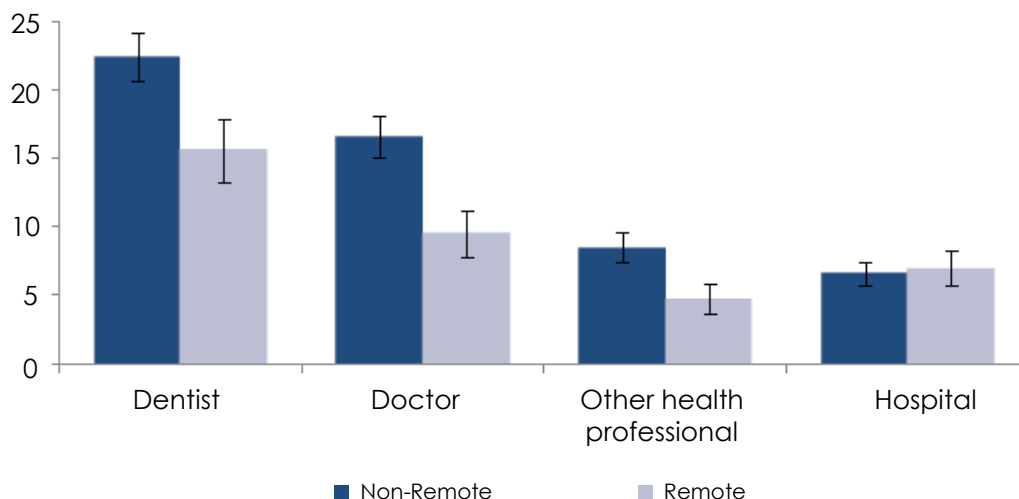


Source: COAG Reform Council 2010. *National Healthcare Agreement: Baseline performance report for 2008-09*.

From this information, it is clear that health services are not always accessible for Aboriginal and Torres Strait Islander peoples. One-fifth of the Aboriginal and Torres Strait Islander population does not receive the necessary care they need from a doctor.

When considering this information from the perspective of ASGC locations, it is clear that there is a significant difference in accessibility between Aboriginal and Torres Strait Islander peoples based in remote and non-remote areas (see Figure 17). Aboriginal and Torres Strait Islanders in *non-remote* areas actually have a *higher* level of unmet need than those living in remote areas (Council of Australian Governments Reform Council, 2010). This challenges the assumption that a greater availability of health services equates to a greater level of accessibility. Although there may be fewer health services located in remote areas, it appears that they might be better able to meet the needs of Aboriginal and Torres Strait Islander peoples than those in non-remote parts of Australia.

Figure 17 – Unmet need for health services, Aboriginal and Torres Strait Islander Australians, by remoteness, 2004-05



Notes: 1. The data shown in this figure include 95 per cent confidence intervals indicated by error bars.

Source: COAG Reform Council 2010. *National Healthcare Agreement: Baseline performance report for 2008-09*; ABS (unpublished) *National Aboriginal and Torres Strait Islander Health Survey 2004-05*.

This finding is reiterated by the National Aboriginal and Torres Strait Islander Health Survey conducted by the ABS in 2004/05. The survey identified that Aboriginal and Torres Strait Islander people living in remote areas were around four times as likely as those living in non-remote areas to use Aboriginal medical services (66% compared with 17%) or to go to hospital (16% compared with 3%) (Australian Bureau of Statistics, 2006e, Steering Committee for the Review of Government Service Provision, 2009a).

Interestingly, although those living in remote areas were more likely to receive health care, they were less likely to seek out this health care themselves when they needed it (2% in remote areas compared to 1.2% in non-remote areas) (Australian Bureau of Statistics, 2006e). This might suggest that the health services that are available in remote areas are more proactive in addressing the needs of Aboriginal and Torres Strait Islander peoples than health services in non-remote areas.

Emerging from these data is one key question: why do health services in remote areas seem to be more accessible to Aboriginal and Torres Strait Islander peoples than health services in urban areas? There are a number of factors that could influence these findings.

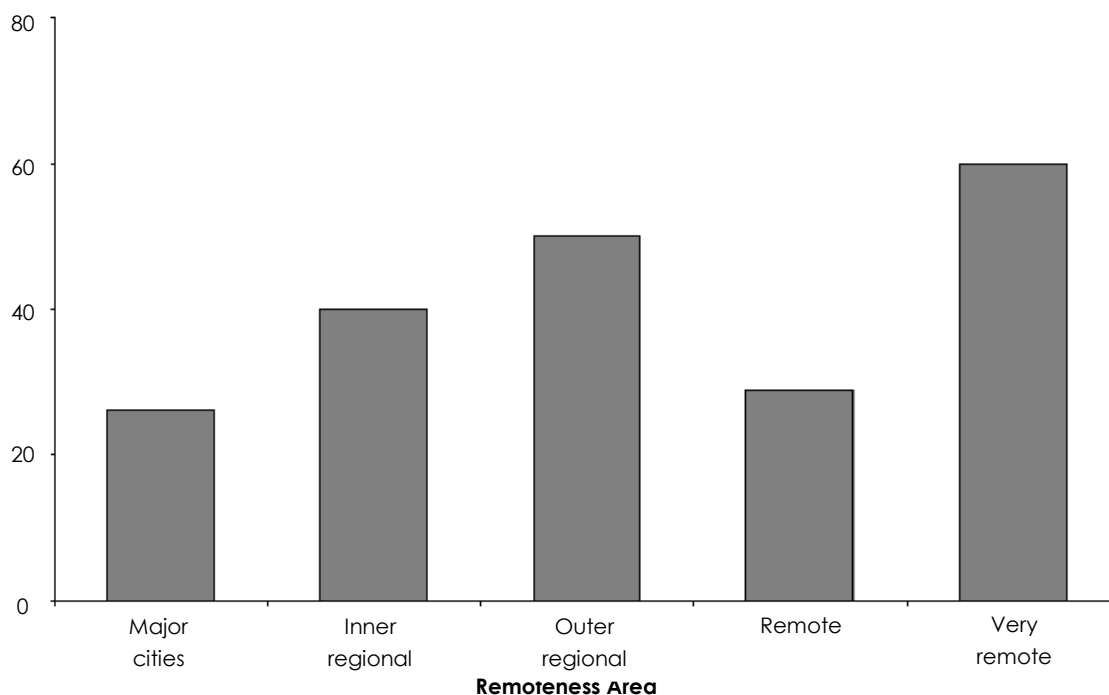
One hypothesis is that health services in remote or very remote locations are more specifically tailored to respond to the unique needs of Aboriginal and Torres Strait Islander peoples than those located in urban areas. This hypothesis is supported by consideration of the distribution of Aboriginal and Torres Strait Islander Community Controlled Health services and Aboriginal and Torres Strait Islander Health Workers.

Data collected in the Aboriginal and Torres Strait Islander Health Services Report indicated that, in 2008-09, 43% of all Aboriginal and Torres Strait Islander primary health services funded by OATSIH were located in remote or very remote areas (Figure 18) (Australian Institute of Health and Welfare, 2010a). The main type of health staff employed by these services were Aboriginal and Torres Strait Islander Health Workers, with eight in ten services (79%) having a Health Worker on staff in 2008-09 (Australian Institute of Health and Welfare, 2010a).

A comparison of the distribution of the Health Worker workforce and the Aboriginal and Torres Strait Islander population emphasises that the distribution of services does not align to the population distribution (Figure 19). Although only 24% of the Aboriginal and Torres Strait Islander population usually resided in remote or very remote Australia in 2006, 48% of the Aboriginal and Torres Strait Islander Health Worker workforce was located in the same regions. In contrast, approximately 31% of the Aboriginal and Torres Strait Islander population resided in the major cities of Australia, where only 18% of the Health Worker workforce was employed (Australian Bureau of Statistics, 2006c, Australian Bureau of Statistics, 2006b, Australian Bureau of Statistics, 2003)

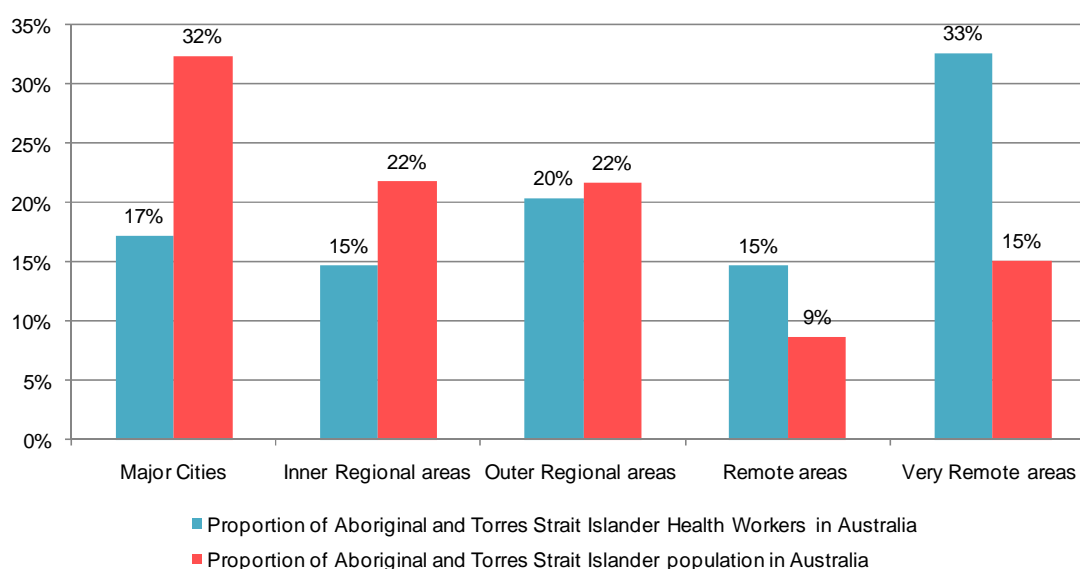
Figure 18 - Distribution of Aboriginal and Torres Strait Islander health-care services funded by OATSIH in 2008-09: by area of remoteness

Number of services



Data source: AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE 2010. *Aboriginal and Torres Strait Islander Health Services Report, 2008-09: OATSIH Services Reporting - key results*. Canberra.

Figure 19 - Proportional comparison of distribution of Aboriginal and Torres Strait Islander population with Health Workers in 2006: by area of remoteness



Data source: AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE. 2006. *Health and Community Services Labour Force 2006: Online data tables* [Online]. Available: http://www.aihw.gov.au/publications/index.cfm/title/10677#detailed_tables [Accessed 13 December 2010]; AUSTRALIAN BUREAU OF STATISTICS 2006. *Census of Population and Housing*. Canberra).

These data suggest that there is an imbalance between the geographic distribution of the Aboriginal and Torres Strait Islander population and primary health care services that specifically target their needs. It appears there may be greater investment in remote and very remote areas, whilst Aboriginal and Torres Strait Islander peoples who reside in more metropolitan areas have a higher level of unmet need.

This could suggest that health services in remote areas are more accessible to Aboriginal and Torres Strait Islander peoples because there is a higher concentration of Health Workers relative to the Aboriginal and Torres Strait Islander population. The fact that Aboriginal and Torres Strait Islander people in remote areas are less likely to seek out health care themselves also supports this hypothesis, particularly given that Health Workers often deliver services proactively by identifying health needs and delivering services during home visits and outreach activities.

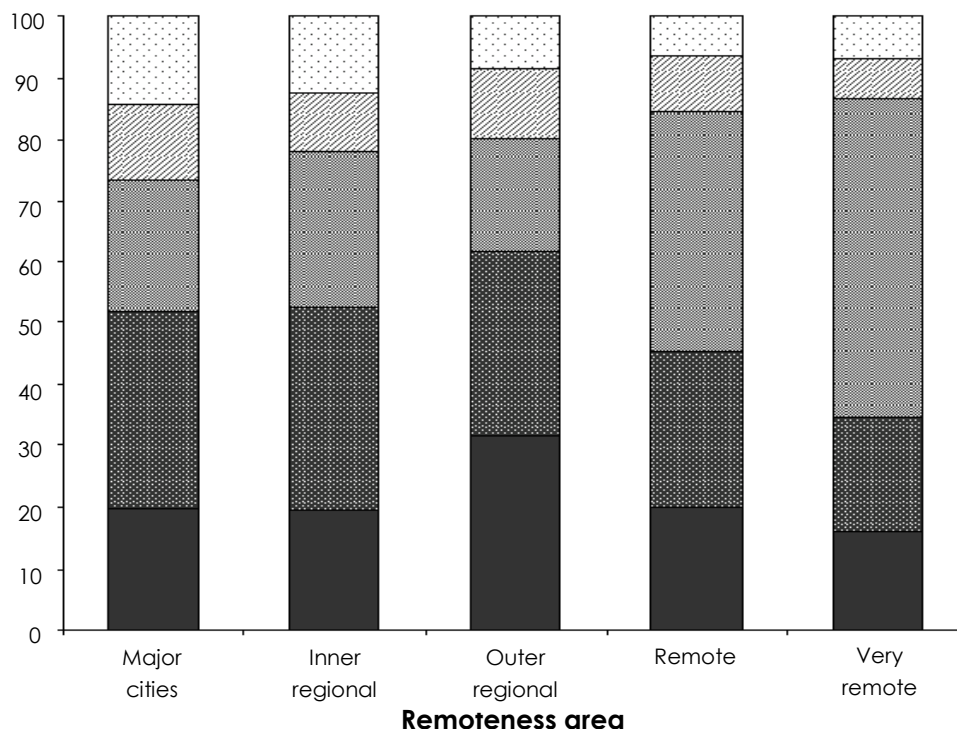
Interestingly, the OATSIH service reporting data from 2008-09 indicates that the proportion of client contact performed by Health Workers in OATSIH funded organisations does not appear to increase in accordance with remoteness (Australian Institute of Health and Welfare, 2010a). In fact, it is the nursing workforce that increases the proportion of client contacts performed, as can be seen in Figure 20. The proportion of client contacts performed by Health Workers in 2008-09 is comparable in major cities, inner regional, remote and very remote areas. However, the proportion of client contacts performed by nurses increases dramatically in remote and very remote areas, compensating for lower doctor participation.

However, it is important to note that this data only relates to OATSIH-funded services. These findings therefore cannot be extrapolated to gain insights into the accessibility of health services more broadly.






In short, at this stage, these data are insightful but inconclusive. The hypotheses posed in this section require further validation. Firstly, because there are other variables that influence accessibility; and secondly, because there are data limitations in the data relating to the Health Worker workforce (these limitations are further outlined in Section 7.1). Links will be further explored during the information collection phases of this project.

Figure 20 - Client contacts provided by respondent Aboriginal and Torres Strait Islander primary health-care services, by type of profession and remoteness, 2008-09

Per cent



KEY

-  Other
-  Allied health professional and medical specialist
-  Nurse (all types)
-  Doctor
-  Aboriginal and Torres Strait Islander health worker

Data source: AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE 2010. *Aboriginal and Torres Strait Islander Health Services Report, 2008-09: OATSIH Services Reporting - key results*. Canberra.

5.2.2 Primary health care accessibility by jurisdiction

Analysis of the change over time in particular MBS items may provide a measure of increasing MBS use and act as a proxy for health care access. This proxy must be interpreted with care due to confounding variables such as moves from programmatic to Medicare based funding in some health services. An analysis of MBS Item 715 (Aboriginal and Torres Strait Islander Peoples Health Assessment) is provided as an example.

The relevant MBS schedule is Item 715, which refers to the. MBS Item 715 is defined to be:

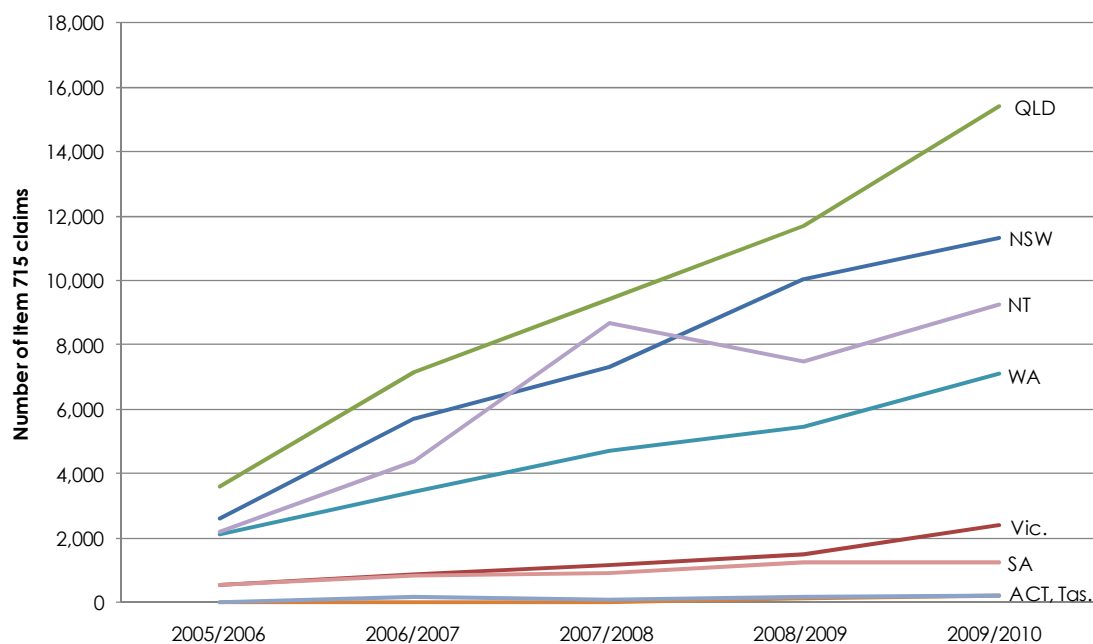
"Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) at consulting rooms or in another place other than a hospital or Residential Aged Care Facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent - not more than once in a 9 month period".

(Australian Government Department of Health and Ageing, 2010e)

When considering the number of claims made for Item 715 in the period between 2005/06 to 2009/10, it is clear that there is an increasing trend in service activity provided by medical practitioners (Figure 21). This trend has increased in every jurisdiction throughout the five year period (Figure 21).

However, without greater context to these figures, it is not possible to make conclusive statements about the way in which they reflect trends in health service access for Aboriginal and Torres Strait Islander peoples. Although these increasing figures may suggest an increasing utilisation of health services, other variables have contributed to the growth in service activity that has been recorded. For example, an increase in the number of Aboriginal and Torres Strait Islander individuals with Medicare numbers, increased knowledge and use of the MBS item number and/or an increase in the number of Health Workers with MBS provider numbers. In other words, these data may simply reflect an increase in recorded health checks, not necessarily an increase in actual health checks undertaken.

Figure 21 – MBS claims for Aboriginal and Torres Strait Islanders Peoples Health Assessment (Item 715) by jurisdiction, 2005/06-2009/10



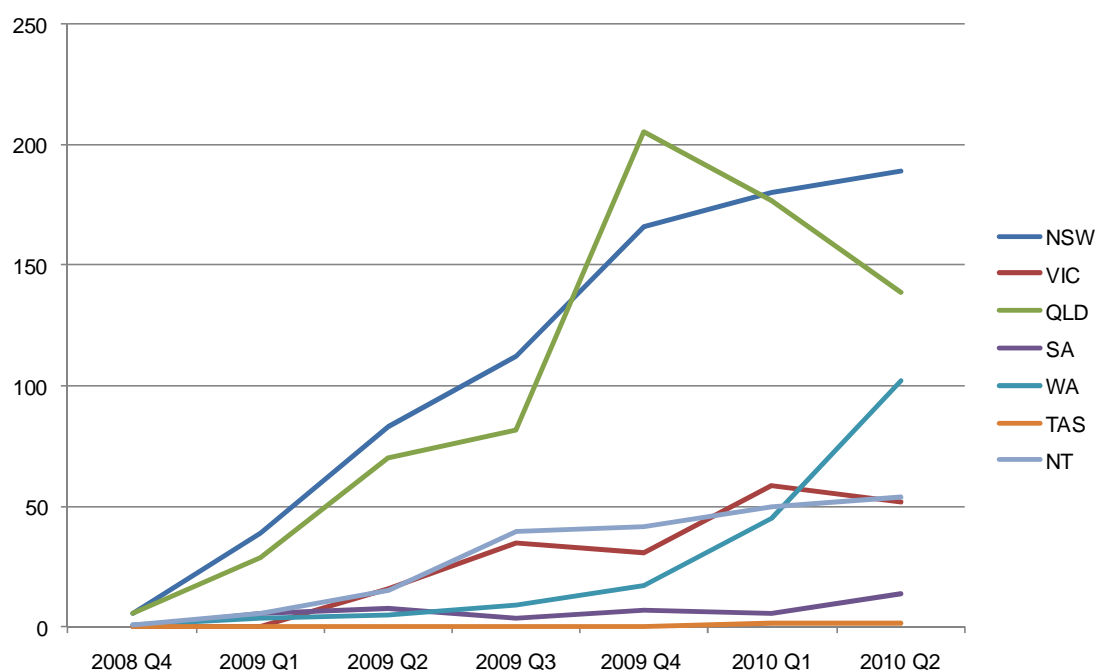
Source: Australian Government Department of Health and Ageing, 2010. Medicare Benefits Schedule - Note A32 [Online]. Canberra.

Table 8 – MBS claims for Aboriginal and Torres Strait Islanders Peoples Health Assessment (Item 715), 2005/06-2009/10

Year	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
2005/06	2,624	553	3,589	550	2,131	23	11	2,206	11,687
2006/07	5,691	868	7,135	849	3,435	16	177	4,393	22,564
2007/08	7,306	1,156	9,416	939	4,701	34	109	8,682	32,343
2008/09	10,046	1,496	11,695	1,264	5,451	142	186	7,503	37,783
2009/10	11,338	2,393	15,393	1,239	7,123	218	210	9,248	47,162
Total	38,413	6,704	49,122	4,966	23,534	448	717	32,828	156,732

Source: Australian Government Department of Health and Ageing. 2010. Medicare Benefits Schedule - Note A32 [Online]. Canberra.

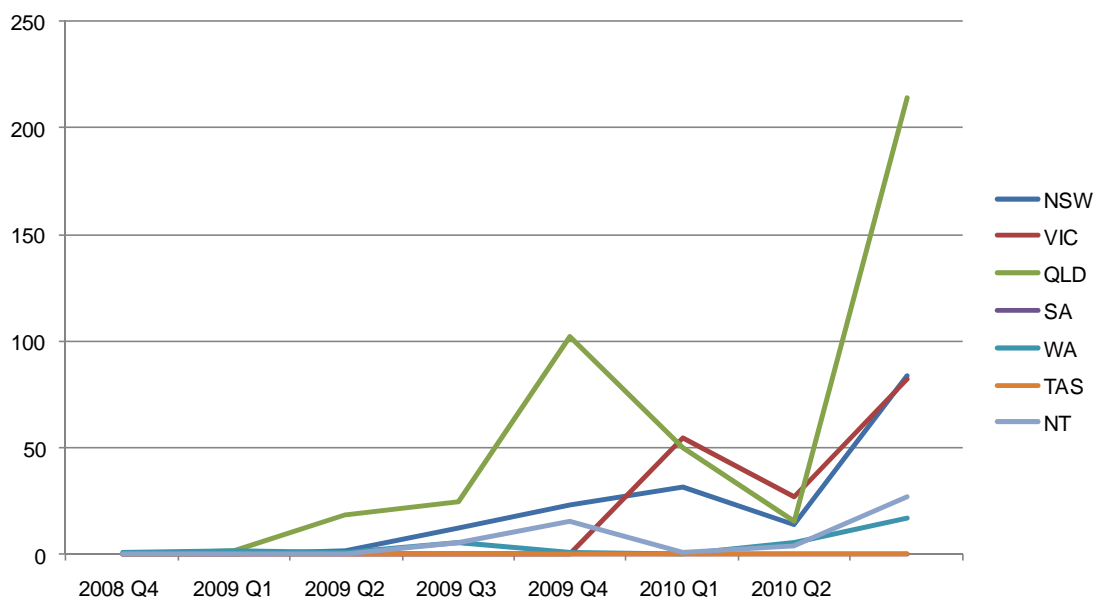
Figure 22 – MBS claims for all Medicare items in Group M11: Allied Health Services for Indigenous People who have had a Health Check, processed from October 2008 to June 2010



Source: MEDICARE AUSTRALIA 2010. Medicare Benefits Schedule (MBS) item claims specifically for Aboriginal and Torres Strait Islander people (correct at 1 April 2010).

An assessment of recent MBS item use Health Workers (e.g. MBS Item 81300) demonstrate a low usage of MBS by Health workers. This may relate to the model of claiming by a health service rather than a measure of access (e.g. Health workers may not be registered with Medicare Australia and may not be claiming).

Figure 23 – MBS claims for Item 81300: Allied Health service provided by an Aboriginal Health Worker, Oct '08-Jun '10



Source: MEDICARE AUSTRALIA 2010. Medicare Benefits Schedule (MBS) item claims specifically for Aboriginal and Torres Strait Islander people (correct at 1 April 2010).

Note: No recorded claims were made for SA during this period

5.2.3 Barriers to health care access

The above section demonstrated that Aboriginal and Torres Strait Islander peoples have a higher level of unmet health care needs in urban areas, despite there being a greater number of health services in these locations. This emphasises the fact that there are a number of barriers impeding health care accessibility for Aboriginal and Torres Strait Islander Australians. This section considers some of the key barriers, including cultural safety concerns; language barriers; fears of racism or discrimination; transportation barriers; and the cost of health care.

Cultural safety

'Cultural safety' is a term that was originally developed by Maori nurses, meaning that 'there is no assault on a person's identity' (Williams, 1999). Some of the literature highlights the valuable role Health Workers are able to perform by brokering culturally safe and appropriate health care and thereby improving health service accessibility.

- Williams refers to the fact that the people 'most able or equipped to provide a culturally safe atmosphere are people from the same culture' (Williams, 1999)
- Hayman et al. highlight the requirement for Aboriginal and Torres Strait Islander health professionals to be involved in delivery of health care to Aboriginal and Torres Strait Islander peoples, noting that it improves continuity of care, communication and understanding, and health promotion (Hayman et al., 2006)

Delivery of health care by Aboriginal and Torres Strait Islander health professionals, including Health Workers, was also highlighted as a key factor in self determination and improving the delivery of chronic care services

- Cass & Lowell, et al. (2002) noted the challenges of cultural barriers in effective doctor-patient relationships and demonstrated concerns regarding miscommunication between non-Aboriginal and Torres Strait Islander health staff and Aboriginal and Torres Strait Islander patients (Cass et al., 2006)
- The Productivity Commission Steering Committee for the Review of Government Service Provision suggests that cultural safety is crucial to improving the accessibility of health services for Aboriginal and Torres Strait Islanders (Steering Committee for the Review of Government Service Provision, 2009a).

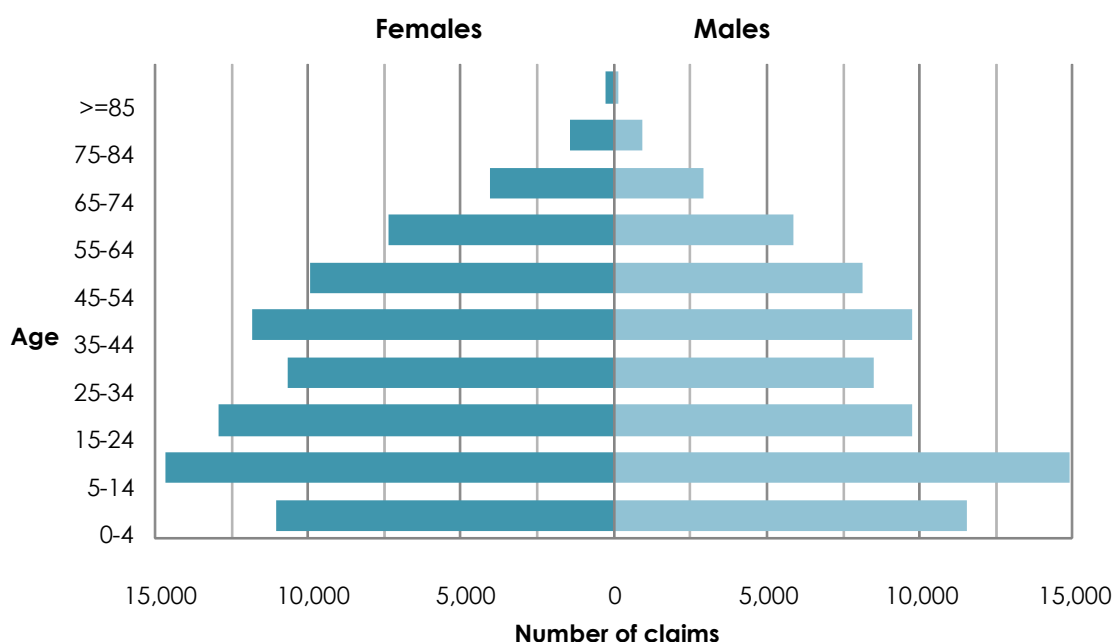
The cultural context outlined in Section 3.2 also provides additional background on this topic, reiterating the unique role that Health Workers can play to ensure that available health services are culturally safe, and thereby more accessible, for Aboriginal and Torres Strait Islander peoples.

For example, many Aboriginal and Torres Strait Islander peoples value separation of “men’s business” and “women’s business”. As identified in Section 3.2, for a health service to be culturally appropriate in the eyes of many Aboriginal and Torres Strait Islander peoples, a male individual would prefer to see a male Health Worker. Health care services that are not aligned to these values may result in a barrier to health care access for male Aboriginal and Torres Strait Islander peoples. This is reflected in the MBS data below.

The MBS data shows a claimant gender imbalance after the age of 14. As demonstrated in Figure 24, the number of Aboriginal and Torres Strait Islander males aged 14 and above who are assessed by a medical practitioner is markedly lower than their female counterparts.

A gender imbalance also exists within the Health Worker workforce. Only 30% of the Health Worker workforce is male (Australian Bureau of Statistics, 2006c). A higher representation of male Health Workers may therefore increase access to health care for male Aboriginal and Torres Strait Islander peoples. This is reiterated in a study performed by Si et al., who found that “presence of male Aboriginal Health Workers was associated with higher adherence to the guidelines” for the management of diabetes (Si et al., 2006). Therefore, the development of the Health Worker workforce provides an opportunity to design the workforce to better target the cultural needs of Aboriginal and Torres Strait Islander males – for example, through strategies to train and recruit more male Health Workers. Consultation with Health Workers and communities throughout this project will assist to validate this hypothesis.

Figure 24 - MBS claims for Aboriginal and Torres Strait Islanders Peoples Health Assessment (Item 715) by gender, 2005/06-2009/10



Source: Australian Government Department of Health and Ageing, 2010. Medicare Benefits Schedule - Note A32 [Online]. Canberra.

Language barriers

Language barriers have also been identified as a factor influencing the accessibility of health services to Aboriginal and Torres Strait Islander peoples (Steering Committee for the Review of Government Service Provision, 2009a, Australian Institute of Health and Welfare, 2006a). This can be a significant barrier for Aboriginal and Torres Strait Islanders who do not speak/write English, or who speak/write English as a second or third language – particularly if health care professionals use medical jargon that is outside the scope of the client's vocabulary, in either a linguistic or cultural sense.

Experiences of discrimination or racism

Experiences of discrimination or racism are not uncommon for persons of Aboriginal or Torres Strait Islander descent. The Productivity Commission Steering Committee for the Review of Government Service Provision referred to a number of studies that confirmed experiences of racism and cultural insensitivity towards Aboriginal and Torres Strait Islanders by mainstream health services. Cutcliffe found that these experiences were not uncommon for Aboriginal and Torres Strait Islander people (Cutcliffe, 2004). Studies by Paradies (2007) and Paradies, Harris and Anderson (2008) also concluded that racism (from all sources and not only related to health care) had negative impacts on Aboriginal and Torres Strait Islander health outcomes (Steering Committee for the Review of Government Service Provision, 2009a, Paradies, 2007, Paradies et al., 2008). Fear of encountering racial discrimination can serve as a profound disincentive for engagement with health services, particularly if they are mainstream services dominated by non-Aboriginal health professionals (Steering Committee for the Review of Government Service Provision, 2009b).

Access to transport

Difficulties in travelling to and from a health service can also undermine the capacity for Aboriginal and Torres Strait Islander peoples to access health care. According to the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), approximately 60% of Aboriginal and Torres Strait Islander people aged 18 years and over have access to and are able to drive a motor vehicle, compared to 85% of non-Aboriginal and Torres Strait Islander people (Australian Institute of Health and Welfare, 2006a). This proportion was lower in remote areas, where only 48% of Aboriginal and Torres Strait Islander people had access to a vehicle (Australian Institute of Health and Welfare, 2006a). Furthermore, Aboriginal and Torres Strait Islander people were 3 times as likely to have transport difficulties in that they could not, or often had difficulties getting to places they need to go, compared to other Australians (12% compared to 4%) (Australian Institute of Health and Welfare, 2006a).

Costs of health care

Although there are a growing number of government initiatives to reduce the financial barrier to health care access for Aboriginal and Torres Strait Islander peoples, the cost of health care can still be prohibitive for some. Just 17% of Aboriginal and Torres Strait Islander peoples in non-remote areas had private health insurance in 2001, compared with 51% of other Australians (Australian Bureau of Statistics, 2001b). This reduces the access of Aboriginal and Torres Strait Islander people to specialist care, such as private hospitals and services within the private health system (Australian Institute of Health and Welfare, 2006a).

5.3 Section summary

This chapter asserts that availability and accessibility of health care are two distinct concepts. Both are required in order to impact upon the Aboriginal and Torres Strait Islander burden of disease highlighted in Chapter 4. The reform of the Health Worker workforce represents an opportunity to ensure this workforce contributes to the broader health system more effectively by improving both service availability and accessibility.

Already, the Health Worker workforce is integral to the delivery of Aboriginal Community Controlled comprehensive primary health care services. Health Workers also serve an important role in some government/private primary health care facilities. However, there is less clarity around how Health Workers contribute to the secondary and tertiary health service environment. Accessible health care is required at every step along the journey through the health system, from primary health care through to acute care.

More importantly, it cannot be assumed that health service availability equates to accessibility. Data has shown that Aboriginal and Torres Strait Islanders in non-remote areas actually have a higher level of unmet need than those living in remote areas (Council of Australian Governments Reform Council, 2010). This is despite the fact that health services are more densely concentrated, and therefore more available, in non-remote areas. One hypothesis explaining this phenomenon is that the increased concentration of Health Workers in remote areas has a positive effect on health service accessibility for Aboriginal and Torres Strait Islander peoples.

Available evidence highlights the fact that a number of barriers impede health service access for Aboriginal and Torres Strait Islander peoples, including the cultural relevance and appropriateness of health services; gender imbalance in the Health Worker workforce; racial discrimination; transport needs; and the cost of health care. The Health Worker workforce has capacity to improve the accessibility of services by breaking down some of these barriers. In reforming the Health Worker workforce, it is therefore crucial to consider its role in improving the accessibility of the broader health system – at every level of the system across the Aboriginal Community Controlled, Government and private sectors.

6. Definition, scope of practice and role of the Aboriginal and Torres Strait Islander Health Worker workforce

A challenge of reforming the Health Worker workforce is the fact that Health Workers perform very different roles across Australia. This chapter explores existing differences across jurisdictions and sectors, asserting the need for a nationally consistent understanding of what it means to be an Aboriginal and Torres Strait Islander Health Worker.

The chapter first highlights different definitions used across the country. For example, noting that the term “Aboriginal and Torres Strait Islander Health Worker” has a different meaning in the Northern Territory than it has in other jurisdictions. Secondly, the chapter discusses variances in the scope of practice that Health Workers are qualified to perform across the country. Thirdly, it considers the actual roles performed by Health Workers in different contexts. In many cases, and for a variety of reasons, the Health Worker role is restricted to only a small portion of the scope of practice they are actually qualified to perform. Fourthly, selected examples of Health worker models of care and the relationship with other care team members are outlined.

The chapter concludes by highlighting the need for further investigation into the effectiveness of different models of care involving Health Workers, emphasising the importance of positive interrelationships with other health professionals to maximise client outcomes.

6.1 Understanding the Health Worker workforce: the challenge

The challenge of developing a nationally consistent understanding of the Aboriginal and Torres Strait Islander Health Worker workforce is widely recognised. Different role definitions have been used by relevant state and territory government departments, agencies, peak bodies, organisations and Health Worker boards and associations. Even within each jurisdiction, the definition of a Health Worker varies significantly depending on the workplace and context in which the Health Worker provides services.

A survey of the available literature identified several areas of difference when considering the definition of the Health Worker workforce. Firstly, sometimes different terminology is used to describe people performing the same role. Secondly, a large range of different roles performed by the people could be considered within the definition of an “Aboriginal and Torres Strait Islander Health Worker” – for example, Mental Health Workers, Hospital Liaison Officers and Indigenous Outreach Workers. Thirdly, there are often significant discrepancies between the scope of practice that different “Health Workers” are qualified to perform. The scope of practice is distinct from the role of the Health Worker, because, for various reasons, some Health Workers might only be given the opportunity to undertake a portion of the full spectrum of tasks they are actually qualified to perform. Each of these components is discussed further in the paragraphs below.

6.2 Defining the Health Worker workforce

The terminology used to describe Health Workers is a key point of difference between the States and Territories. In some jurisdictions, such as New South Wales and the Northern Territory, the term “Aboriginal Health Worker” is most prevalent throughout the literature. This is the case even when Torres Strait Islanders are explicitly included in the definition provided. In other jurisdictions, such as Queensland, the term “Aboriginal and Torres Strait Islander Health Worker” is more commonly used. What is meant by these terms does vary depending on the jurisdictions.

6.2.1 Examples of variations in the definition of an Aboriginal and/or Torres Strait Islander Health Worker

Several examples of the different definitions of Aboriginal and Torres Strait Islander Health Workers used across Australia are outlined below to demonstrate these variations in definition. This is by no means an exhaustive list of the definitions used; it merely serves to highlight the existing discrepancies.

NACCHO

The National Aboriginal and Community Controlled Health Organisations (NACCHO) and Aboriginal or Torres Strait Islander Health Worker as an Aboriginal and/or Torres Strait Islander person who:

- Works within an Aboriginal Primary Health Care framework to achieve better health outcomes and better access to health services for Aboriginal or Torres Strait Islander individuals, families and communities
- Holds a minimum qualification of Certificate III in Aboriginal or Torres Strait Islander Primary Health Care and
- Advocates for the delivery of services in accordance with the Cultural Respect Framework.⁵

(National Aboriginal Community Controlled Health Organisation, 2008c)

New South Wales Department of Health

The NSW Department of Health defines an Aboriginal Health Worker to be someone who is:

- An Aboriginal or Torres Strait Islander person, and
- Employed in an identified position in the NSW Public Health System and provides health services or health programs directly to Aboriginal people regardless of whether the person is employed in a generalist or specialist position. It encompasses all/any areas, irrespective of the award that covers employment of the worker'. (New South Wales Health, 2005)

The NSW Health definition of a Health Worker is explicitly inclusive of those that specialise in mental health, family health, sexual health, and drug and alcohol issues, and those who are health education or hospital liaison officers (New South Wales Health, 2005).

⁵ See Section 3.3.4 for more information on the Cultural Respect Framework

Northern Territory

In the Northern Territory, the term “Aboriginal Health Workers” only applies to those Health Workers who perform clinical responsibilities. This means that people who are defined as Aboriginal Health Workers in other jurisdictions but do not perform clinical roles would not fit within the definition of Aboriginal Health Workers used in the Northern Territory.

This is partly attributable to the fact that the Northern Territory is the only Australian jurisdiction that legally registers and regulates the Health Worker scope of work practices, particularly clinical work, in order to minimise the risks to public safety (Aboriginal Health Workers Board of the Northern Territory, 2008). In the Northern Territory, the qualifications required for a Health Worker are legislated, as are the scope of practice, code of ethics and clinical competency framework. Health Worker practice is regulated by the Aboriginal Health Workers Board of the Northern Territory, which defines the role of the Northern Territory Aboriginal Health Worker (AHW) as follows:

“AHWs predominately work in Primary Health Care (PHC) in remote Aboriginal communities. They are often recruited from their remote communities enabling local participation in the direction and delivery of health services. AHWs also work in urban community health, in public health and in hospitals. AHWs are involved in specialist areas of health care such as, but not limited to , renal dialysis, women's and men's health screening, early childhood screening and development, nutrition, mental health, alcohol and other drugs, health service management and design. AHWs often use complex medical equipment, take and test samples of biological material, sometimes requiring invasive procedures such as venipuncture. They are also authorised to administer a limited range of medications in accordance with the Northern Territory Poisons and Dangerous Drugs Act and have significant cultural brokerage role in the provision of health care, enabling them not only to be health care providers but also to facilitate care provided by other health professionals... While the Territory has a range of other roles such as Aboriginal mental health worker, Aboriginal nutrition worker and Aboriginal community worker, these do not have the same clinical focus as AHWs and are not registered.”

(Aboriginal Health Workers Board of the Northern Territory, 2008)

Queensland Health

The Queensland Health definition of an Aboriginal and Torres Strait Islander Health Worker is:

- An Aboriginal and/or Torres Strait Islander person, who
- Works within a Primary Health Care (PHC) framework to achieve better health outcomes and better access to health services for Aboriginal and Torres Strait Islander individuals, families and communities
- Holds an Aboriginal and Torres Strait Islander Primary Health Care qualification
- Advocates for the delivery of services in accordance with the Cultural Respect Framework, and
- Is appointed under the Aboriginal and Torres Strait Islander Career Structure (Queensland Health, 2007a)

Western Australia

The Western Australian Department of Health defines an Aboriginal Health Worker to be someone who is:

- An Aboriginal and/or Torres Strait Islander person or descendent and is recognised as such by their community
- Holding a recognised qualification from an accredited Registered Training Organisation at "Certificate III in Aboriginal Health Work" (Poelina et al., 2006).

6.2.2 What are the implications of inconsistent definitions for the Health Worker workforce?

The range of definitions included above demonstrates that there are clear discrepancies in the definition of an Aboriginal and/or Torres Strait Islander Health Worker across Australia. In particular, there is not a common view on whether the term should only refer to those who perform clinical tasks, or if it refers to a wider group of health professionals.

Without a national definition of the Health Worker workforce, certain challenges may arise during the process of reforming the workforce. It will be necessary to reach some sort of national agreement on the Health Worker role to gain clarity around the appropriate roles, scopes of practice, qualification and training requirements, and career pathways. The information collection phases of this project provide an opportunity to gain additional insights into the different perspectives on this issue held by relevant stakeholders.

6.3 Identifying the Health Worker scope of practice

6.3.1 What does scope of practice mean?

The scope of practice of a profession is distinct to the definition of a particular workforce. The definition of scope of practice, for the purposes of this document, is drawn from that used for nursing by the Queensland Nursing Council (Queensland Nursing Council, 2005). An overarching scope of practice is the range of activities and tasks a health professional is educated, competent and authorised to perform. The actual scope of an individual nurse's or midwife's practice is influenced by the:

- context, organisation and location in which the Health worker practices (urban, regional or remote)
- client's health needs
- level of competence, education and qualifications and credentialing of the individual Health Workers
- availability of other health professionals
- service provider's policies (Queensland Nursing Council, 2005).

The role and function of a health professional may vary in line with scope of practice limitations placed on the individual by an organisation/service, jurisdiction or through local credentialing processes. This may result in an individual practitioner being trained and competent in a particular activity but not allowed to practice to their full scope due to local restrictions, client or service needs.

6.3.2 Examples of different scopes of practice

A number of reports have explored the scope of practice of Aboriginal and Torres Strait Islander Health Workers. The broad focus of the profession is the delivery of primary health care within a supervised and collaborative model. This supervision may be direct or indirect (for example telephone support by a district medical officer in remote locations in the Northern Territory). The role includes the provision of primary health care within a cultural context and promoting and facilitating access and delivery of culturally safe health care for clients.

The practice of the Aboriginal and Torres Strait Islander Health Worker profession, on the whole, appears to correlate to the National Competencies Framework as outlined as minimum standards in the HLT43907. Some more specific examples of Scopes of Practice in use across Australia are included below.

NSW Greater Western Area Health Service

The Greater Western Area Health Service in NSW has developed and outlined the Aboriginal Health Worker Scope of Practice (Greater Western Area Health Service, 2009). The principles outlined are based on HLT43907. The nine principles of practice are:

1. Identify, plan, develop and implement respectful and responsive holistic healthcare for improved services and access for Aboriginal peoples in collaboration with the healthcare team and community.
2. Advocate for Aboriginal clients individual needs
3. Undertake health promotion and community development activities that Aboriginal people value and can participate in
4. Be a resource for non-aboriginal staff and management on Aboriginal community perspective
5. Participate in community networks (i.e. Aboriginal community/organisations, other service providers, internal Aboriginal health network
6. Liaise with others – internally and externally – especially the Aboriginal community.
7. Work in partnership, within a multidisciplinary team environment, with other health professionals and service providers
8. Provide clinical care and task within individual scope
9. Refer clients to other health professionals when necessary and ensure continuity of care (Greater Western Area Health Service, 2009).

Victorian Aboriginal Community Controlled Health Organisations

The Victorian Aboriginal Community Controlled Health Organisation reported on the scope of practice of their Aboriginal Health workers in 2010 (Victorian Aboriginal Community Controlled Health Organisation, 2010a). Recognising the individual scope of practice may vary for the above outlined reasons, VACCHO developed a scope of practice assessment tool. The tool, developed in 2010, allows Health workers and their managers to review the individual scope of practice, and subsequently the health worker role, in line with the education, knowledge, experience and skills. In this way VACCHO attests the scope of practice of Aboriginal Health Workers will not remain stagnant over time but will evolve to meet client and service needs, within a competence framework (Townsend, 2008).

Queensland Health

In Queensland, a draft Scope of Practice was also designed to meet the needs of Aboriginal and Torres Strait Islander Health Workers. This Scope of Practice states that:

'Aboriginal and Torres Strait Islander Health Workers provide clinical and primary health care for individuals, families and community groups. They deal with patients, clients and visitors to hospitals and health clinics and assist in arranging, coordinating and providing health care in community health clinics. Their practice is varied and complex and they may work with communities and other health professionals to integrate health practices with the cultural values of that community. They may be employed in either health teams or work independently with:

- Acute, hospital based services
- Community health care clinics and services
- Community controlled health services
- Specialised health care programs
- Preventative and public health services
- Aged care services and facilities
- Management and policy settings'

(Queensland Health, 2007b)

South Australia

South Australia also developed a draft Scope of Practice prior to the endorsement of the new Aboriginal and Torres Strait Islander Primary Health qualifications in the CS&HISC Health Training Package. This identified four levels of practice, including Health Workers employed in rural, remote and urban areas and across health environments (Victorian Aboriginal Community Controlled Health Organisation, 2010a, Aboriginal Health Council of SA, 2004).

6.3.3 Conceptualising a national Health Worker scope of practice

Part of the remit of this project is to define the role of the Health Worker and describe their scope of practice. It is expected that many Health Workers may or may not be performing to their full scope of practice. As such, it is important to understand two things: what the scope of practice of Health Workers is; and what the different roles performed by Health Workers are against that full scope of practice. One of the key tasks of the community mapping activities is to collect the right data to enable these insights to be developed.

In order to facilitate this process, the project team has developed a conceptual diagram outlining the scope of practice for Health Workers including primary health, cultural brokerage and specific areas of focus. The HLT43907 qualification has been utilised as a reference document to establish this diagram. As the community mapping exercise continues, data will be collected via surveys to populate this scope of practice diagram. In so doing, it will be possible to map the scope of practice nationally and individually against the diagram, thereby confirming this conceptual framework with the reality of the role of Health Workers on the ground. The interim report for this project will thereby provide the first national picture of the on the ground reality of the extent to which Health worker are performing to their full scope of practice.

The cultural care role of Health Workers is a core component of their role, and can include supporting the cultural needs of the client; developing the cultural

understanding of the health service; and fostering/developing the wellbeing of the community. This is reflected in the following excerpt from the literature:

'Aboriginal Health Workers bridge the "cultural chasm" separating the traditional and Western worldviews. They relate Western beliefs to an Aboriginal conceptual framework, making it possible for Aboriginal patients to understand what is being said and to assess the validity of the statements. They make it possible for the health centre teams to communicate with Aborigines in language and concepts that they understand. In most Aboriginal communities, the people's point of entry into the Western health system is through the Aboriginal Health Worker who may refer them to a nurse...'

(Devanesen and Maher, 2003)

6.4 Understanding the role of the Health Worker workforce

Part of the reason for the inconsistency in definition outlined above is the historical development of the Health Worker role. In the 1950s, Health Workers were employed primarily as leprosarium workers; this evolved into a medical assistant role in the Northern Territory in the 1960s; and was further consolidated and developed with the emergence of Aboriginal community-controlled health services in the 1970s (National Rural Health Alliance, 2006). In this period, the Health Workers primarily provided a cultural safety and liaison role between Aboriginal and Torres Strait Islander health consumers and medical professionals. Today, the Health Worker role has become increasingly multifunctional and has extended to include the direct provision of clinical care in some contexts. The Health Worker role has evolved over the years in response to contextual demands that vary between geographic location, workplaces and communities. As such, there are significant differences between the roles performed by Health Workers across Australia.

Health Workers are employed by a number of different service providers, including Aboriginal Community Controlled Organisations, Aboriginal Medical Services, hospitals and GP clinics. These workplaces require different levels of involvement by Health Workers. Some factors that may influence the role of a Health Worker include:

- The number of additional health facilities and staff available to meet demand for Aboriginal and Torres Strait Islander health services within the community or geographic area
- The unique health needs of the population receiving the services
- The cultural status of the Health Worker within the recipient groups
- The seniority, skills and depth of experience of the Health Worker
- The historical funding precedents and current funding levels
- The availability of supporting resources
- The Health Worker scope of practice if it is legally defined at a jurisdictional level.

These variables affect the level of complexity and responsibility of the role performed by Health Workers (Curtin Indigenous Research Centre with Centre for Educational Research and Evaluation Consortium and Jojara & Associates, 2000).

Health Workers also have the opportunity to perform generalist roles or to specialise in a range of different areas. Specific areas of focus include alcohol and drug treatment; mental health; diabetes; eye and ear health; and sexual health (Australian Institute of

Health and Welfare and Australian Bureau of Statistics, 2008). These specialisations are often reflected in different titles used to describe Health Worker roles. For example:

- Aboriginal and Torres Strait Islander Mental Health Worker
- Aboriginal and Torres Strait Islander Family Health Worker
- Aboriginal and Torres Strait Islander Sexual Health Worker
- Aboriginal and Torres Strait Islander Health Education Officer
- Aboriginal and Torres Strait Islander Hospital Liaison Officer
- Aboriginal and Torres Strait Islander Drug and Alcohol Worker

In most Australian jurisdictions, each of these roles is considered to be within the definition of a Health Worker. However, in the Northern Territory, these roles are considered to be distinct from the Health Worker role (Aboriginal Health Workers Board of the Northern Territory, 2008). There is therefore some discrepancy between the definitions of the Health Worker role used by the States and Territories.

Towards a national definition of the Health Worker role

In recognition of the diversity of Health Worker roles, a broad definition is provided by the Australian and New Zealand Standard Classification of Occupations (ANZCO). Under ANZCO Code 411511, 'Indigenous Health Workers assist with the coordination and provision of health care delivery to Indigenous communities' (Australian Bureau of Statistics, 2006a). This definition is sufficiently broad to include the role of Health Workers in all jurisdictions. However, it provides little insight into the actual scope of practice of Health Worker.

The National Review of Aboriginal and Torres Strait Islander Health Worker Training identified some common characteristics of the various jurisdictional definitions of roles (Curtin Indigenous Research Centre with Centre for Educational Research and Evaluation Consortium and Jojara & Associates, 2000). These include:

- Primary health care being regarded as a fundamental aspect of the role
- The importance of local cultural knowledge in terms of the effectiveness of the role, and the different emphasis placed on the role depending on the employment context
- The provision of direct care to individuals, family and community groups as well as the promotion of well being
- The use of a holistic approach to the physical, emotional and social aspects of health.

In addition, it is generally accepted that the term "Aboriginal and/or Torres Strait Islander Health Worker" refers to a discrete health profession. It does not include Aboriginal and Torres Strait Islander people who are doctors, nurses, or other allied health professionals (National Rural Health Alliance, 2006).

Clearly, there are some common characteristics of Health Worker roles that may lend themselves to the development of a nationally consistent definition of the workforce, with regard to terminology, scope of practice and roles. There is also strong will from relevant peak bodies to embark upon this process. The National Aboriginal Community Controlled Health Organisation (NACCHO) argued for a nationally consistent definition in their submission for the inclusion of Aboriginal and Torres Strait Islander Health Workers into the National Regulation and Accreditation of health professionals scheme (National Aboriginal Community Controlled Health Organisation, 2010a). A similar

argument was also put forward by the Aboriginal Health Workers Board of the Northern Territory (Aboriginal Health Workers Board of the Northern Territory, 2008).

This project will contribute to the process of canvassing the diverse perspectives that do exist in order to move towards a nationally defined Health Worker workforce.

6.4.1 How do Health Workers fit within the organisational structure and service delivery models of health services?

The role performed by Health Workers often depends upon the organisational structure and model of service delivery used at their health service. The diversity of Health Worker roles was discussed in Abbot, Gordon and Davison (2007). The article noted the key role of Health workers in cultural brokerage, community advocacy, health promotion, clinical care, family support, research and management (Abbott et al., 2007)

Some Health Workers are employed as part of multidisciplinary primary health care teams alongside other health professionals, including doctors, nurses, and allied health staff. Others are located within distinct teams of the organisational structure, such as a "Health Promotion Unit" or an "Aboriginal Liaison Unit". There was no literature identified that discussed the merits of each different approach. Therefore, evidence is lacking with regard to what kinds of team structures are most effective.

Some literature referred to the use of a "Health Worker first" approach, meaning that Health Workers are the first (and sometimes the only) point of contact with the client during client consultations (Curtin Indigenous Research Centre with Centre for Educational Research and Evaluation Consortium and Jojara & Associates, 2000). According to this document, this model of service delivery is used at the Danila Dilba Medical Service in Darwin. Given the lack of information available with regard to these types of models, there is an opportunity to address this information gap via the project consultations.

Other grey literature emphasised the importance of culturally appropriate workplaces and raising cultural awareness of other health professionals working alongside Health Workers. For example, a toolkit was developed in Victoria providing guidance on how to improve the culture of hospitals in order to improve Aboriginal and Torres Strait Islander patient outcomes (Willis, 2010).

Any systematic consideration of appropriate management structures for Health Workers was also minimal in the available literature. Just one source, *Beyond Charcoal Lane*, considered Aboriginal and Torres Strait Islander health managers (Wakerman et al., 2000). However, this was from the perspective of recruiting and retaining managers; not from the point of view of whether or not Aboriginal and Torres Strait Islander managers influence Health Workers and their roles.

Considering the minimal literature identified, it can be concluded that there is a lack of evidence regarding the most appropriate organisational structures and service delivery models involving Health Workers. It is expected that these will vary greatly depending on contextual circumstances. This project will investigate these topics during the data collection phases.

6.4.2 Contribution of Aboriginal and Torres Strait Islander Health Workers to health access and chronic disease management.

A limited number of studies have discussed the benefits of Health Workers and Aboriginal Community Controlled Organisations in contributing to improving health outcomes for Aboriginal and Torres Strait Islander people. Larkins et al. demonstrated a

greater number of health issues being managed during a primary care consultation compared to mainstream health services (Larkins et al., 2006). The study showed Health Workers as key to the management of primary care presentation in the particular community controlled health services, being involved in the vast majority of presentations. Aboriginal Health Workers provided independent management of patients in 42.6% of presentations and collaborative management with a medical practitioner in 53.5% of presentations. Emerging evidence demonstrates increased numbers of Health Workers employed in remote communities as independently associated with improved diabetes care (Si et al., 2006).

Health Workers have demonstrated their ability to provide high quality chronic care screening and management. Selected examples include:

- Highly accurate point-of-care urine albumin screening as part of diabetes screening and management (Shephard and Gill, 2005)
- Taking responsibility for clinical activities such as immunisations, pap smears and health checks (Mitchell and Hussey, 2006)
- Being the key health care provider in conducting clinical examinations in child health checks (Bailie et al., 2008)
- Delivering perinatal care to women and babies in a collaborative partnership model with non-indigenous midwives (Stamp et al., 2008)
- Screening for nicotine dependence and providing smoking cessation education during antenatal care (Panaretto et al., 2009) Improvements in post discharge care, recording of social history and improved inpatient care for admitted mental health patients (Nagel and Thompson, 2006)
- Demonstrable improvements in diabetes care and adherence to clinical guidelines with the employment of AHWs in remote community health centres (Si et al., 2006)
- Providing high quality diabetic retinopathy screening using retinal cameras (Murray et al., 2005)
- Otitis media screening, videotoscopy, antibiotic treatment in adherence with clinical guidelines for children with chronic otitis media (Couzos et al., 2003)

Other studies have highlighted the impact of a lack of Aboriginal Health workers. Si, D., et al (2008) assessed the strength of chronic illness care in 12 Aboriginal communities in the Northern Territory. Weakened chronic illness care to community members (as assessed against the Wagner Chronic Care Model) was associated with a shortage in Aboriginal Health Workers. McGrath, P.D., et al (2007) highlighted the value of Health Workers in providing culturally appropriate palliative care but the challenge of providing this best practice model of care with a shortage of AHWs in the Northern Territory (McGrath et al., 2007).

6.5 Section summary

This chapter of the Environmental Scan has highlighted the variation in definitions, scopes of practice and roles of Aboriginal and Torres Strait Islander Health workers across Australia. These differences must be appropriately navigated in the lead up to national registration and accreditation, which will work towards the establishment of a nationally consistent Health Worker definition and scope of practice. Central to this process will be recognition of the fact that the Health Worker role is inevitably, and necessarily, shaped by varying contextual demands and unique community needs.

According to available literature, it seems that there are certain core aspects of the Health Worker role. These relate to the provision of culturally relevant and appropriate health care – through direct client interaction, supporting other health professionals, and/or working to develop community wellbeing.

An area of particular difference across Australia is in relation to the level of clinical responsibility involved in the role of a Health Worker. Depending on a variety of contextual factors, it may be more or less appropriate for the Health Worker to perform a clinical role. In the Northern Territory, Western Australia, Northern Queensland and other remote locations, Health Workers tend to have much broader clinical scopes of practice. Another key consideration is the opportunity for the development of specific areas of clinical focus.

There are a variety of different models of care in use involving Health Workers, including the “Health Worker-first” model, integration of Health Workers within the Multi-disciplinary team, or including Health Workers as a separate team within a health service. There is a limited evidence base to show which models of care and team structures are most effective. However, there is emerging evidence in relation to the contribution that Health Workers make to improving the access to health care and chronic disease management.

The data collection phase of the project provides an opportunity to validate these findings and gather new evidence.

Areas for exploration during this phase include:

- To what extent are Health Workers providing health services as part of a multidisciplinary primary health care team?
- To what extent are the roles of Health Workers in primary health care teams clearly delineated and understood?
- What are the barriers and enablers for participation of Health Workers in multidisciplinary health care teams?
- In what settings and health service teams are Aboriginal and Torres Strait Islander Health Workers most effective?
- What variables affect the responses to the above questions, for example:
 - Location (urban, regional, remote)
 - Unique health and cultural needs of local population
 - Place of employment (AMS/ACCHO, community health clinic, hospital, etc.)
 - Service delivery model
 - Access to/interface with other health professionals

7. Distribution and demographics of the Aboriginal and Torres Strait Islander Health Worker workforce

To strengthen the Health Worker workforce so that it can better meet the needs of Aboriginal and Torres Strait Islander communities, it is necessary to understand:

- The size of the workforce
- The demographic profile of the workforce, and
- The geographic distribution of the workforce.

This information contributes to workforce planning and the development of recruitment and retention strategies.

This chapter presents available data in relation to the above topics. A number of data limitations are outlined, emphasising that the national understanding of the current Health Worker workforce is piecemeal and inconsistent. A more robust, complete and up-to-date data set is required to better inform Health Worker workforce planning.

7.1 Data limitations

The contents of this chapter are dependent upon available data sources at the time of writing. As will be demonstrated throughout the chapter, there are some limitations inherent to this data set.

The most obvious limitation relates to the fact that there is no nationally consistent definition of an Aboriginal and Torres Strait Islander Health Worker, as noted in Section 6.2. This means that, at the jurisdictional level, each jurisdiction may be including or excluding different types of roles in their Health Worker workforce data set. For example, the Northern Territory only includes registered Health Workers who perform clinical tasks; whereas other states might also include Health Workers who do not perform clinical tasks but instead focus on health promotion activities. This is clearly problematic to the process of developing a national picture of the size of the health worker workforce.

Further, the only source of national Health Worker workforce data available (the Australian Bureau of Statistics) does not address the above issue by clearly defining the Health Worker workforce for the purpose of their data collection. In fact, ABS data also include “non-Indigenous Aboriginal and/or Torres Strait Islander Health Workers”, when identification as an Aboriginal and/or Torres Strait Islander person is a key attribute according to most available definitions. Therefore ABS data are unlikely to provide a nationally consistent representation of the Health Worker workforce numbers across Australia.

The ABS data are also predominantly at a high level, thus limiting the extent to which any major jurisdictional differences can be observed. Publicly available data do not have the level of granularity required to understand the distribution of Health Workers across urban, regional, rural and remote areas. To gain a more detailed understanding of the geographical distribution of Health Workers, additional empirical studies are required. In recognition of these data limitations, the size and geographic distribution of the Health Worker workforce is discussed below using the best available data.

Moreover, the most recent ABS data are from 2006 and are therefore four years old. During this period, the policy landscape has changed significantly and many new positions have been funded. It would be useful to have a more up-to-date data set.

The data limitations briefly outlined highlight the need for national data collection and reporting systems in order to accurately understand and develop the Health Worker workforce in future.

7.2 The size and geographic distribution of the Health Worker workforce

7.2.1 The national picture

The ABS Census of Population and Housing surveys the number of Aboriginal and Torres Strait Islander Health Workers in Australia. Included in these data is an analysis of the number of Health Workers that are of Aboriginal and Torres Strait Islander descent, in addition to those that are from a non-Aboriginal or Torres Strait Islander background descent (Australian Bureau of Statistics, 2006b).

According to the ABS, there were a total of 1,010 Health Workers in Australia in 2006, of which 965 were of Aboriginal and/or Torres Strait Islander descent (Australian Bureau of Statistics, 2006b). This represents an increase of 10.4% since 2001, when there were 915 Health Workers in Australia (Australian Bureau of Statistics, 2001a).

Figure 25 – Numbers of Aboriginal and/or Torres Strait Islander Health Workers

Year	Total	Aboriginal and Torres Strait Islander	Non-Aboriginal and Torres Strait Islander	Not stated	% that are Aboriginal and Torres Strait Islander
2006	1,010	965	39	6	95.5%
2001	915	853	59	3	93.2%

Source: ABS Census of Population and Housing, 2001 and 2006

A customised request to the ABS provided a more granular set of data that gives some valuable insights for this project. The key findings of these data are summarised below under relevant subheadings.

Geographic distribution

The data relating to the geographic distribution of Health Workers by Australian Standard Geographic Classification is provided in Figure 26.

This evidence shows that, in 2006:

- 32% of Health Workers work in major cities or inner regional areas
- Just under half (48%) of all Health Workers nationally reported to be working in either remote or very remote regions of Australia (Australian Bureau of Statistics, 2006c).

As noted in Section 5.2 above, this finding is interesting to note considering that only one-quarter of the total Aboriginal and Torres Strait Islander population resides in remote or very remote locations (Australian Bureau of Statistics, 2006c). Therefore, the distribution of the total Health Worker workforce does not align to the distribution of the Aboriginal and Torres Strait Islander population.

Figure 26 – Geographic distribution of Health Workers in Australia by ASGC, 2001 and 2006

Location - Australian Standard Geographic Classification (ASGC)	Number of Health Workers		% of Health Worker workforce	
	2001	2006	2001	2006
Major cities of Australia	122	177	14%	18%
Inner-regional Australia	113	146	13%	14%
Outer-regional Australia	179	200	20%	20%
Remote Australia	103	155	12%	15%
Very remote Australia	358	329	41%	33%
TOTAL	875	1007	100%	100%

Source: AUSTRALIAN BUREAU OF STATISTICS 2006. *Census of Population and Housing, Customised Data Report requested by Health Workforce Australia*. Canberra.

Further information regarding geographic distribution from a jurisdictional perspective is provided in the following section.

Education and qualification

ABS data reveals that the level of education and qualification of Aboriginal Health Workers is improving. In 2001, just under half of the Health Workers surveyed indicated that they either did not have any qualifications, or had qualifications outside the scope of their work; this dropped to only 36% of those surveyed in 2006 (Australian Bureau of Statistics, 2006c). In addition, the proportion of Health Workers reporting Certificate-level qualifications rose from 16% to 30% in the same period (Australian Bureau of Statistics, 2006c). This suggests that the Health Worker workforce is becoming more appropriately qualified.

Remuneration

A trend has also been observed across all jurisdictions in relation to the remuneration of Health Workers. Those working in major cities and/or inner regional areas record a higher median income compared to those working in remote and/or very remote areas (Australian Bureau of Statistics, 2006c). This finding was true for every state and territory in Australia.

On the other hand, between 2001 and 2006 the median income for most Health Workers increased irrespective of their geographic location. The magnitude of the increase did, however, vary quite significantly. At one end of the spectrum, Aboriginal Health Workers in very remote areas of NSW and WA reported an increase of 143% and 100% respectively in their median income; while Health Workers in inner regional areas of SA reported a 30% decrease in their median income (Australian Bureau of Statistics, 2006c).

Other demographic characteristics

Some of the general statistics highlighted in the data provided via this ABS request include that, in 2006:

- 81% of Aboriginal Health Workers were aged between 25 and 54 years of age
- The majority of Aboriginal Health Workers were female (70%)
- Approximately two-thirds (67%) work full time (35 hours or more per week) (Australian Bureau of Statistics, 2006c)

7.2.2 Analysis by jurisdiction

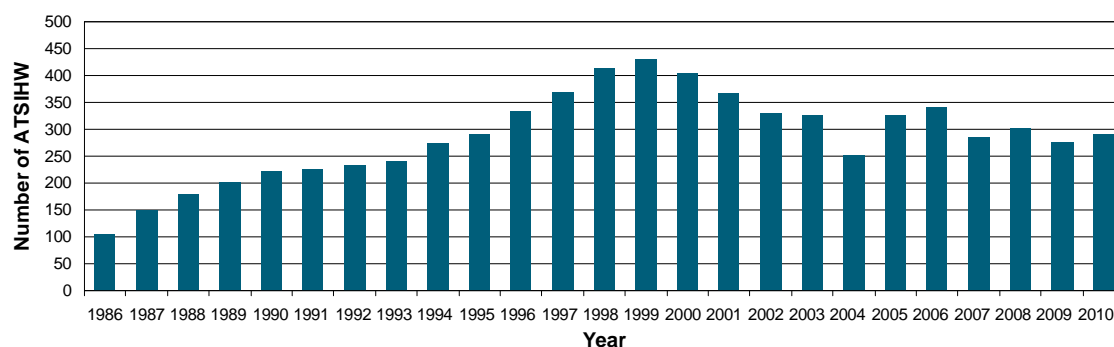
At a State and Territory level, the quality and availability of data relating to the Health Worker workforce varies significantly. The paragraphs below outline the available data in each jurisdiction.

Northern Territory

The Northern Territory is the only jurisdiction for which there was a secondary data set publicly available with regard to the Health Worker workforce. The NT collect data on the Health Worker workforce via the Health Worker Registry, and have done so since 1986 (Northern Territory Department of Health and Families, 2010). This set of data provided an opportunity to compare jurisdictional data with ABS data and test for discrepancies. As expected, the data varied significantly.

According to the data from the Northern Territory Health Worker Registry, the numbers of registered Health Workers in the Northern Territory steadily increased between 1986 and 1999 (Figure 27). Since 2000, the Health Worker numbers have varied between 252-404 registered health workers each year (Aboriginal Health Workers Board of the Northern Territory, 2008, Northern Territory Health Professions Licensing Authority, 2009, Northern Territory Health Professions Licensing Authority, 2010).

Figure 27 – Number of registered Aboriginal and Torres Strait Islander Health Workers in the Northern Territory



1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
105	151	178	202	222	227	233	240	275	291	334	368	414
1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	-
431	404	367	332	326	252	326	340	286	302	276	291	-

Source: Aboriginal Health Workers Board of The Northern Territory 2008; Northern Territory Health Professions Licensing Authority 2009, 2010

Using available NT data, it is unclear whether the steady increase of Health Workers that has been recorded is indicative of an increase in actual numbers of Health Workers providing services in the Northern Territory; or whether it reflects an increase in the proportion of Health Workers being registered. Furthermore, it is assumed that Torres Strait Islander Health Workers have been included in this data, despite the fact that the Northern Territory uses the term "Aboriginal Health Worker". This assumption requires validation.

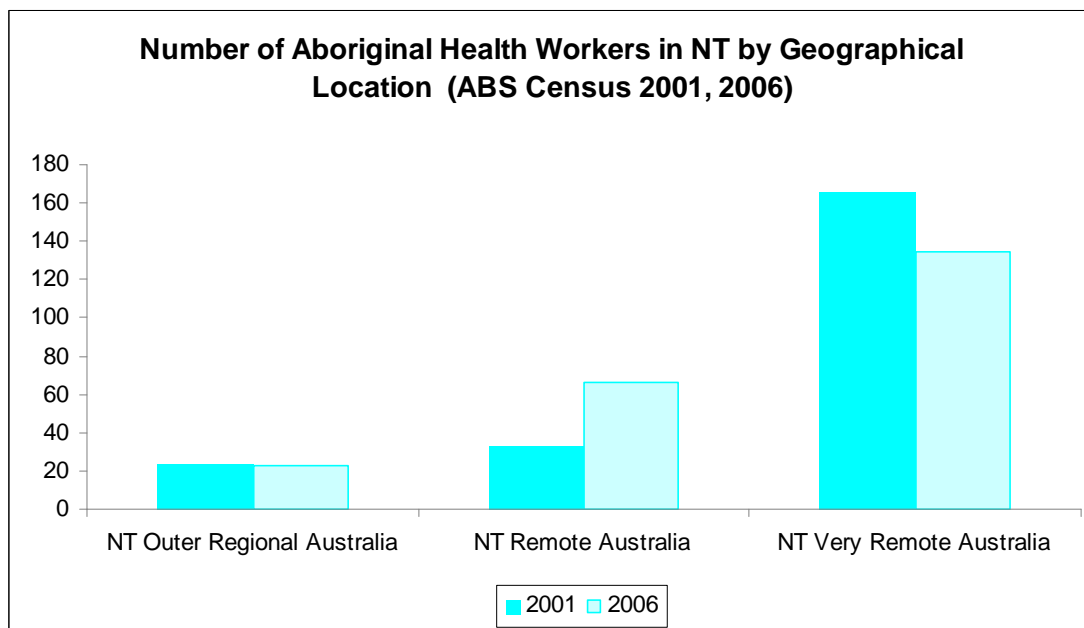
Regardless, a comparison of the Northern Territory data with the ABS data reveals significant disparities. The ABS reported that there were 223 Health Workers in the Northern Territory in 2001, and 224 in 2006 (Australian Bureau of Statistics, 2006c). In comparison, the data collected by the NT Department of Health and Families identified 367 Health Workers in 2001, and 340 in 2006 (Northern Territory Health Professions Licensing Authority, 2010). There is therefore a significant discrepancy between these two existing datasets, with a difference of 144 Health Workers in 2001, and 116 Health Workers in 2006.

This discrepancy brings to light the issue of data accuracy in relation to the Health Worker workforce. In both 2001 and 2006, the figures collected by the Northern Territory Health Professions Licensing Board are higher than those collected by the ABS. As indicated previously, ABS data is collected through self reporting as part of the Census; whereas the Northern Territory dataset is an official record of registered Health Workers. Self-reported data has a higher possibility of data entry error and misreporting than data obtained through a formal registration process. This comparison suggests that ABS data is likely to be under-representing the actual numbers of Health Workers across Australia.

Nonetheless, a brief analysis on the ABS data is provided because it provides further information on variables such as the distribution of these Aboriginal and Torres Strait Islander Health Workers across the different geographical locations, their education and qualification levels and remuneration levels.

The ABS reports that majority of Aboriginal Health Workers in both 2001 and 2006 are located within remote or very remote regions of the NT. This distribution has remained relatively consistent over the four years.

Figure 28 – Number of Aboriginal Health Workers in NT by level of remoteness



Source: AUSTRALIAN BUREAU OF STATISTICS 2006. *Census of Population and Housing, Customised Data Report requested by Health Workforce Australia*. Canberra.

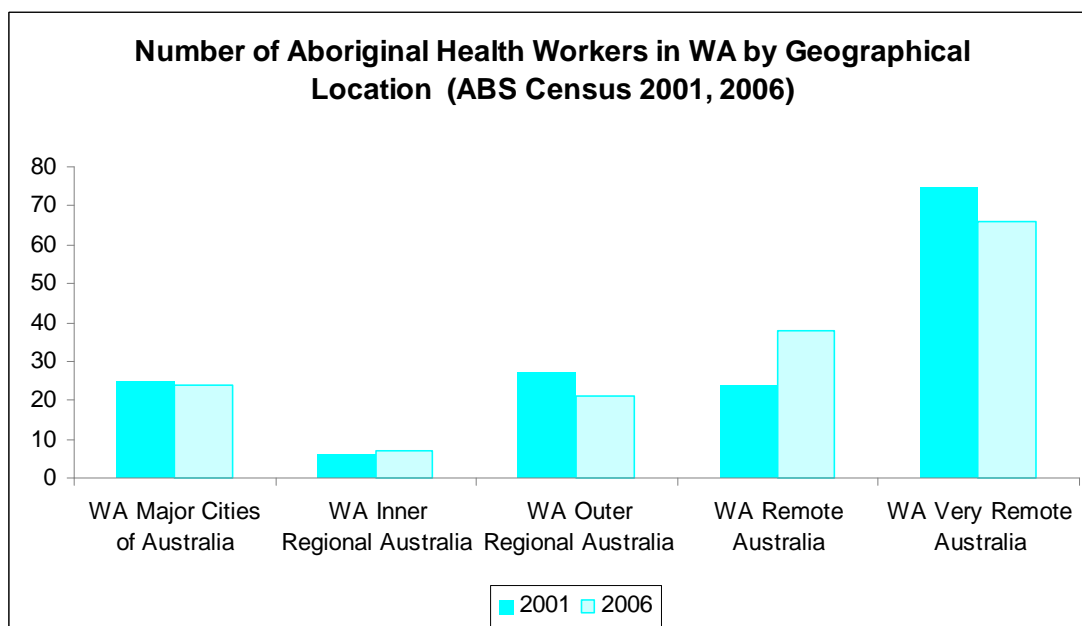
With regard to the levels of education and qualifications of the Health Workers in the Northern Territory overall, a significant increase was observed in the proportion of workers holding Certificate level qualifications from 17% in 2001 to 41% in 2006.

There were fairly evident disparities in the reported median incomes of Aboriginal Health Workers in the Northern Territory by geographical location, in keeping with the national trend whereby those in major cities had higher median incomes compared to those in remote and very remote areas. Interestingly, the median income of Health Workers in the NT on average rose by approximately 11% since 2001, with the exception of those in remote areas where the median income was reported to have fallen by 15%. It is unclear as to why this has occurred.

Western Australia

The ABS reported that there were 156 Aboriginal Health Workers in Western Australia in 2006, compared to 157 in 2001, representing no change over the four year period (Australian Bureau of Statistics, 2006c). Just over half of the Aboriginal Health Workers were located in remote or very remote areas (Figure 29).

Figure 29 – Number of Aboriginal and Torres Strait Islander Health Workers in Western Australia by geographical location, 2001 and 2006



Source: AUSTRALIAN BUREAU OF STATISTICS 2006. Census of Population and Housing, Customised Data Report requested by Health Workforce Australia. Canberra.

The level of education and qualifications of the Aboriginal Health Workers in Western Australia have also increased over the 2001 and 2006 period, with more than half the workforce holding minimum Certificate Level qualifications. Particularly noteworthy is the increase in the proportion of Health Workers holding Advanced Diploma qualifications from 7% in 2001 to 23% in 2006 (Australian Bureau of Statistics, 2006c). This may relate to the fact that the Kimberly AMS is one of only two RTOs in Australia that offer Advanced Diploma courses (See Section 10.1.2.).

While disparities in the median incomes of those working in major cities and remote/very remote areas in Western Australia were evident in 2001, those in very remote areas reported a 100% increase in their median incomes in 2006, thereby reducing the magnitude of the gap in their remuneration to some degree.

According to a secondary data source, there are approximately 167 Aboriginal and Torres Strait Islander Health Workers in WA in 2010 (Get Access, 2010). The same website claims that around 29% of Western Australian Health Workers work in the Kimberley region, 20% in the South East, 23% in the Perth metropolitan, and 21% Pilbara and Mid-West regions of the State. However, the website does not specify where this data was sourced from, or whether it is current. As such it may not reflect the actual numbers of Health Workers in Western Australia.

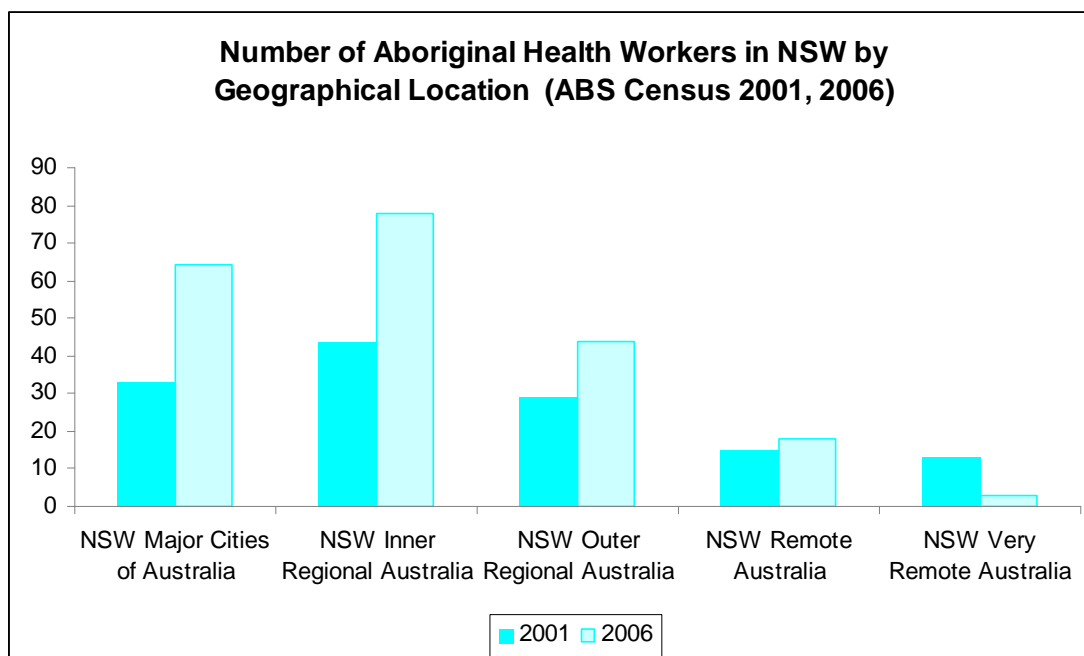
New South Wales

The ABS reported that there were 207 Health Workers in NSW in 2006. This represents a 54% increase in the number of Health Workers since 2001, when there were reportedly 134 Health Workers. While the majority of Health Workers were still predominantly female in 2006, there appeared to be a slight increase in the proportion of male Health Workers between 2001 (25%) and 2006 (28%) (Australian Bureau of Statistics, 2006c).

In 2001 and 2006, the greatest concentration of Health Workers in NSW were based in inner regional areas and major cities, at 33% and 38% respectively. Approximately 10%

of the Health Workers in 2001 were located in very remote regions and, as demonstrated in Figure 30, this dropped to only 1% in 2006.

Figure 30 - Number of Aboriginal and Torres Strait Islander Health Workers in New South Wales by geographical location, 2001 and 2006



Source: AUSTRALIAN BUREAU OF STATISTICS 2006. Census of Population and Housing, Customised Data Report requested by Health Workforce Australia. Canberra.

In keeping with the national trends, the qualifications held by Aboriginal Health Workers in NSW improved with the proportions of Aboriginal Health workers with Certificate Levels or higher - increasing to 54% in 2006, compared with 43% in 2001 (Australian Bureau of Statistics, 2006c).

With respect to remuneration, the disparity in median income levels between those working in major cities compared to those working remote and very remote areas was evident. This trend took an interesting turn in 2006, with Health Workers in very remote areas reporting an increase of 146% in their median income, thus having the highest median income in 2006 of the Health Workers in NSW - well surpassing those in major cities. The other Health Workers all reported higher median incomes between 2001 and 2006 as well, however at more modest increments.

South Australia

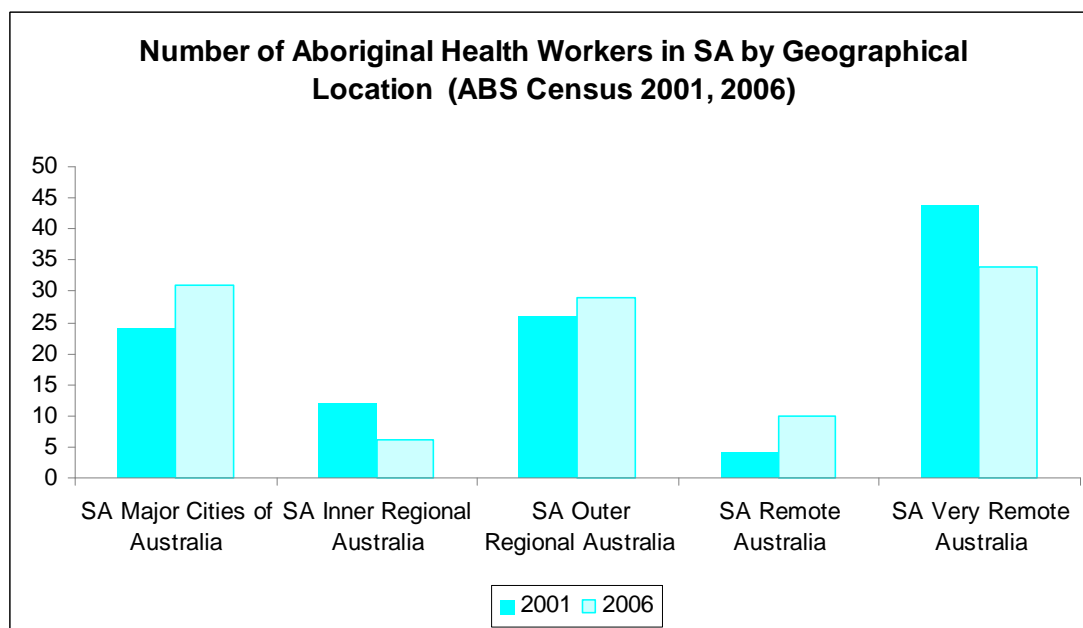
The ABS reported that there were 110 Health Workers in South Australia in both 2001 and 2006, representing no change in workforce size. The greatest proportion of Health Workers in South Australia were reported to be located in very remote areas - 40% in 2001, and 31% in 2006.

In keeping with the national trend, the level of education and qualifications of Health Workers increased, with those holding Certificate level qualifications rising by 29% over the four year period between 2001 and 2006 (Australian Bureau of Statistics, 2006c).

While inconsistencies in the median income levels of Health Workers between those in major cities and very remote areas were already apparent in 2001, those differences in 2006 were exacerbated. The median income for those working in major cities increased

by 32%, while increase of only 8% and 18% were observed for those working in remote and very remote areas respectively (Australian Bureau of Statistics, 2006c). Interestingly, those working in inner regional areas reported a 30% drop in their median income (Australian Bureau of Statistics, 2006c). It is unclear as to why this has occurred.

Figure 31 - Number of Aboriginal and Torres Strait Islander Health Workers in South Australia by geographical location, 2001 and 2006



Source: AUSTRALIAN BUREAU OF STATISTICS 2006. *Census of Population and Housing, Customised Data Report requested by Health Workforce Australia, Canberra.*

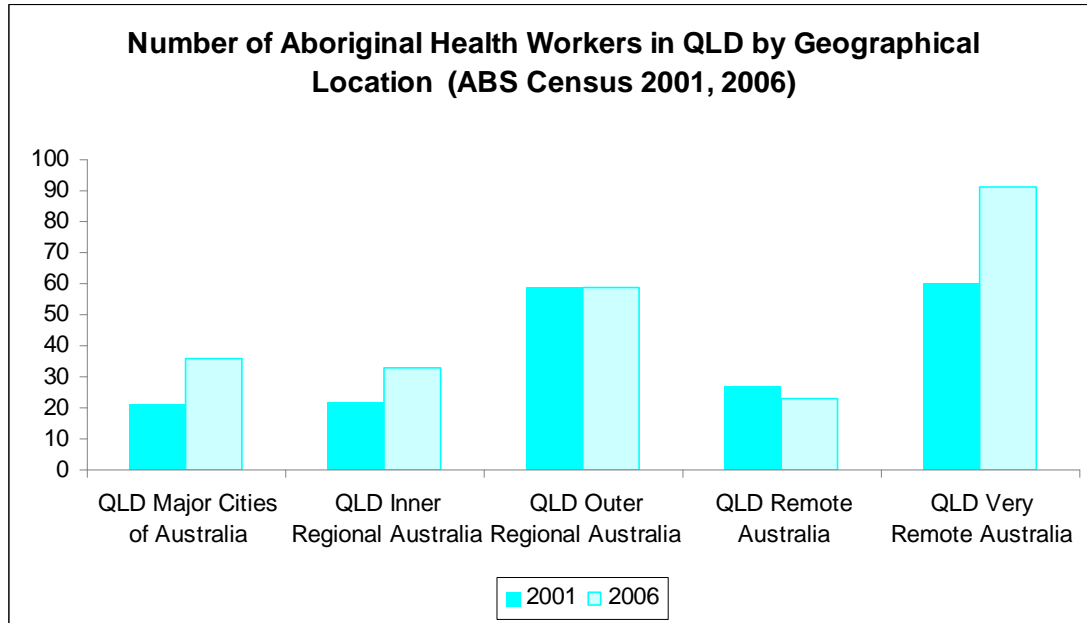
Australian Capital Territory

Data on the ACT was not reported by the ABS due to small sample size and privacy concerns. As such, there is no evidence available to this project on the size and distribution of the Health Worker workforce in this territory.

Queensland

Between 2001 and 2006, the ABS reported a 28% increase in the number of Health Workers in Queensland from 189 to 242 (Australian Bureau of Statistics, 2006c). The distribution of Health Workers across the different geographical locations in Queensland remained fairly consistent between 2001 and 2006, with the greatest proportion (38%) of Health Workers located in very remote areas of Queensland in 2006 (Figure 32).

Figure 32 - Number of Aboriginal and Torres Strait Islander Health Workers in Queensland by geographical location, 2001 and 2006



Source: AUSTRALIAN BUREAU OF STATISTICS 2006. Census of Population and Housing, Customised Data Report requested by Health Workforce Australia. Canberra.

Consistent with the national trend, Health Workers in Queensland are becoming increasingly more qualified as demonstrated in a reduction in the proportion of Health Workers reporting that they had either no qualifications or qualifications that were outside the scope of their work from 43% in 2001 to 29% in 2006 (Australian Bureau of Statistics, 2006c). The proportion of those holding Certificate level qualifications rose from 14% to 28% in the same period.

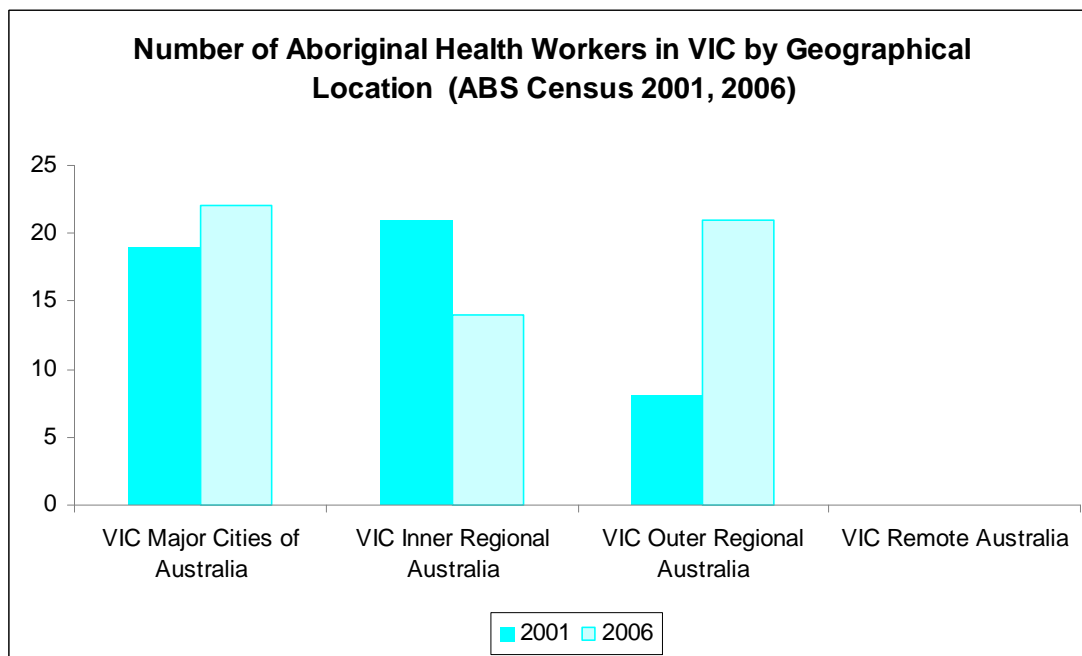
The variation in levels of remuneration of Health Workers across geographical locations remained constant between 2001 and 2006, with those working in remote to very remote areas still reporting lower median incomes compared to those in major cities or inner regional areas of Queensland despite slight increments over the same period (Australian Bureau of Statistics, 2006c).

However, the review of literature has revealed that Queensland has a Secure AMS Information System (SAMSIS) which provides a comprehensive workforce profile (Queensland Aboriginal and Torres Strait Islander Health Partnership Workforce Working Group and Carla Cranny & Associates, 2008). This database is used by the Queensland Aboriginal and Islander Health Council (QAIHC), QAIHC members, and the Office of Aboriginal and Torres Strait Islander Health (OATSIH). Access to this data source would enable more detailed analysis on the size and distribution of the Health Worker workforce in Queensland.

Victoria

The ABS reported a small increase in the number of Health Workers in Victoria between 2001 and 2006, from 47 to 57 (Australian Bureau of Statistics, 2006c). While in 2001, Health Workers in Victoria were mostly concentrated in either major cities or inner regional areas, there was a significant shift in the distribution of Health Workers in 2006 to the outer regional areas of Victoria.

Figure 33 - Number of Aboriginal and Torres Strait Islander Health Workers in Victoria by geographical location, 2001 and 2006



Source: AUSTRALIAN BUREAU OF STATISTICS 2006. Census of Population and Housing, Customised Data Report requested by Health Workforce Australia. Canberra.

Interestingly, in contrast to the national overall trend, the level of qualifications held by Health Workers in Victoria between 2001 and 2006 declined slightly with just over 50% of those surveyed reporting qualifications outside the scope of work or with no qualification compared to only 40% in 2001 (Australian Bureau of Statistics, 2006c).

The disparity in the levels of remuneration of Aboriginal Health Workers in Victoria by geographical location however do not appear to be as marked as other jurisdictions and all cohorts received relatively similar increments in their median incomes between 2001 and 2006.

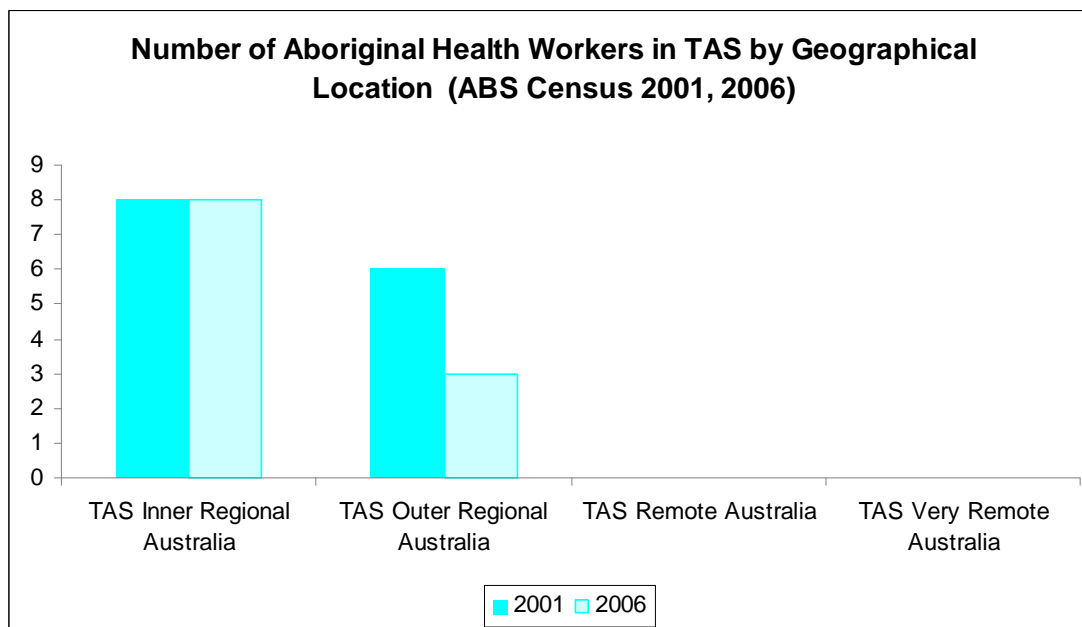
Tasmania

The ABS reported a 21% decrease in the numbers of Aboriginal Health Workers in Tasmania from 14 to 11 between 2001 and 2006, with the majority of them based in inner regional areas of Tasmania (Figure 34) (Australian Bureau of Statistics, 2006c).

Interestingly, in Tasmania approximately three quarters of the Aboriginal Health Workers reported having no qualifications or qualifications outside the scope of their work, while the remaining quarter reported holding Bachelor degree level qualifications (Australian Bureau of Statistics, 2006c). It is not clear whether this is still the case in Tasmania, considering that these data are now four years old, and the CS&HISC national qualifications framework was introduced in the mean time.

In 2006, the remuneration disparities that existed between Aboriginal Health Workers working in inner regional and outer regional areas in 2001 were reduced significantly, with those in outer regional areas receiving an 81% increase in their median income, bringing the income levels close to parity (Australian Bureau of Statistics, 2006c).

Figure 34 - Number of Aboriginal and Torres Strait Islander Health Workers in Tasmania by geographical location, 2001 and 2006



Source: AUSTRALIAN BUREAU OF STATISTICS 2006. *Census of Population and Housing, Customised Data Report requested by Health Workforce Australia, Canberra.*

7.3 Comparison with the broader Aboriginal and Torres Strait Islander health workforce

Due to the Health Worker workforce data limitations, it is helpful to consider the broader Aboriginal and Torres Strait Islander health workforce to gain insights into the workforce response to Aboriginal and Torres Strait Islander health needs. Figure 35 compares the geographic distribution of the Aboriginal and Torres Strait Islander population with the geographic distribution of Aboriginal and Torres Strait Islander people employed in health occupations. This includes Health Workers and other Aboriginal and Torres Strait Islander health professionals, such as doctors, nurses and allied health professionals.

Figure 35 provides a ratio of the Aboriginal and Torres Strait Islander population to Aboriginal and Torres Strait Islanders employed in health occupations. From this analysis, it is clear that Northern Territory has the highest ratio, with one Aboriginal and Torres Strait Islander health professional for every 157 Aboriginal and Torres Strait Islander individual. In comparison, the ACT has the lowest ratio with one Aboriginal and Torres Strait Islander health professional for every 81 Aboriginal and Torres Strait Islander individuals. A low ratio is preferable because it indicates a greater supply of Aboriginal and/or Torres Strait Islander health professionals.

This information provides some insights into the broader response to Aboriginal and Torres Strait Islander health needs, but does not provide details of the availability of Health Worker services specifically. According to a comparison of 2006 ABS Census data with the 2006 AIHW Health and Community Services Labor Force data, approximately 17% of the total Aboriginal and Torres Strait Islander health workforce (5,535 persons) are Aboriginal and Torres Strait Islander Health Workers (965 persons). However, it is unlikely that this ratio is consistently applicable in every State and Territory.

Figure 35 - Distribution of Aboriginal and Torres Strait Islander persons employed in health occupations, 2006

Jurisdiction	Aboriginal and Torres Strait Islander population	Aboriginal and Torres Strait Islander population as a proportion of total population in jurisdiction (%)	Aboriginal and Torres Strait Islander population employed in health occupations	Ratio of Aboriginal and Torres Strait Islander population to Aboriginal and Torres Strait Islander health professionals
NSW	161,910	2.3	1,948	83:1
Qld	156,454	3.6	1,491	105:1
WA	74,859	3.4	570	131:1
NT	67,441	30.2	430	157:1
Vic	35,894	0.7	455	79:1
SA	29,775	1.8	367	81:1
Tas	19,641	3.9	214	92:1
ACT	4,599	1.3	57	81:1
Unspecified	4,844	N/a	60	N/a
Australia Total	550,818	2.5	5,535	100:1

Source: ABS Census of Population and Housing, 2006, AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE, 2006. Health and Community Services Labour Force 2006: Online data tables [Online]. Available: http://www.aihw.gov.au/publications/index.cfm/title/10677#detailed_tables [Accessed 13 December 2010].

7.4 Section summary

Data relating to the size, geographic distribution and demographic profile of the Aboriginal and Torres Strait Islander Health Worker workforce are integral to the process of workforce planning.

However, as this section has demonstrated, Australia does not have a clear national picture of the Health Worker workforce at this point in time. The data that are available have many limitations. For example, there is no clear definition of Aboriginal and Torres Strait Islander Health Workers used across Australia to define the data set; available data are not up-to-date; there is no national data source apart from the ABS, yet a comparison of ABS data with that from the Northern Territory Health Worker Registry highlights concerns about the accuracy of the ABS data set.

In short, there is a limited evidence base regarding the size and distribution of the Aboriginal and Torres Strait Islander Health Worker workforce.

However, using the best available data, certain key points are clear:

- The distribution of the total Health Worker workforce does not align to the distribution of the Aboriginal and Torres Strait Islander population – 48% of the Health Worker workforce is located in remote or very remote areas of Australia, whilst only 24% of the Aboriginal and Torres Strait Islander population is
- There are remuneration disparities between urban and remote areas, with those based in remote areas earning significantly less than those based in urban areas
- The majority of Health Workers are female (70%)

These findings raise some important considerations for the future development of the Health Worker workforce.

During the consultation phases of this project, an attempt will be made to gain supplementary evidence to gain additional insights from this data.

8. Quality and safety

Quality and safety mechanisms are crucial part of any health service. They protect the safety of the public and ensure that appropriate support is provided to health professionals delivering services.

This chapter considers the quality and safety mechanisms that exist in relation to services provided by Health Workers. The relevant body of information is outlined, focusing on three key areas in particular:

- Health Worker regulation and licensing processes across Australia
- Supervisory structures in place, and
- The data collection systems that facilitate performance evaluation processes for Health Workers.

Only a very limited body of information is available in relation to each of these areas. This does not demonstrate that good quality and safety mechanisms are lacking; rather, it shows that evidence of good practice is poorly documented. There is therefore an opportunity for this project to make a contribution to the limited knowledge base currently available.

8.1 Regulation and licensing of Health Worker services

There are limited experiences of regulation and licensing of Health Worker services across Australia. The Northern Territory is the only jurisdiction in Australia with a formal registration process for Health Workers. The only other state/territory with a relevant experience is Queensland, which has regulations that provide some Health Workers with Isolated Practice Authorisation. The literature does, however, reveal support for the process of moving towards a national registration system for the Health Worker workforce.

8.1.1 Health Worker Registration in the Northern Territory

The Northern Territory is the only jurisdiction in Australia that has a formal registration system for Aboriginal Health Workers. For this reason, literature relating to the regulation and licensing of Health Workers is predominately generated from the Northern Territory.

In the Northern Territory, Health Workers are registered with the Health Professionals Licensing Authority and regulated by the Aboriginal Health Workers Board of the Northern Territory. Regulation in the Northern Territory commenced in 1984 (Aboriginal Health Workers Board of the Northern Territory, 2008). Currently, Health Workers in the Northern Territory are regulated under the Health Practitioners Act 2004 (Northern Territory Consolidated Acts, 2004).

The Aboriginal Health Workers Board of the Northern Territory has developed a number of relevant policies on the following topics (Health Professions Licensing Authority, 2010):

- Entitlement to Registration
- Clinical Competency Guidelines
- Currency of Competence

- Code of Ethics
- Sexual Relationship with Patients
- Good Character.

These policies provide a formal framework for the required Health Worker competencies, qualifications and conduct.

The NT Aboriginal Health Worker Board also requires that, if practitioners have not been in clinical practice for more than 12 months, the practitioner needs to have a current "Apply First Aid" Certificate (an initial requirement for the current qualification) to be fully registered by the Board. If the practitioner registration has lapsed and has not been in clinical practice for more than 3 years and wishes to re-register and return to clinical practice, the Board requires that they be assessed by an accredited workplace assessor against the Clinical Competencies.

Clinical Units for reassessment include:

- HLTAHW301B: Apply First Aid
- HLTAHW401A: Assessment of Client Physical Wellbeing
- HLTAHW406A: Work with Medicines
- HLTAHW404A: Monitor Health Care
- HLTAHW402A: Assess and Support Client Social and Emotional Wellbeing only;
- Element 2 – Performance Criteria 1–10 Essential Skills and Essential Knowledge

Medication management by Aboriginal Health Workers in the Northern Territory is regulated through the Poisons and Dangerous Drugs Act (1983). Section 29 of the Act allows Registered Aboriginal Health Workers at Specified locations and centres to possess and supply certain Schedule 2, 3 and 4 medications in line with approved clinical protocols.

8.1.2 Isolated Practice Authorisation in Queensland

Although no other jurisdiction has a formal registration system for Aboriginal and Torres Strait Islander Health Workers, in Queensland some Health Workers can be licensed to perform certain clinical practices under the Health (Drug and Poisons) Regulation 1996 (Queensland Parliamentary Counsel, 2010).

Health Workers that receive Isolated Practice Authorisation are permitted to:

- a Obtain and possess a restricted drug; or
- b Administer or supply a restricted drug, under a drug therapy protocol, on the oral or written instruction of a doctor or nurse practitioner (Queensland Parliamentary Counsel, 2010).

This regulation was designed to facilitate the delivery of health services in areas of Queensland that do not have regular access to the services of other health professionals. According to this regulation, an Isolated Practice Area (IPA) is defined to be a place that is:

- a Cow Bay, Marpuna and Weipa
- b Remote from pharmaceutical services

- c Serviced by a plane operated by the Royal Flying Doctor Service (Queensland Government, 2010).

The literature available at the time of writing did not indicate how many Health Workers in Queensland currently have Isolated Practice Authorisation or use it on a regular basis. Furthermore, there is no evidence available that distinguishes how Isolated Practice Authorisation influences the Health Worker role. There is an opportunity to investigate this further during the Community Mapping process.

8.1.3 The National Registration and Accreditation Scheme

Apart from the Northern Territory and some instances of Isolated Practice in Queensland, no other jurisdiction in Australia specifically regulates their Health Worker workforce.

Australian Health Ministers have determined Aboriginal and/or Torres Strait Islander Health Practitioner will be registered under the National Registration and Accreditation Scheme for Health Workers from July 2012. The consideration of the entry level requirements for registration as an Aboriginal and/or Torres Strait Islander Health Practitioner will be the responsibility of the National Aboriginal and/or Torres Strait Islander Health Practitioner Board once established. Information from the HWA Aboriginal and Torres Strait Islander Health Worker project will assist in informing the work of the Board.

AHPRA has a number of mandatory registration standards that are common across all ten registered health professions. The mandatory registration standards include (Australian Health Practitioner Regulation Agency, 2010):

- Criminal history
- English language skills
- Professional indemnity insurance arrangements
- Continuing professional development
- Recency of practice

Although these standards might change for the registration of Aboriginal and Torres Strait Islander Health Practitioners, it is likely that they will be consistent.

8.2 Policy and procedures related to Health Workers

In Queensland, authorised Aboriginal and Torres Strait Islander Health Workers are trained in, and work according to, the Primary Clinical Care Manual (PCCM). The PCCM is the primary clinical guideline for Health workers in Queensland. The manual is a strong contributor to safe, timely and quality health care for the communities in which Health Workers practice.

Since 2005 the PCCM has been utilised by remote Registered Nurses within the Greater Western Area Health Service through a collaborative practice model with medical practitioners and rural hospitals. The PCCM is reviewed every two years in line with the requirements of the Queensland Health (*Drugs and Poisons*) Regulation 1996.

Health Workers in the Northern Territory practice in line with the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual. CAPRA has been the basis of remote practice in the NT for Aboriginal Health Workers and Remote Area Nurses since the mid 1980s. The manual contains standard clinical protocols for:

- Common conditions (such as STIs, Diabetes)
- Life threatening conditions that can benefit from emergency procedures (e.g. pneumothorax)
- Guidance on common conditions that might otherwise be intimidating for staff (such as psychotic patient), and
- Guidance on issues of public health importance relevant to clinical practice (such as early intervention for chronic disease and smoking interventions).

The CAPRA manual is updated every three to four years following extensive expert review.

Health Workers in a number of jurisdictions are required to complete the *About Giving Vaccines (AGV) Course* prior to being credentialed to administer immunisations. The AGV Course for Health workers is delivered through a five day face-to-face mode. The AGV course provides professional evidenced based education, to manage and administer vaccines in compliance of standard 13 of National Health and Medical Research Council (NHMRC) requirements for vaccinations. In the Northern Territory, health care providers who have not completed the course are required to administer immunisations under direct supervision (NT Health, *About Giving Vaccines in Remote Health Atlas*, May 2007).

8.3 Supervision of Health Workers

There is very limited information available on the supervisory structures in place around Health Workers.

In Queensland, Aboriginal and Torres Strait Islander Health Workers operate within a delegated model of care (Queensland Health, 2007a). This means that some Health Workers may be responsible for managing other Health Workers, which could include both delegating and supervising responsibilities (Queensland Health, 2007a). This supervisory structure was clearly delineated when Queensland undertook a significant body of work to develop the Aboriginal and Torres Strait Islander Health Worker Career Structure, which was introduced in 2007.

None of the other documents collected during the course of this Environmental Scan specifically alludes to supervision practices in other jurisdictions or in the Aboriginal and Torres Strait Islander Community Controlled Sector. This does not mean that effective supervision is not occurring. Rather, it shows that it has not been an area of focus in the past, and that there may not be sufficient evidence to understand what type of supervision is appropriate for Health Workers.

The community mapping process is well-placed to gain insights into these information gaps, and consider the perspectives of Health Workers, their Managers, and other Health Professionals that work alongside them.

8.4 Data collection and monitoring and evaluation

There is also a shortage of literature in relation to the collection of data on Health Worker services, or the process of monitoring and evaluating their outcomes.

The Victorian Aboriginal Health Plan developed by the Victorian Advisory Council on Koori Health refers to the need to address existing gaps in data and information collection and management (Victorian Advisory Council on Koori Health, 2009).

According to this document, data collection is perceived to be a vital step towards strengthening the evidence base around the value of the Health Worker role.

Winnunga Nimmityjah Aboriginal Health Service provides one example of a service that is implementing systems to ensure consistent feedback from community members and program participants (Winnunga Nimmityjah Aboriginal Health Service, 2007).

The project is also aware that a recent review of the Health Worker Profession being undertaken in the Northern Territory considers Health Worker performance management; however, at this stage this review is not publicly available.

Aside from these examples, there is not much additional information available.

8.5 Section summary

Quality and safety mechanisms are crucial aspects of any health service. Although the Health Worker role does vary significantly across Australia, some Health Workers are performing clinical tasks that pose a risk to the safety of their clients, themselves and their health service. As with any health profession, it is necessary to establish appropriate quality and safety mechanisms to protect Aboriginal and Torres Strait Islander clients and appropriately support Health Workers delivering services.

However, there is limited discussion in the literature about quality and safety processes in place in relation to Health Worker services. This does not indicate that good performance monitoring processes do not exist; only that little is documented about how to appropriately ensure the quality and safety of Health Worker services. Quality and safety is therefore a key area for further investigation during the Community Mapping phase of this project.

In particular, it will be worth establishing the following:

- To what extent do the roles performed by Health Workers involve a level of clinical and public risk?
- What quality and safety processes do health services already have in place manage this risk (including supervision, data collection, monitoring and evaluation)?
- What quality and safety processes are appropriate to manage this risk?
- What are the options for the development and implementation of consistent standards of Health Worker practice?
- How is clinical risk management built into the current Health Worker education and scope of practice?
- Are collaborative networks in place to support Health Workers in recognising and managing situations which are outside their scope of practice?
- What variables affect responses to the above questions? For example:
 - Jurisdictional requirements
 - Location (urban, regional, remote)
 - Place of employment (AMS/ACCHO, Public health clinic, Public hospital, etc.)
 - Access to/interface with other health professionals
 - Level of experience and/or competence

9. Career pathways

The development of a strong, competent Health Worker workforce depends upon the creation of accessible and well-supported career pathways. Robust career pathways are an effective way of empowering Health Workers to reach their full capacity.

This chapter provides an overview of past and existing initiatives that are relevant to the development of stronger career pathways for Health Workers. A significant body of work has already been undertaken in this area. Notably, over a number of years the Community Services & Health Industry Skills Council (CS&HISC) has worked to establish a nationally consistent, cross-sector Health Worker qualifications framework and toolkits to support Health Worker employers.

However, barriers for Aboriginal and Torres Strait Islander people who wish to enter the Health Worker workforce, or access opportunities for career progression once in the workforce, still remain. For example, there are economic, literacy/numeracy and geographic barriers to accessing requisite training courses; qualification requirements vary across Australia; and the pathways for articulating into other health professions are poorly defined. These barriers are highlighted in this chapter with reference to recommendations identified in the literature about how to overcome these challenges.

9.1 Overview of existing research and initiatives relating to career pathways

A number of different studies and initiatives have been undertaken across Australia in relation to the career pathways available to Health Workers. However, many of these studies or initiatives have been undertaken in a single jurisdiction; and others have been solely in relation to Health Workers employed by either the Government sector or the Aboriginal Community Controlled sector. The source of some of the most recent, nationally recognised initiatives is the Community Services & Health Industry Skills Council (CS&HISC).

9.1.1 The development of a national qualification framework for Aboriginal and Torres Strait Islander Health Workers

The CS&HISC has generated an ongoing body of work over a number of years, which has been developed in close consultation with relevant stakeholders and representatives of the Health Worker workforce.

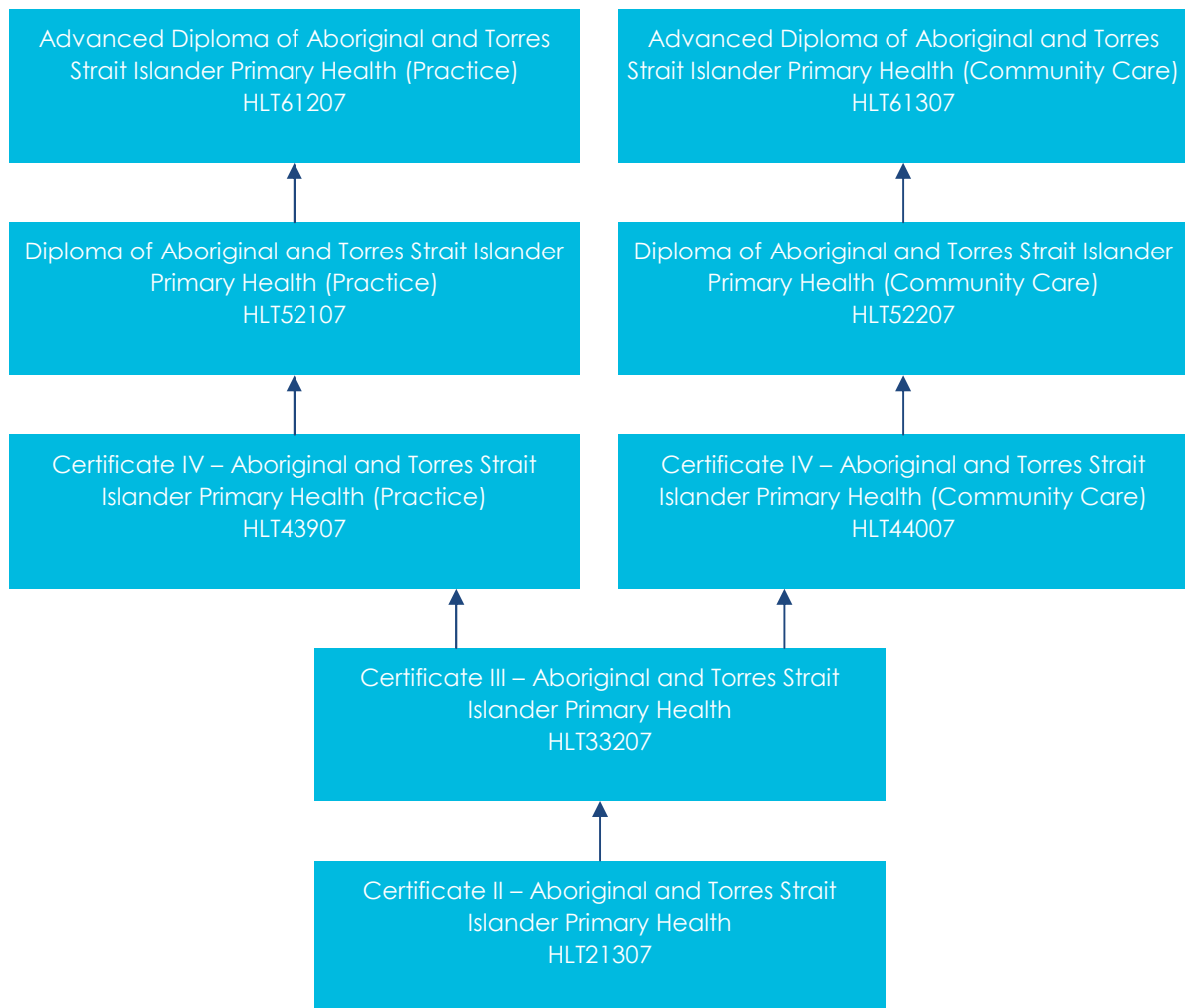
In 2002, CS&HISC engaged technical writers from each State and Territory to assist in the development of a national Aboriginal and Torres Strait Islander Health Worker qualification framework. The new framework positioned the Health Worker qualification within a mainstream training package for the first time. This training package, the Health Training Package HLT07, was released in February 2007 inclusive of the national Aboriginal and Torres Strait Islander Health Worker qualifications. Since then, the package has been revised with the most recent version (Version 2.1) being released in 2008 (Community Services & Health Industry Skills Council, 2008b).

Figure 36 below provides the qualification framework developed by CS&HISC. The relevant qualifications and competencies required at each level of the career structure

are outlined in the CS&HISC Competency Matrix, which is an online tool that assists Health Workers to identify which qualifications they require in accordance with the national framework (Community Services & Health Industry Skills Council, 2010). This tool presents a framework of nationally agreed skills required to work in the Aboriginal and Torres Strait Islander Primary Health Care sector.

Worth noting is the fact that the CS&HISC provides two career pathways for Health Workers – either as part of the Community Care stream, or the Clinical Practice Stream.

Figure 36 – Community Services & Industry Skills Council Health Worker Qualification Framework



(Community Services & Health Industry Skills Council, 2008b)

CS&HISC is also undertaking evaluations of the implementation of this training package in each state and territory in order to assess the impact that it has had in each jurisdiction (Community Services & Health Industry Skills Council, 2008a).

In addition, the CS&HISC undertakes annual Environmental Scans. These Environmental Scans:

- Summarise the latest industry intelligence
- Identify workforce development needs

- Outline some of the impacts of training packages, and
- Highlight possible future directions for components of training packages (Community Services & Health Industry Skills Council and Workplace Research Centre, 2010, Community Services & Health Industry Skills Council, 2009).

The ongoing work of the CS&HISC is highly relevant to the future development of strong career pathways for Health Workers.

9.1.2 Career pathways in practice

A number of actions undertaken by the Community Controlled sector and State and Territory Government sector organisations demonstrate a general commitment to implementing the CS&HISC qualification framework across the nation.

However, some discrepancies in available career pathways on the ground in each jurisdiction do exist. These are highlighted by considering the Northern Territory and Queensland below, and identifying their distinguishing features.

Northern Territory

The Northern Territory career structure reflects the framework developed by the CS&HISC to some extent. However, there are several points that distinguish the NT. Firstly, the minimum entry level requirement to become a Health Worker is the Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Practice) (Health Professions Licensing Authority, 2008b). Qualifications that are deemed equivalent by the Aboriginal Health Workers Board of the Northern Territory are also accepted. The Northern Territory therefore demands a higher entry-level requirement than that expected in other jurisdictions.

Secondly, Aboriginal or Torres Strait Islander people that do not have a Clinical Practice stream qualification cannot be registered. The Community Care stream is not recognised as part of the registered Health Worker career pathway.

Another point to note is that, in order to progress up the qualification framework, Clinical Competence Assessments must be undertaken by a Registered Training Organisation (RTO) (Health Professions Licensing Authority, 2008a).

The Northern Territory Department of Health and Families has recently conducted an extensive review of the Health Worker profession. It is expected that this review will provide valuable information about Health Worker career pathways in the Northern Territory, much of which will be relevant across the nation. This project looks forward to the public release of this review.

Queensland

Queensland Health developed an Aboriginal and Torres Strait Islander Health Worker Career Structure in 2007 (Queensland Health, 2007a). This document outlines the mandatory qualifications for Aboriginal and Torres Strait Islander Health Workers, and is closely aligned to the CS&HISC Health Worker Qualification Framework (Queensland Health, 2007a). The Queensland Career Structure establishes minimum qualifications that are required at each level of the Health Worker's career in a Government-employed setting (depicted in Figure 37). In contrast to the Northern Territory, Cert III is the minimum standard of qualification for entry into the Health Worker profession.

Queensland Health identifies three paths for career progression for the Health Workers that it employs – Personal Progression Scheme A, Conditional Advancement Scheme B; and Recruitment selection process based on merit (Queensland Health, 2007a).

Figure 37 – QLD Health Aboriginal and Torres Strait Islander Career Structure from 1 November 2007

Career structure level	Health Worker title	Minimum qualification
002	Trainee Health Worker	Enrolled in Certificate III Primary Health Care
003	Health Worker Generalist	Certificate III Primary Health Care
004	Health Worker Advanced	Certificate IV Primary Health Care
005	Health Worker Advanced	Diploma Primary Health Care
006	Health Worker Advanced IPA	Diploma in Primary Health Care and Isolated Practice Authorisation
006	Health Worker Advanced	Diploma in Primary Health Care
007	Senior Health Worker Programs	Diploma in Primary Health Care
007	Senior Health Worker IPA	Diploma in Primary Health Care and Isolated Practice Authorisation
007	Senior Health Worker	Diploma in Primary Health Care
007	Cluster Coordinator	Diploma in Primary Health Care
008	Cluster Coordinator	Advanced Diploma in Primary Health Care
007	Manager Health Programs	Diploma in Primary Health Care
008	Manager Health Programs	Diploma in Primary Health Care
008	Manager Health Worker Services	Diploma in Primary Health Care
009	Manager Health Worker Services	Advanced Diploma in Primary Health Care

Source: Queensland Health 2007. *The Aboriginal and Torres Strait Islander Health Worker Career Structure*. Brisbane.

The available literature does not provide clear evidence on how effective the experience of introducing a new career structure has been in Queensland. This type of information would provide some valuable insights for the process of moving towards national registration of the Health Worker workforce.

Other states and territories

Some information on the career pathways of Health Workers in other states and territories is available, but it does not go into the same level of depth as that published in the Northern Territory and in Queensland.

It will be interesting to learn more about the differences in available career pathways for Health Workers during the Community Mapping phase of the project. This will facilitate the development of a more national picture of the available opportunities for and barriers to career progression. Importantly, Community Mapping activities provide an opportunity to validate some of the themes that are emerging.

9.2 Themes emerging from the literature

Available documentation highlights several key themes that are pertinent to the future development of the Health Worker workforce. For example:

9.2.1 Entry-level requirements to become a Health Worker vary across the country

This is demonstrated by the differences between the Northern Territory and Queensland highlighted above (Queensland Health, 2007a, Health Professions Licensing Authority, 2008a). It is also emphasised by the CS&HISC's analysis of the impact of the roll-out of the national qualification framework in NSW (Community Services & Health Industry Skills Council, 2008a).

Therefore, an area for further investigation should focus around identifying what qualification level is appropriate for entry into the Health Worker profession.

9.2.2 Opportunities for career progression are limited

These limitations might be due to a number of factors, including:

- Limited career paths for AHWs who wish to move into management positions or specialist areas (Community Services & Health Industry Skills Council, 2008a)
- A lack of structured professional development training programs tailored individually for all AHWs with career progression goals
- Inconsistent management approaches by different government employers to the interpretation of the scope of practice of Health Workers (Community Services & Health Industry Skills Council, 2008a)
- Community Controlled Organisations Enterprise Bargaining Agreements and award systems (Community Services & Health Industry Skills Council, 2008a)
- Pay parity across sectors, health services and in comparison to nursing staff (Townsend, 2008)

This project is aware that some of these limitations are explored in more detail by a recent review of the Health Worker Profession that was undertaken in the Northern Territory, and hopes to include additional references to this work once the review is made publicly available.

In addition, any evidence that is collected throughout this project that will validate the limitations identified in the literature will serve as an important contribution to the process of strengthening career pathways for Health Workers.

9.2.3 Nationally recognisable and transferable skill sets are crucial

Aboriginal and/or Torres Strait Islander Health Workers often move interstate and seek to practice in more than one jurisdiction. Some states/territories have different requirements and standards of practice for Health Workers and different career pathways. The issue of transferability of skills across jurisdictions is therefore relevant.

Some jurisdictions address this by explicitly acknowledging equivalent qualifications obtained in other jurisdictions. For example, the Northern Territory permits interstate graduates of the Certificate IV Aboriginal and Torres Strait Islander Primary Health Care (Practice) qualification to apply for Health Worker registration. Those applicants who do not hold a recognised qualification are able to undertake an assessment against identified core clinical competencies (Aboriginal Health Workers Board of the Northern Territory, 2008). This assessment identifies whether the person has equivalent clinical competencies, or whether further training is required. An applicant may be granted Conditional Registration whilst they are undertaking this assessment (Aboriginal Health Workers Board of the Northern Territory, 2008).

The CS&HISC national qualifications framework for Aboriginal and Torres Strait Islander Health Workers further contributes to the issue of skills transfer. This qualification framework is being rolled out across jurisdictions, in both the Government and Aboriginal Community Controlled sectors (Community Services & Health Industry Skills Council, 2008a). It is likely this will facilitate opportunities for interstate mobility and career progression. However, it is not yet possible to demonstrate the impact of these national qualifications.

9.2.4 There is limited information on the articulation pathways of Health Workers into other health professions

Much of the literature that is available focuses upon the progression of Health Workers within the Health Worker profession. However, in the interest of providing a full picture of career pathways for Health Workers, it is also important to consider their pathways into other health professions. There is a lack of information about how common it is for Health Workers to articulate into other health professions; there is also minimal analysis on how challenging these pathways are for Health Workers to navigate.

9.3 Section summary

A significant body of work has already been undertaken in relation to the career pathways of Aboriginal and Torres Strait Islander Health Workers. The body of knowledge formed by these collective learnings provides a valuable foundation for this project to draw from and continue to build upon. Every effort should be made to contribute to this evidence base, rather than duplicate past work.

However, the majority of past efforts have been confined to particular jurisdictions. Furthermore, most have been restricted in focus to Health Workers who are employed by the Government, or those who are employed by the Aboriginal and Torres Strait Islander Community Controlled sector. Therefore, although highly valuable and informative studies have already been undertaken in the past, this project represents an important opportunity to synthesise and build upon this knowledge base.

Although the available literature highlights a variety of perspectives, several key themes have emerged. These include:

- Entry-level requirements to become a Health Worker vary across the country
- Opportunities for career progression are limited by a variety of factors
- Nationally recognisable and transferable skill sets are crucial
- There is limited information on the articulation pathways of Health Workers into other health professions

Information collected throughout the course of this project can be used to validate these themes, thereby establishing a clearer picture of how to strengthen the career pathways available to Health Workers across the country.

In particular, evidence can be used to respond to the following questions:

- What is an appropriate entry-level qualification standard for Health Workers?
- What are the inter- and intra-professional career pathways available to Health Workers?
- What are the barriers to progression within the Health Worker career structure?
- What are the barriers to articulation into other health professions?
- What continuing professional development activities do Health Workers undertake?

There are also a number of important questions arising in relation to the appropriate qualification level of health workers. This will be discussed further in the following chapter, which considers the education and training avenues available for Health Workers.

10. Education and training

Health Worker education and training is fundamental to the development of a workforce that is sufficiently qualified and competent to respond to the health needs of Aboriginal and Torres Strait Islander communities. This section synthesises information regarding the educational and training opportunities available to Health Workers, commenting on the different education providers available and the distribution of Health Worker training courses across Australia. It highlights the fact that there are limited tertiary educational courses available, despite purported interest in raising the educational qualifications of the Health Worker workforce. Enablers of education for Health Workers are also considered, including financial assistance, travel support and leave arrangements.

10.1 What educational opportunities are available?

10.1.1 Overview of developments in Health Worker education and training

There have been significant changes to the education and training environment in the last decade. In 2000, Health Worker training was poorly planned, coordinated, and distributed across the country, with inconsistent training standards and curricula (Curtin Indigenous Research Centre with Centre for Educational Research and Evaluation Consortium and Jojara & Associates, 2000).

The development of a national health worker training package by the Community Services and Health Industry Skills Council in 2007 helped to overcome some of these issues, introducing clearly defined, national training requirements for Health Workers (Community Services & Health Industry Skills Council, 2008b). This paved the way for greater consistency of curricula and training standards across jurisdictions.

More recently, the Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network (ATSIHRTONN) undertook a national review of the orientation, education and training needs for the Aboriginal and Torres Strait Islander health workforce (2009) (Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network, 2009). This review identified some important areas of development that continue to exist, recommending strategies for addressing them moving forward. For example:

- There is a need for a single national orientation resource to provide adequate orientation for new workers in Aboriginal and Torres Strait Islander Primary Health Care
- Education and training needs to include "culturally appropriate, high quality and flexible pathways; and a blended delivery approach involving face-to-face interaction, written resources, eLearning tools and workplace learning" (Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network, 2009)
- Specific attention needs to be given to training opportunities in rural and remote areas
- There needs to be further development and coordination of professional development opportunities, and

- There is a need for a more equitable funding model for Aboriginal Community Controlled Health Registered Training Organisations (RTOs). These organisations are not perceived to be funded on a consistent, effective or equitable basis, despite recognition of their unique role in delivering culturally appropriate educational opportunities (Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network, 2009).

Therefore, although the education and training environment has undergone significant changes in the past decade, there are still opportunities for further development to better meet the training needs of Health Workers.

Importantly, a high level examination of the various opportunities available in the VET sector and the university sector reveal certain gaps that may affect the development of the Health Worker workforce going forward. VET sector opportunities are not evenly distributed across the country; and there are limited opportunities available in relation to entry-level or post-graduate university courses. These factors are explored in more detail below.

The Australian Government has recently supported actions to improve the quality and consistency of vocational education nationally. Legislation to establish the national VET regulator was introduced by the Australian Government into the Senate on 26 November 2010. The regulator, an independent statutory Commonwealth authority, is planned to commence operations in April 2011 (Minister Chris Evans Media Release, Establishment of the National VET Regulator, 26 November 2010).

The national VET regulator will be responsible for the maintenance of minimum standards for VET courses in all states and territories with the exception of Western Australia and Victoria. The work of the national regulator will be relevant to ATSIRTONN and providers of VET level Health Worker training.

10.1.2 VET sector educational opportunities

The majority of entry level training for Health Workers occurs in the VET sector. However, VET sector opportunities are not evenly distributed across Australia. Furthermore, there are more VET sector courses available at the Cert III and Cert IV levels, with less available at the Diploma or Advanced Diploma levels.

The geographic and qualification level distribution of VET sector opportunities is depicted in Table 9 below, which was created by examining the available courses offered by Registered Training Organisations identified by the CS&HISC (Community Services & Health Industry Skills Council, 2010). This list includes 33 RTOs in total, who are able to offer a range of programs for Aboriginal and Torres Strait Islander Health Workers. While interpreting the table, it is important to note that it reflects all courses that are within the scope of each RTO's registration. This does not mean that all of these courses are currently being delivered. There may, therefore, be fewer courses currently available than those depicted in the table below.

Table 9 – Distribution of Health Worker training opportunities across Australia, by geography and qualification

No	Registered Training Organisation	Cert III	Cert IV		Diploma		Advanced Diploma	
		HLT 33207	Practice HLT 43907	Community care HLT 44007	Practice HLT 52107	Community care HLT 52207	Practice HLT 61307	Community care HLT 61207
New South Wales								
1	Aboriginal Health College*	✓	✓	✓	✓	✓		
2	Booroongen Djugun College*	✓	✓	✓				
3	deFaye College	✓	✓	✓				
4	NSW Health	✓		✓		✓		
5	TAFE NSW – Illawarra Institute	✓	✓					
6	TAFE NSW – New England Institute	✓		✓				
7	TAFE NSW – North Coast Institute	✓	✓	✓				
8	TAFE NSW – Riverina Institute	✓	✓	✓				
9	TAFE NSW – South Western Sydney Institute			✓				
10	TAFE NSW – Western Institute	✓	✓	✓				
Northern Territory								
11	Batchelor Institute of Indigenous Tertiary Education	✓	✓	✓				
12	Central Australian Remote Health Development Services Limited*	✓	✓		✓			
Queensland								
13	Central Queensland Institute of TAFE	✓	✓	✓				
14	Cunningham Centre			✓				
15	First Aid Safety Training	✓						
16	Health Industry Training Queensland	✓		✓		✓		
17	Queensland Aboriginal and Torres Strait Islander College for Health	✓	✓	✓	✓	✓	✓	

No	Registered Training Organisation	Cert III	Cert IV		Diploma		Advanced Diploma	
		HLT 33207	Practice HLT 43907	Community care HLT 44007	Practice HLT 52107	Community care HLT 52207	Practice HLT 61307	Community care HLT 61207
	Education and Training*							
18	Queensland Aboriginal and Torres Strait Islander Health Worker Education Program Aboriginal Corporation	✓	✓	✓	✓	✓	✓	
19	Southern Queensland Institute of TAFE	✓		✓	✓	✓		
20	The Bremer Institute of TAFE	✓						
21	Tropical North Queensland Institute of TAFE	✓						
South Australia								
22	Aboriginal Health Council of South Australia Inc*	✓	✓	✓	✓	✓		
23	Nganampa Health Council Inc*	✓	✓	✓				
Tasmania								
24	Tasmanian Aboriginal Centre Inc*	✓	✓	✓				
Victoria								
25	Bendigo Regional Institute of TAFE			✓				
26	East Gippsland Institute of TAFE	✓						
27	Victorian Aboriginal Community Controlled Health Organisation Inc*	✓	✓	✓				
28	Sunraysia Institute of TAFE	✓						
Western Australia								
29	Aboriginal Health Council of Western Australia*	✓	✓	✓	✓	✓		
30	Bega Garnbirringu Aboriginal Corporation*	✓	✓					
31	Kimberley Aboriginal Medical Services Council Inc*	✓	✓	✓	✓	✓	✓	✓

No	Registered Training Organisation	Cert III	Cert IV		Diploma		Advanced Diploma	
		HLT 33207	Practice HLT 43907	Community care HLT 44007	Practice HLT 52107	Community care HLT 52207	Practice HLT 61307	Community care HLT 61207
32	Marr Mooditj Training Inc	✓	✓		✓			
33	Wirraka Maya Health Service Aboriginal Corporation*	✓	✓	✓				

*Note: these RTOs are Aboriginal and Torres Strait Islander Community Controlled

From Table 9 above, the following observations have been made on the basis of RTOs with ATSIHW related training in their scope:

- The majority of the RTOs provide training for Certificates III and IV level only. Just one-third (11) RTOs offer higher qualifications for Health Workers
- Only two RTOs in the country offer Advanced Diplomas. These are located in Queensland and Western Australia.
- NSW has the highest number of RTOs of any jurisdiction (10)
- In Victoria, there are no RTOs offering Health Worker courses at a level higher than Certificate IV
- In the ACT, there are no RTOs. However, three of the RTOs registered in NSW reported that they provide training in the ACT (the Aboriginal Health College, the Booroongen Djugun College and the deFaye College)
- In Tasmania, there is only one RTO offering courses for Health Workers, where the highest level of qualification is Certificate IV
- Of these RTOs, 15 are Aboriginal and Torres Strait Islander Community Controlled and form part of The Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network (ATSIHRTONN).

These observations have been made based on an examination of the courses that are within the RTOs scope as listed on the CS&HISC website (Community Services & Health Industry Skills Council, 2010).

However, this table does not show the number of places that are available at each RTO or that the course is currently being provided. This information therefore cannot be used as an adequate indicator of the supply of educational places across Australia in order to understand whether this supply sufficiently meets demand. This will be an important area of further investigation that should guide the development of the Health Worker workforce in future.

What this information does show is that the distribution of RTOs across the country is not consistent; and there are limited opportunities for advanced Health Worker education. This suggests that there are issues of training accessibility, particularly for those Health Workers who wish to pursue higher education.

It is not clear what factors contribute to this uneven distribution – it could be a reflection of student course demand, Health Worker qualification requirements, available funding opportunities, or a combination of variables. Further investigation into the factors contributing to this distribution pattern is required.

10.1.3 University sector educational opportunities

The above section demonstrates that there are limited higher educational opportunities in the VET sector for Health Workers above the Certificate IV level. This trend is also reflected in the availability of Health Worker-specific educational opportunities offered by the university sector.

The work of the Australian Teaching and Learning Council (ATLC) through the Learning and Teaching Academic Standards Project is noted. This project links to the work of the new Tertiary Education Quality and Standards Agency (TEQSA) and may be relevant to the undergraduate courses provided by the Higher Education sector for Health Workers. The project, funded by the Australian Government Department of Education, Employment and Workplace Relations (DEEWR) and has been established to facilitate the development of minimum education standards expressed as core learning outcomes for higher education courses (Australian Learning & Teaching Council, 2010)

University sector: undergraduate courses

There are two undergraduate level university courses available in Australia that specifically target Health Workers – one at the University of Wollongong in NSW, and one at Curtin University in Queensland. There is also a university major currently offered at the University of Queensland.

The University of Queensland was one of the first universities to recognise the gap and the need for formal qualifications for Aboriginal Health Workers and in 1994 developed an undergraduate course focussing on Aboriginal and Torres Strait Islander primary health care. The Bachelor of Health Science (Aboriginal and Torres Strait Islander Primary Health Care) was specially designed for Aboriginal and Torres Strait Islander health workers, and was headed by Professor Cindy Shannon (University of Queensland, 1996). This program is no longer available as a specialised Bachelor degree, however a major in Aboriginal and Torres Strait Islander Health can be undertaken through other related Health Science degrees (University of Queensland, 2010).

The NSW University of Wollongong, in collaboration with the Aboriginal Education Centre, Tharawal Aboriginal Corporation, developed the Bachelor of Aboriginal and Torres Strait Islander Health Studies Program in 1995 (Stein and Gluck, 1995). The stated objectives of the program were to increase the competencies and numbers of trained Aboriginal Health Workers, with the aim of enhancing access to health and education for the Aboriginal community. The program was initially structured to enable students to exit the course following the completion of each full year of study, thus awarding a Certificate, Diploma and/or Bachelor dependent upon the time of exit.

Today, the University of Wollongong program is offered as a three year full time Bachelor of Health Science in Aboriginal and Torres Strait Islander Health Studies degree and is opened to students of both Aboriginal and Torres Strait Islander and non-Aboriginal or Torres Strait Islander descent (University of Wollongong, 2010).

Curtin University through their Centre for Aboriginal Studies also offer a similar undergraduate course in Aboriginal and Torres Strait Islander Community Health which is undertaken over a three year period on a full time basis. Entry into this course is available through an Associate Degree, which is undertaken over a two year period. Completion of this Associate Degree enables entry into the final year of the Bachelor's degree.

Both the courses offered by University of Queensland and Curtin University emphasise the practical training components of the program and that much of the work is

completed in the community (University of Queensland, 2010, Curtin University, 2010). All these places are eligible for financial assistance from the Commonwealth and are only made available for those of Aboriginal and Torres Strait Islander descent (Curtin University, 2010).

In addition to the courses outlined above, there is one course that is specifically designed for Mental Health Workers offered in NSW at Charles Sturt University. This is a Bachelor degree in Health Science (Mental Health) (Charles Sturt University, 2010).

There are therefore a variety of undergraduate courses being offered by Universities across Australia focussing specifically on Aboriginal and Torres Strait Islander health. While many of the subjects offered in these courses may be undertaken students of other related programs, there are a small number that have been developed especially to address the need for further and formal qualifications for Aboriginal Health Workers.

Beyond the courses that specifically target Health Workers, there are a range of university courses that are relevant to the Health Worker profession. However, as yet there has not been an attempt to map the Health Worker qualifications to these courses in a systematic way in order to facilitate articulation pathways.

University – post-graduate

There do not appear to be any post-graduate programs specifically related to furthering the education of Aboriginal Health Workers currently available. However, there are a number of mainstream post-graduate courses that focus on Aboriginal Health. An example of this is the Masters in Aboriginal Health (University of Western Australia, 2010).

10.2 What are the barriers and enablers of education for Health Workers?

10.2.1 Barriers and enablers of education

The literature has identified a number of barriers to pursuing a career as a Health Worker. These barriers are explored in more depth in the following chapter, which focuses on Health Worker recruitment and retention (Section 11.3). For the purpose of this chapter, a summary of these barriers is provided below:

- Financial barriers. The cost of training courses undermines course accessibility for many aspiring or continuing Health Workers.
- Geographic barriers. This is particularly a barrier for Health Workers in remote areas that need to travel to urban hubs to access training.
- Family commitments. Again, particularly when the course requires travel away from the Health Worker's community and family.
- Low literacy/numeracy. Many courses have a literacy and numeracy requirement that prevents some Health Workers from undertaking the course, unless adequate supports are in place.
- Lack of culturally appropriate course delivery format. For example, delivery by an Aboriginal and/or Torres Strait Islander teacher, and flexible course structures (e.g. quarterly block periods)

The provision of adequate supports to overcome these barriers should be a core consideration of Health Worker workforce development initiatives.

As mentioned above, there are limited numbers of courses available at the higher degree level of the qualification spectrum. One study conducted by the James Cook University identified three key factors for this low-participation rate of Health Workers in advanced studies (Felton-Busch, 2009):

- Support barriers, ranging from family, to workplace, to wider community barriers
- Infrastructure barriers, namely access to library and internet services
- Inadequate marketing and promotion of opportunities to articulate into other health professions.

This research provides some insights into the levers available to encourage a higher participation rate in higher educational courses.

10.2.2 Available avenues for financial support to enable education

Commonwealth

The Commonwealth Government has a number of initiatives that aim to support the education and training of Aboriginal and Torres Strait Islander individuals. These programs do not specifically target the Health Workers workforce, but are an available avenue for support.

The Department of Employment, Education and Workplace Relations (DEEWR) provides an Aboriginal and Torres Strait Islander Wage Subsidy which supports the employment of both full-time and part-time Aboriginal and Torres Strait Islander Australians (Australian Government Department of Education Employment and Workplace Relations, 2010b). It provides employers with financial incentives to retain Aboriginal and Torres Strait Islander employees. DEEWR also offers an Aboriginal and Torres Strait Islander Cadetship Support to employers offering Aboriginal and Torres Strait Islander cadetships, which involve full-time study and work placements (Australian Government Department of Education Employment and Workplace Relations, 2010a). However, the incentives offered by these programs target the employers of Aboriginal and Torres Strait Islanders; they do not provide direct support to Health Workers in education and training. It is also not clear to what extent these avenues for support have been used by Health Workers and/or their employer organisations.

The Indigenous Employment Program through DEEWR is able to provide tailored assistance on a case by case basis. This assistance is reported to be able to provide support and prepare Aboriginal and Torres Strait Islander Australians for employment. This may be through support in numeracy and literacy. Other DEEWR literacy and numeracy support is provided through the Workplace English language and Literacy (WELL) and the Language, Literacy and Numeracy (LLNP) programs. These programs may be available through a competitive grants process (WELL program) or through particular providers on referral through Centrelink/Job Service Australia (LLNP program).

ABSTUDY is available to Aboriginal and Torres Strait Islander Australians undertaking vocational and tertiary study. The scheme is available to students undertaking the Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care. The Indigenous Tutorial support scheme may also be available to pay tutors to support people studying entry level VET Health Worker courses.

Queensland

In Queensland, all Aboriginal and Torres Strait Islander Health Workers employed by the QLD Department of Health are eligible for the Study and Research Assistance Scheme (SARAS) (Queensland Health, 2010). This policy provides Health Workers with some flexibility and support to pursue additional qualifications. The type of support that SARAS may provide to Health Workers includes:

- Paid leave from work commitments to attend courses, study, undertake exams and partake in residential or practical courses
- Unpaid leave
- Financial assistance and approval to contribute to course costs
- Scholarships.

Three categories of assistance are offered to Health Workers employed by QLD Health. The categories of assistance are defined by the desirability of the qualification to the role performed by the Health Worker, and include "Essential", "Highly Desirable" and "Desirable".

However, it is worth noting that Health Workers employed in Queensland by the Aboriginal and Torres Strait Islander Community Controlled Sector are not eligible for these supports.

Victoria

In Victoria there are several programs available to support Aboriginal and Torres Strait Islanders access training and employment.

Victoriaworks for Young People is provided by the Victorian Department of Human Services to employers of unemployed and disadvantaged people aged under 24 years (Victorian Department of Human Services, 2010b). Some Health Workers would be included within the scope of this initiative.

The Department of Human Services and the Department of Health also offer the Aboriginal Study to Work Program to Aboriginals who wish to work for either Department (Victorian Department of Health, 2010). This initiative includes Health Workers working in the public health sector, but does not extend to those employed by Aboriginal Community Controlled Organisations and Health Services.

Skills Victoria also has two training support programs that some Victorian Health Workers are eligible for: the Skills for Victoria Training Subsidy and the Retrenched Worker Initiative (Victorian Department of Health, 2010).

Other scholarships

In addition to the major government financial assistance programs, there appear to be a small number of privately and/or government subsidised scholarships that are available for those choosing to undertake further education. Examples of these include:

- The Puggy Hunter Memorial Scholarship Scheme. This scholarship is funded by Australian Government Department of Health and Ageing and provides financial assistance to Aboriginal and Torres Strait Islander people who are undertaking study or are intending to undertake study in a health related discipline at an undergraduate or TAFE (Certificate IV and above) level. This scholarship is provided across the spectrum of health services, of which Aboriginal Health Workers are eligible to apply (Royal College of Nursing Australia, 2010).

- The Rio Tinto Aboriginal Health Partnership – this was a two year partnership between Rio Tinto and the Telethon Institute for Child Health Research through the Kulunga Research Network commencing in 2009. As part of this partnership, there was a provision of direct support to Aboriginal people wanting to pursue further education to advance their careers as health workers in their communities. Financial assistance up to the value of \$5000 were being offered to Aboriginal Health Workers in Western Australia to undertake the Diploma of Aboriginal and/ or Torres Strait Islander Primary Health Care (Practice) in 2009 (Rio Tinto Aboriginal Health Partnership, 2009).
- Ida West Aboriginal Health Scholarships – administered by the Department of Health and Human Services in Tasmania. This is a scheme for Tasmanian Aboriginal students studying an accredited health or human services related undergraduate course at University, or an accredited health or human services related Vocational Education and Training course. Health Workers are eligible for this scholarship, and there are three scholarships awarded each year (Services, 2010).
- InTrain (Indigenous Training and Recruitment Initiatives Program) – funded by the Victorian Department of Human Services and the Department of Health have also recently commenced. InTrain scholarships are offered to Victorian Indigenous people to assist them in completing various educational programs including diplomas, undergraduate and postgraduate degrees in the health and community sector. These scholarships provide financial assistance to enable participants to complete either full time or part time study in relevant areas by providing fortnightly living allowances (Victorian Department of Human Services, 2010a).
- Office of Aboriginal Health (OAH) Scholarship program – was established by the Western Australian Government in 1998 to encourage the retention of Aboriginal students in health related fields, to progress with their studies. A range of scholarships are offered for various health related fields including those pursuing qualifications in medicine, nursing, allied health, and Aboriginal health work (the Mary Albert Scholarship for Aboriginal Health Work). These scholarships provide financial assistance for those undertaking full time study in their relevant fields and are awarded by a panel of representatives from the Department, University of Western Australia, Edith Cowan University and Curtin University (Western Australian Office of Aboriginal Health, unknown).
- Country Health SA Aboriginal Professional Employment Program – administered by Country Health SA, offers financial assistance for ten places to Aboriginal and Torres Strait Islander students currently studying or about to commence an undergraduate degree in a relevant health discipline. This scholarship program is not specifically targeting Aboriginal Health Workers rather it provides for a broad range of health disciplines including medicine, allied health and nursing. Recipients of this scholarship are also provided a guarantee of employment within Country Health SA upon successful completion of their program and they are also required to work in a rural public health service for Country Health SA upon completion of their course for a period equivalent to the number of years program funding is awarded (Country Health SA, 2009).

10.3 Section summary

Health Worker education and training is critical to the process of maintaining a qualified Health Worker workforce in future. OATSIH funded a comprehensive national review of Health Worker Training in 2000 (Curtin Indigenous Research Centre with Centre for Educational Research and Evaluation Consortium and Jojara & Associates, 2000). After extensive consultation with relevant stakeholders, this review concluded that training opportunities for Health Workers were fragmented and poorly distributed across Australia; and that course were often inaccessible and unable to meet the learning needs of many Health Workers (Curtin Indigenous Research Centre with Centre for Educational Research and Evaluation Consortium and Jojara & Associates, 2000).

Since then, a number of developments have occurred to improve the education and training landscape for Health Workers. Critically, the CS&HISC developed a national Health Training Package HLT07, promoting nationally consistent Health Worker training standards (Community Services & Health Industry Skills Council, 2008b). This established opportunities for Health Worker to choose between Clinical Practice and Community Care streams of education, and identified training parameters for each level of qualification.

In spite of these important developments, barriers to education and training for Health Workers remain. The literature documents a number of views on how to target these barriers and develop more streamlined and supported educational pathways for Health Workers. These recommendations will be validated and build upon throughout the consultation phases of this project.

In particular, it will be valuable to use these consultations to gain insights into the following:

- What is the distribution of qualification levels across the Health Worker workforce?
- What qualification level(s) do relevant stakeholders believe should be required of Health Workers? Do Health Workers, the Aboriginal Community Controlled sector and the public sector health services have different perspectives on this?
- Is there a gap between the existing qualification levels of Health Workers and the aspirational qualification levels identified in the question above? What steps would be required to close this gap?
- What are the barriers to obtaining higher level education and training courses?
- Are Health Worker qualification levels consistent and reliable across Australia (e.g. do Certificate III qualifications obtained in different jurisdictions provide Health Workers with the same level of competency)?
- What forms of education and training support would assist to strengthen the Health Worker workforce in future?

11. Health Worker workforce context; recruitment and retention

Successful, targeted recruitment and retention of Health Workers is core to the process of expanding the workforce to better address the health needs of Aboriginal and Torres Strait Islander communities. In order to understand how best to maintain and expand the Health Worker workforce it is important to understand:

- The current recruitment market for Health Workers and the broader Aboriginal and Torres Strait Islander healthcare community
- The typical drivers which motivate Aboriginal and Torres Strait Islander Peoples to pursue a career as a Health Worker and in the related healthcare sector
- Barriers to pursuing a career as a Health Worker, and
- Recruitment and retention strategies.

This chapter explores each of these areas respectively, providing an overview of the recruitment and retention of the Health Worker workforce. It finds that there is a limited evidence base regarding which recruitment and retention strategies are most effective, thereby identifying an important area of focus for the data collection phase of this project.

11.1 The Health Worker recruitment market

11.1.1 Context to the Health Worker workforce recruitment market

A number of recent studies have identified the need to increase the representation of Aboriginal and Torres Strait Islander people in the health workforce as a key part of developing a competent health workforce to serve their communities (Standing Committee on Aboriginal and Torres Strait Islander Health, 2002, Australian Health Ministers' Advisory Council, 2008a). This is regarded as an important route to improving the health outcomes of Aboriginal and Torres Strait Islander peoples, and also increasing their participation in the Australian economy (Australian Health Ministers' Advisory Council, 2008a, Australian Government, 2010, Australian Health Ministers' Advisory Council, 2008b).

Development of the Health Worker workforce provides one opportunity to increase the representation of Aboriginal and Torres Strait Islander peoples in the health workforce. However, in an effort to expand this workforce, it is necessary to have a clear picture of the broader recruitment market that can be targeted.

It is also recognised that coordinated action is required by the Commonwealth, State and Territory governments to improve the recruitment and retention of appropriately skilled health professionals and to maintain the sustainability of Aboriginal and Torres Strait Islander health care services (Australian Health Ministers' Advisory Council, 2008b, Australian Health Ministers' Advisory Council, 2008a). In particular, recruitment and retention issues were deemed to be more challenging for Aboriginal and Torres Strait Islander health services located in rural and remote Australia (Australian Health Ministers' Advisory Council, 2008a).

Consistent with the issues highlighted in Section 6.1 in relation to identifying a national definition of Health Workers and the size of the workforce, there is limited transparency on the Aboriginal and Torres Strait Islander Health Worker recruitment market. Without a reliable understanding of the size and geographic distribution of the workforce, in depth analysis of the Health Worker recruitment market and the identification of key trends and developments is not possible. However, several studies have provided some information to indicate the basic supply and demand of Health Workers.

11.1.2 Supply of Health Workers: Working age Aboriginal and Torres Strait Islander population

The number of Aboriginal and Torres Strait Islander people in Australia in the 2006 census was 517,043 (Australian Bureau of Statistics, 2006b). With a participation rate of 55% (Australian Bureau of Statistics, 2008), this indicates that there were an estimated 177,537 Aboriginal and Torres Strait Islander people employed at the time of the 2006 Census (which reported that a total of 322,794 were of employable age) (Australian Bureau of Statistics, 2008). However, as noted in Section 4.1, over 37% of the Aboriginal and Torres Strait Islander population falls in the 0-14 age group. This fact, in addition to improvements in school retention rates and educational attainment of Aboriginal and Torres Strait Islander peoples, indicates that the supply of overall Aboriginal and Torres Strait Islander workforce is set to increase.

Although these figures are high level and dependent upon existing data, they provide some preliminary insights into the size of the potential recruitment market. There is an opportunity to pursue a more detailed analysis of the Health Worker workforce supply during Phase 3 of this project.

11.1.3 Demand for Health Workers: Number of vacancies

According to an analysis of the Service Activity Reporting for Aboriginal and Torres Strait Islander primary health care services conducted in June 2006, the Health Worker workforce was the health profession with the highest number of health staff vacancies, totalling 99 (Australian Health Ministers' Advisory Council, 2008a).

However, this data is now out of date and it is not clear whether the reported vacancies are an accurate reflection of the number of vacancies in practice. In fact, it may be the case that the vacancies rates have increased since 2006. This can be surmised given a number of factors:

- In the 6 years leading up to June 2006, the Aboriginal and Torres Strait Islander Health Performance Framework reported an increase of 61% in Government-funded positions in Aboriginal and Torres Strait Islander primary health care services (Australian Health Ministers' Advisory Council, 2008a)
- There was a 65% increase in Australian Government annual expenditure on Aboriginal and Torres Strait Islander specific health programs in the two years subsequent to June 2006 (Australian Health Ministers' Advisory Council, 2008a)
- The rate of increase in the Aboriginal and Torres Strait Islander population is estimated to be 11% (Australian Bureau of Statistics, 2009)

However, these assumptions have not yet been tested using a robust evidence base.

11.1.4 Other trends affecting the recruitment market

Whilst high-level estimations can be made over the demand and supply of Aboriginal and Torres Strait Islander workforce, little analysis of the underlying factors, trends and dynamics that impact upon the recruitment market of Health Workers is publicly available. One study has considered geographical distribution of vacancies in the wider health profession and the staff attrition rate (Australian Health Ministers' Advisory Council, 2008a).

In addition, a report from the Australian Public Service Commission examined what type of work the Aboriginal and Torres Strait Islander public sector workforce was involved in (Australian Public Service Commission, 2009). This report found that:

- 41% of the Aboriginal and Torres Strait Islander workforce was involved in service delivery to the public with the most common other types being program design and/or management (15%) and corporate services (12%)
- 65% of the Aboriginal and Torres Strait Islander workforce were in roles that involved interaction with Aboriginal and Torres Strait Islander people and communities, indicating that this was an important source of employment and a likely competitive advantage, and
- 73% of Aboriginal and Torres Strait Islander employees were satisfied overall with their job with just 13% stating that they were dissatisfied. This gives some insight into the likelihood of them moving to other professions and job satisfaction criteria which will be considered in the next section (Australian Public Service Commission, 2009).

A 2007 VACCHO report highlighted that whilst Australia faces medical workforce shortages, these shortages are much more acute in rural and remote areas, although the degree to which this affects the Health Worker workforce where staff are more community orientated, requires further analysis (Victorian Aboriginal Community Controlled Health Organisation, 2008).

Whilst these reports give some insight into the different professions that Aboriginal and Torres Strait Islander peoples are employed in and their motivations, further analysis is required to understand the recruitment market of Health Workers, including geographical distribution, staff turnover / attrition rate, mobility and alternative employment options (within both the Government and Community Controlled sectors), and the impact of recent government initiatives. This analysis is outside the scope of this current phase of the project, but is expected to be included within Phase 3.

11.2 Key drivers for pursuing a career as a Health Worker

The key to successfully recruiting and retaining Health Workers is to understand the motives of why individuals pursue a career as a Health Worker. An understanding of the primary levers of job satisfaction is also relevant to the development of retention strategies.

However, only a limited number of studies have been undertaken to gain insights into what motivates Health Workers to pursue their careers. One relevant study is available regarding job satisfaction, but it is not specific to Health Workers (i.e. it pertains to all Aboriginal and Torres Strait Islander public-sector employees) and excludes consideration of those employed in the Aboriginal and Torres Strait Islander Community Controlled sector (Australian Public Service Commission, 2009).

11.2.1 Career motivations for Aboriginal and Torres Strait Islander people in the health sector

Some analysis has been performed on Aboriginal and Torres Strait Islander managers of health services which may be relevant when considering potential motivations for pursuing a career as a Health Worker (Wakerman et al., 2000). This work indicated that there were a number of individual, organisation and community factors which affected the values and ways of working of Aboriginal and Torres Strait Islander health managers, which included:

- A strong personal motivation to assist the Aboriginal and Torres Strait Islander community to the degree that they saw themselves as “agents of change” within the system to advance better health and self-determination for their people
- A strong direct sense of obligation and accountability to the community (rather than formal bureaucratic or management structures), and
- Accountability to the Aboriginal and Torres Strait Islander community included direct and immediate interactions which blurred the boundaries between their work and personal lives (Wakerman et al., 2000).

Beyond Charcoal Lane acknowledged that pursuing careers as an Aboriginal and Torres Strait Islander health managers provided status and access to networks for Aboriginal and Torres Strait Islander individuals in their community (Wakerman et al., 2000). Indeed, some health managers confided that they had become health managers because of the inspiration, direct support, or even ‘coercion’ of the family or community members (Wakerman et al., 2000).

However, this report also emphasises that the same values driving careers in the health sector for Aboriginal and Torres Strait Islander people can also make their roles stressful and persistently demanding (Wakerman et al., 2000). Community expectations of Aboriginal and Torres Strait Islanders are significant, and rarely bound by the temporal parameters of the typical 9-5 working day (Wakerman et al., 2000). This is a consideration that may feed into retention strategies for the Health Worker workforce. Its relevance to the Health Worker profession will be established during this project's community mapping activities.

There is, therefore, some literature relating to career drivers for Aboriginal and Torres Strait Islander peoples in health professions in general; but little is specific to the Health Worker workforce.

11.2.2 Job satisfaction of Aboriginal and Torres Strait Islander people employed in the Australian Public Sector

As mentioned above, a study into the Aboriginal and Torres Strait Islander public sector workforce provides some insights into the underlying factors that impacted upon job satisfaction of Aboriginal and Torres Strait Islander public sector employees (Australian Public Service Commission, 2009).

The key findings were:

- 64% of those surveyed considered good working relationships to be important for their job satisfaction, with other commonly nominated factors being flexible working arrangements, salary, the chance to make a useful contribution to society/ Aboriginal and Torres Strait Islander Australians, and having a good supervisor

- Factors which were reported by Aboriginal and Torres Strait Islander public sector employees as being of less relative importance were seeing tangible results from their work, appropriate workload, the opportunity to be creative/innovative, and the appropriate level of autonomy in the work
- There were a number of variations between the responses of Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander public sector employees: the Aboriginal and Torres Strait Islander workforce were more likely to identify good working relationships, the opportunity to develop skills, duties/expectations being made clear, and opportunities for career development as important to them than the non- Aboriginal and Torres Strait Islander workforce whilst they were less likely to identify interesting work provided, appropriate autonomy, appropriate workload, seeing tangible results from their work, salary, and flexible working arrangements, and
- The workplace factors which the Aboriginal and Torres Strait Islander workforce identified as being important varied significantly according to their classification level: Higher classified staff regarded making a useful contribution to society/ Aboriginal and Torres Strait Islander Australians, appropriate autonomy, seeing tangible results from their work, and the chance to be creative/innovative as important to them, whereas their more junior colleagues were more likely to feel that having their duties/expectations made clear and opportunities to develop their skills were important to them (Australian Public Service Commission, 2009).

The report also noted that the two factors which Aboriginal and Torres Strait Islander employees were most likely to consider having a significant impact on their job satisfaction (good working relationships and flexible working arrangements) were also the two factors that recorded the highest satisfaction ratings (both over 80%), indicating that those in workforce were satisfied with their positions. This report provides useful insight into job satisfaction of Aboriginal and Torres Strait Islander employees in the public sector which are useful when considering recruitment and retention strategies.

11.2.3 Planned or expected studies

There are some current or planned studies that may provide additional information in future. The recent review of the Aboriginal and Torres Strait Islander Health Worker Profession conducted by the Northern Territory Department of Health and Families is expected to shed light on Health Worker career drivers once it is published.

According to the 2009 Environmental Scan published by the CS&HISC, the University of Newcastle was undertaking a research project regarding the issues that affect Aboriginal and Torres Strait Islander peoples' decisions to enter the health workforce (Community Services & Health Industry Skills Council, 2009). At the time of writing, publicly available information on this project had not been identified.

These studies may provide a more detailed understanding of the drivers for pursuing a career as an Aboriginal and Torres Strait Islander Health Worker. However, there is also an opportunity for this project to further develop the national understanding of Health Worker motivations via the interviews conducted with Health Workers during Community Mapping activities. These activities may confirm that Health Workers experience similar motivations and pressures from their communities as those experienced by the health managers in the *Beyond Charcoal Lane* study. Alternatively, they may reveal a different set of motivations that will be relevant to the development of effective recruitment and retention strategies.

11.3 Barriers to pursuing a career as a Health Worker

Understanding the motivations for Aboriginal and Torres Strait Islander people to become Health Workers provides insight into only one part of the labour supply side of the workforce. It is also important to understand the key barriers restricting some Aboriginal and Torres Strait Islander people from becoming Health Workers.

More effort has been invested in understanding the barriers to pursuing a career as a Health Worker than understanding the career drivers. This perhaps reveals a policy emphasis on removing career barriers rather than empowering Aboriginal and Torres Strait Islander individuals. Some of the key barriers identified by existing research is summarised below.

11.3.1 Financial barriers

Aboriginal and Torres Strait Islander people experience higher levels of socioeconomic disadvantage than other Australians (National Aboriginal and Torres Strait Islander Health Worker Association, 2010). A study conducted by Universities Australia found that Aboriginal and Torres Strait Islander students' general and study-related expenses are higher overall than those of other students, and that Aboriginal and Torres Strait Islander students are more likely to agree that their financial situation is often a source of worry to them (72.5%) than other students (52.5%) (National Aboriginal and Torres Strait Islander Health Worker Association, 2010, Richard, 2007).

There are a range of financial support programs available to Aboriginal and Torres Strait Islander Health Workers, including the Australian Government ABSTUDY scheme. However, in some instances it has been reported that, whilst financial support may cover the cost of a course, it might not be sufficient to cover the living costs of a student (Roussos, 2010).

Although there are financial supports available to overcome barriers in educational costs, there is no national understanding of the nature, extent and availability of financial support for Health Workers in training across the country (National Aboriginal and Torres Strait Islander Health Council, 2008). This may contribute to decisions not to pursue training and employment as a Health Worker.

11.3.2 Geographic barriers

Where Aboriginal and Torres Strait Islander people live, and where they prefer to work determines to a large extent which career options will be considered (Community Services & Health Industry Skills Council, 2006). Health Worker education and training courses are only offered in certain geographical locations. Consequently, those wishing to pursue a career as a Health Worker are often required to move in order to access educational opportunities. For many, there is an unwillingness to leave their community for cultural or family reasons (Community Services & Health Industry Skills Council, 2006). As a result, inaccessible training and employment opportunities may rule out a career as a Health Worker for some who consider it.

For those that are within reasonable travelling distance to their education provider, transport can also be an issue (Community Services & Health Industry Skills Council, 2006). Transport options are not always accessible and affordable.

11.3.3 Family commitments

Family commitments can affect the ability of an Aboriginal or Torres Strait Islander person to pursue a career as a Health Worker. This is particularly the case when courses

are located far from the home community, meaning that potential Health Workers are faced with the decision of whether to uproot their family in order to pursue educational opportunities. This was identified in a research study conducted by James Cook University into barriers to advanced Education for Aboriginal and Torres Strait Islander Health Workers (Felton-Busch, 2009). One participant surveyed in this study commented that *'They really have to leave town if they want to become doctors or if they want degrees, and that's a barrier because of the support they get from family and community when they are studying'* (Felton-Busch, 2009).

A lack of child care services can also provide a significant barrier for Health Workers with children during their training and employment (Community Services & Health Industry Skills Council, 2006). This was also highlighted in the James Cook University study, with one participant stating that *'One of the main issues, is the lack of childcare facilities, there were a lot of young mums and women and men who wanted to come along and do the courses that we were running but couldn't commit due to their kids not being the school age and there was no childcare available they could attend or people they could trust to leave their children with. So childcare is a huge issue...'* (Felton-Busch, 2009).

11.3.4 Lack of culturally appropriate educational format and delivery

The way in which a course is delivered can also provide educational barriers to Aboriginal and Torres Strait Islander students. Research has found that Aboriginal and Torres Strait Islander students see less reason to participate in courses that do not account for their knowledge, values, history and experience (National Aboriginal and Torres Strait Islander Health Council, 2008, McConaghy, 2000, Helme, 2005) (National Aboriginal and Torres Strait Islander Health Council, 2003a).

Given the barriers posed by geographic distances and family commitments to Health Worker education, the format in which a course is delivered can improve its accessibility. Options to study in intensive periods (rather than on a semester basis) or undertake on-the-job training might be more appropriate educational formats for some.

11.3.5 Low literacy and/or numeracy

The prerequisites and/or expected knowledge for Health Worker Primary Health Care qualifications can serve as a barrier to entry into the Health Worker workforce for some Aborigines and Torres Strait Islanders. Aboriginal and Torres Strait Islander students are achieving well below the national averages in English literacy and numeracy (National Aboriginal and Torres Strait Islander Health Council, 2008). Furthermore, for some aspiring Health Workers, English is a second or third language (National Aboriginal and Torres Strait Islander Health Council, 2008).

However, many training courses require certain standards of literacy and numeracy as a condition of entry. Courses are generally delivered in English, which disadvantages those with less developed English language skills (National Aboriginal and Torres Strait Islander Health Council, 2008). Without adequate bridging courses and support, these potential students may be excluded from pursuing educational opportunities to become a Health Worker. NATSIHC also emphasises the importance of teaching literacy and numeracy *'as part of regular health-related training, rather than as stand-alone courses'* (National Aboriginal and Torres Strait Islander Health Council, 2008). This is likely to increase the relevance and applicability of literacy and numeracy for students.

Low level of literacy and numeracy not only pose barriers to education, but also to employment. If the educational qualifications cannot be obtained, eligibility requirements for becoming a Health Worker may not be met in the majority of jurisdictions. For example, the Northern Territory requires that Health Workers have sufficient command of the English language to be eligible for registration (Health Professions Licensing Authority, 2008b).

11.3.6 Fragmented and piecemeal availability of various kinds of support for Health Workers

NATSIHC define “support” for Health Workers to include (National Aboriginal and Torres Strait Islander Health Council, 2008):

- Career information
- Culturally safe application processes
- Mentoring
- Access to Aboriginal and Torres Strait Islander staff
- Resources (such as text books and information technology)
- Access to professional networks
- Tutorial assistance

The fragmented and piecemeal availability of this support to those pursuing a career as a Health Worker can mean that some potential candidates are unaware of the level/type of support they have access to. Lack of awareness of the full scope of support available may contribute to decisions not to pursue a career as a Health Worker.

This is partly due to the fact that the kind of support available to an individual Health Worker is largely dependent upon what is offered by their specific education providers, employers and communities. There is no national, structured approach to the provision of educational, professional and personal support for Health Workers.

NATSIHC emphasises the need to develop seamless policy and program approaches *between* these avenues of support, to provide ‘strategic, whole-of-life approaches to support’ for Health Workers (National Aboriginal and Torres Strait Islander Health Worker Association, 2010, National Aboriginal and Torres Strait Islander Health Council, 2008).

The recent establishment of the National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA) may provide a greater understanding of /access to support for Health Workers than was previously available (National Aboriginal and Torres Strait Islander Health Worker Association, 2010). NATSIHWA plans to provide a range of communication resources to assist members keep up-to-date with developments in their profession, such as evidence-based position statements, online journals, and research updates (National Aboriginal and Torres Strait Islander Health Worker Association, 2010). As yet these resources have not been posted on the website.

However, in future NATSIHWA may serve as a resource to help increase Health Workers’ awareness of and access to available support.

11.4 Recruitment and retention strategies

There are a number of national and state initiatives on recruitment and retention which are being developed and implemented since the Aboriginal and Torres Strait Islander

Health Workforce National Strategic Framework was released in 2002 (National Aboriginal and Torres Strait Islander Health Council, 2003b). One of the key objectives identified in this document was the need to improve the effectiveness of training, recruitment and retention measures within Aboriginal and Torres Strait Islander primary health services.

This initiative has continued to evolve at a Commonwealth and State level. Some of the more recent articulations include:

- The Council of Australian Government's development of indicators of Aboriginal disadvantage under the 'Close the Gap' initiative which included the National Indigenous Reform Agreement (NIRA) 'halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade'
- The Aboriginal Public Sector Employment strategy 2009-2015 which was submitted to the Premier in June 2009 and sought to improve accountability and transparency of public sector organisations and their compliance to perform under the strategy
- Various State and Territory strategies and initiatives (e.g. Queensland Urban and Regional Indigenous Strategy, Victorian Aboriginal Recruitment and Retention Strategy 2010-2013, Aboriginal and Torres Strait Islander Employment and Career Development Strategy),
- Continuing research initiatives, such as that undertaken by the Desert Knowledge Cooperative Research Centre investigating attraction and recruitment of professionals to remote locations (McKenzie, 2007).

The Australian Government Department of Health and Ageing and Orima research to inform communications activities designed to attract more Aboriginal and Torres Strait Islander secondary school students to work in health (Australian Government Department of Health and Ageing and Orima, 2010). This research found that effective communication campaigns for recruitment should focus on achieving changes in knowledge, attitudes and behaviours towards working in health. It emphasised the benefits of a horizontally integrated communications approach, incorporating multiple layers of messaging and challenging. These state and commonwealth strategies, policies and initiatives have targeted different aspects of recruitment and retention. More specifically, they have been focused on the following approaches:

Enabling and empowering the Aboriginal and Torres Strait Islander workforce

- Providing funding to employees which is linked to training and apprenticeships (e.g. Living away from home allowance under the Commonwealth Government 'Australian Apprenticeship' scheme)
- Offering cadetships and traineeships (e.g. under the New South Wales Aboriginal Employment Strategy)
- Promoting Health Worker careers to high school students

Recruitment

- Giving financial incentives to employers linked to training and apprenticeships (e.g. the Commonwealth Government 'Australian Apprenticeship' scheme, Victorian Department of Human Services 'Victoriaworks for Young People', Skills Victoria's Skills for Victoria and the Retrenched worker initiative) or employer wage support (e.g. Indigenous Wage Subsidy provided by the Department of Employment and Education and Workplace Relations)

- Revising recruitment processes to support Aboriginal and Torres Strait Islander employment (e.g. Aboriginal and Torres Strait Islander recruitment targets, Victorian government's exemption from the prohibition of race discrimination to enable it to advertise for and employ Aboriginal people only)
- Promoting pathway programs and the Health Worker 'brand'
- Providing employment opportunities to Aboriginal and Torres Strait Islander people, such as through a "grow your own workforce" approach in more remote communities (McKenzie, 2007)
- Offering incentives for ex-Health Workers to return to the workforce, including reviews of remuneration against nursing and housing provision

Retention

- Recognising and valuing Aboriginal and Torres Strait Islander cultures and building cultural awareness and competence of existing managers and leaders (e.g. cultural awareness and cross-cultural communication training, Aboriginal Support Networks, equality of benefits and working conditions with nurses, tackle racism at work)
- Providing explicit support to new and existing Aboriginal and Torres Strait Islander staff (e.g. additional or tailored inductions, bridging courses)
- Encouraging professional development opportunities (e.g. NSW Mentoring Program, NSW Aboriginal Support Network)
- Building skills and capabilities of existing staff with view to succession planning (e.g. internal promotion and nurturing of talented junior staff)

Evaluation of performance of these bodies against their strategies is, however, less transparent. Few performance reports or analyses were in evidence. Understanding and assessing the effectiveness of current and potential strategies will form an important part of the Community Mapping stage of the project.

11.5 Section summary

Successful recruitment and retention strategies are essential to the expansion of the Health Worker workforce. These strategies will be most effective if they are informed by firm evidence around the Health Worker recruitment market, the drivers of pursuing a career as a Health worker, and the barriers that hinder some Aboriginal and Torres Strait Islander people from following this career path.

Although Health Worker recruitment and retention has been the focus of a number of past reviews, far more is documented about the barriers for recruitment and retention than the drivers of this profession. It would be worthwhile considering recruitment and retention of Health Workers from a positive perspective, highlighting what is appealing about being a Health Worker.

This concept relates to the significant body of information discussing recruitment and retention strategies that can be leveraged going forward. These strategies are well-developed and widely implemented. Further evidence demonstrating which of these strategies are being most effective in practice would be useful.

The consultation phases of this project therefore provide a good opportunity to gain a more nuanced understanding of what motivates Health Workers, and what is working well in recruitment and retention. Interviews with Health Workers and their Managers will also provide an opportunity to identify other success stories that have not yet been canvassed in the literature.

Therefore, the core set of questions that will guide these activities includes:

- What are the most common recruitment pools for the Health Worker profession?
- What are the key challenges in the recruitment and retention of Health Workers?
- What strategies have been successful in Health Worker recruitment and retention?
- What measures would improve Health Worker retention rates?

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Appendix B Project activities and timeline

11.5.1 Project activities

Four project streams have been developed to contribute to each project phase. They include:

Stream 1	Environmental Scan and Health Needs Analysis
	<p>The goals of Stream 1 are twofold: (a) to understand the existing health status of the Aboriginal and Torres Strait Islander population; and (b) to use available literature and data to understand the current Health Worker workforce. The activities to be conducted include desk top research; review of literature; and consultations with key stakeholders in each jurisdiction, including jurisdictional health workforce planners and relevant experts. The findings will identify gaps for further investigation during the following work streams, and frame the community mapping methodology.</p> <p>This document, the Environmental Scan, is the key output from Stream 1. This document is also considered to be a key input into the Interim Report.</p>
Stream 2	Community and Aboriginal and Torres Strait Islander Health Worker mapping
	<p>The purpose of Stream 2 is to gain a more granular level of information about the existing Health Worker workforce than that which was available in the Environmental Scan. Approximately 35 locations in urban, regional and remote areas will be visited in order to conduct a series of site visits at each location. Aboriginal and Torres Strait Islander Health Workers will be directly engaged with via focus groups, role analyses and interviews in order to understand the type of tasks they perform, the level of skills required to perform those tasks, the type of training they received, and other relevant workforce issues. Some managers and other health professionals will also be consulted in order to get a range of perspectives on the Health Worker role.</p> <p>The key output of Stream 2 is a summary of the key findings, which will also be an input into the Interim Report.</p>
Stream 3	Future Health Worker workforce design
	<p>Stream 3 aims to draw from the findings of Stream 1 and 2 in order to develop recommendations for the design of the future Health Worker workforce. The recommendations will relate to the development of a national definition of Health Worker roles, competency and skills requirements, education and training opportunities, potential career structures, recruitment and retention, and regulation. A set of options will be developed for jurisdictions to consider in preparation for the registration of some Health Workers under the National Registration and Accreditation Scheme (NRAS).</p> <p>The output of Stream 3 is the Final Report.</p>
Stream 4	Supply and Demand modelling
	<p>Stream 4 has not yet been confirmed; it is dependent on the outcomes of the first three work streams. If Stream 4 were to be implemented, it would draw upon</p>

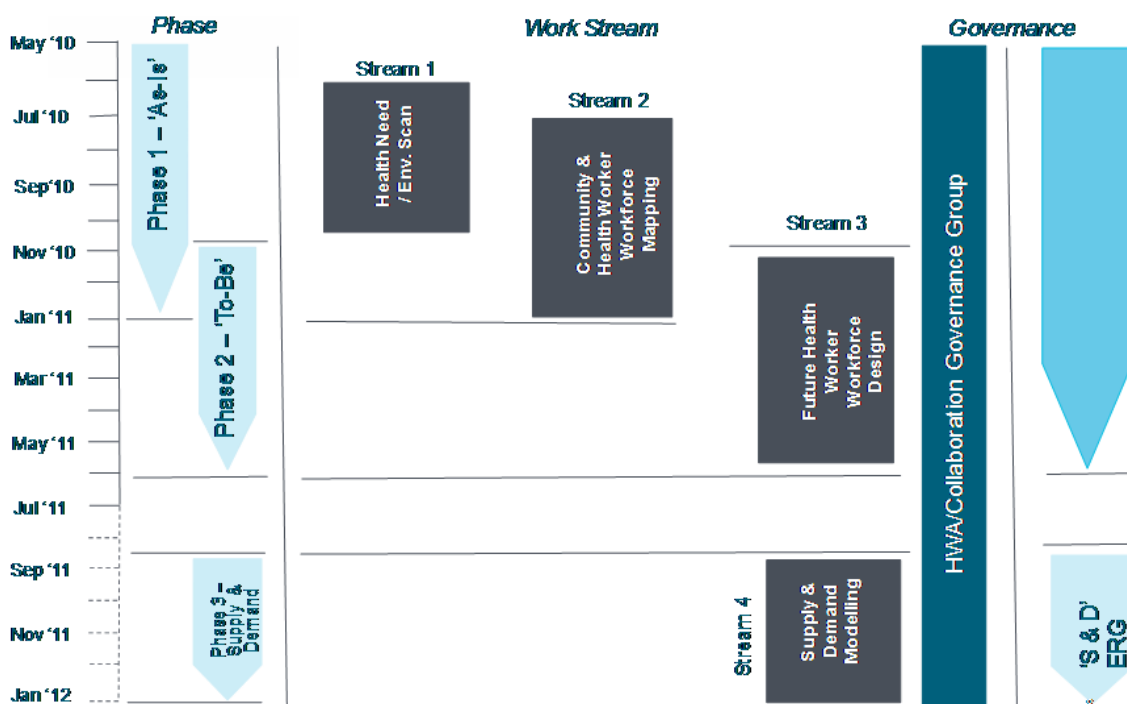
supply and demand data to model the future workforce in accordance with the recommendations identified in Stream 3.

11.5.2 Project timeline

Some of the work streams contribute to more than one project phase, and overlap chronologically. This reflects the fact that the Project has adopted a consultative approach that involves iteration of ideas as new information is collected throughout the process. A high-level outline of the project timelines is depicted in

. However, these timeframes may vary depending on the logistical requirements of the project activities.

Figure 38 - Aboriginal and Torres Strait Islander Health Worker Project Timeline



11.5.3 Project outcomes

The information collected throughout this project will generate a nationally consistent view of the existing Health Worker workforce for the first time. It will develop Australia's most comprehensive body of evidence in relation to the Health Worker workforce, including information on their roles and skill levels; the size and distribution of the workforce; existing policies and competency requirements across the country; barriers and enablers of education, training, recruitment and retention; and career structures or pathways for progression.

This body of evidence can be used by relevant Government stakeholders and Aboriginal and Community Controlled Health Services to strengthen the Health Worker workforce to better respond to the burden and distribution of disease in Aboriginal and Torres Strait Islander peoples. It will also inform the development of the National



Registration and Accreditation Scheme for Aboriginal and Torres Strait Islander Health Practitioners.