



# Aboriginal & Torres Strait Islander Health Worker Project Interim Report

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Health Workforce Australia acknowledges the past, current and future contributions of Aboriginal and Torres Strait Islander Health Workers (Health Workers) to the physical, emotional and spiritual wellbeing of their communities.

Many views were gathered as part the development of this report; the aim of which was to establish the first truly national picture of the Health Worker workforce.

We are very grateful to the Aboriginal and Torres Strait Islander Health Workers that participated in this project; whether through focus groups, surveys, or both. In addition, thank you to the health service CEOs, managers and other health professionals who generously gave their time and offered their perspectives during the community mapping site visits. Many other key informants also contributed their views, including representatives from the Aboriginal Community Controlled Health Sector, the government health sector and Registered Training Organisations.

Importantly, we recognise the advice provided by the project reference groups, which have each given a unique perspective to the issues presented in this report. These groups include the Aboriginal Community Controlled Health Sector Reference Group (ACCHSRG); the Jurisdictional Planning Group (JPG); and the Expert Reference Group (ERG). The time invested by the members of each group is testament to their ongoing commitment to develop and strengthen the Health Worker workforce.

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### Logo design

The project logo was developed by the Jumbana Group, an Australian Indigenous Strategy and Design Company. It depicts a scroll, symbolising the unfurling of action. The blue, brown and red ochre lines are interconnected to represent the Aboriginal and Torres Strait Islander community, government and health professionals. The dynamic of a scroll, which creates its own movement, reinforces the new, sustainable energy of the Aboriginal and Torres Strait Islander Health Worker project. The dots and quality of line refer to the universal Aboriginal and Torres Strait Islander style.



## Authorship

This report was researched and prepared by a collaborative project team including members of Health Workforce Australia (HWA), PricewaterhouseCoopers (PwC) and Shannon Consulting Services (SCS):

### PricewaterhouseCoopers

Caitlin Francis, Craig Gear, Liz Cameron-Smith, Matt Cleary, Karen Lee

### Shannon Consulting Services

Cindy Shannon, Condy Canuto, Tom Ogwang, Brett Shannon

### Health Workforce Australia

Pat Maher, Anna Leditschke, Bev McIntyre, Elaine Treloar

## Contents

<b>Executive summary</b>	<b>xiii</b>
<b>1. Context for the project</b>	<b>1</b>
1.1 The project	1
1.2 Background	2
1.3 Definition of terms	9
1.4 The Interim Report	12
<b>2. Approach to the project</b>	<b>14</b>
2.1 Information collection	14
2.2 Key informant interviews	15
2.3 Health Worker and manager surveys	16
2.4 Community Mapping focus groups	19
<b>3. The existing Health Worker workforce</b>	<b>25</b>
3.1 Context	26
3.2 Defining the workforce	27
3.3 Size and geographic distribution	31
3.4 Gender profile	34
3.5 Health Worker income scale	35
<b>4. The health and service needs of Aboriginal and Torres Strait Islander people</b>	<b>37</b>
4.1 Context	38
4.2 Health needs of Aboriginal and Torres Strait Islander peoples	38
4.3 Health service needs of Aboriginal and Torres Strait Islander peoples	46
<b>5. The role of the Health Worker workforce</b>	<b>51</b>
5.1 Context	52
5.2 Understanding the existing Health Worker scope of practice: overview of results	53
5.3 Culturally safe health care roles	57
5.4 Prevention and health promotion roles	60
5.5 Variation in complexity of clinical roles	63
5.6 Variation in areas of specific focus	65
5.7 Future opportunities: optimising the Health Worker workforce	66
<b>6. Health Worker workforce models supporting health service delivery</b>	<b>70</b>
6.1 Context	71
6.2 The continuum of patient care	71

6.3	Health Worker-first models	74
6.4	Comprehensive primary health care models	77
6.5	Community-based workforce models	78
6.6	Outreach models	81
6.7	Prevention and health promotion program-based models	81
6.8	Health Worker models used in acute health care settings	86
<b>7.</b>	<b>Health Worker education and career pathways</b>	<b>89</b>
7.1	Context	90
7.2	Existing education and career pathways	90
7.3	Looking forward: perceptions on what these pathways ought to look like	97
7.4	Roadblocks: barriers to education and career progression	105
7.5	Transitioning into other workforces	111
<b>8.</b>	<b>Professional development, supervision and safety</b>	<b>114</b>
8.1	Context	115
8.2	Professional development and support opportunities	115
8.3	Supervision arrangements	123
8.4	Other quality and safety mechanisms	129
8.5	Performance monitoring and impact measurement	130
<b>9.</b>	<b>Underlying themes emerging from the analysis</b>	<b>133</b>
9.1	Context	134
9.2	Enabling Health Workers in the workplace	134
9.3	Recruitment and retention barriers and enablers	149
9.4	The systemic context	157
<b>10.</b>	<b>Opportunities for action: where to from here?</b>	<b>163</b>
10.1	Context	163
10.2	The current picture	163
10.3	The opportunity to transform the workforce	164
10.4	Define the workforce	166
10.5	Clarify and strengthen educational and career pathways	169
10.6	Build a systematic approach to workforce planning	172
10.7	Create enabling workplace and community environments	174
10.8	Collect and share an evidence base	175
	<b>Conclusion</b>	<b>180</b>
Appendix A	List of references	181

Appendix B	Additional information on the project methodology	(Attachment)
Appendix C	Information collection tools	(Attachment)
Appendix D	Self-reported titles: additional data analysis	(Attachment)
Appendix E	The Health Worker scope of practice: additional data analysis	(Attachment)
Appendix F	Education and qualifications: additional data analysis	(Attachment)
Appendix G	Supervision practice: additional data analysis	(Attachment)
Appendix H	Reference group members	(Attachment)

## List of figures

Figure 1: Recognising and empowering the Health Worker workforce – a virtuous cycle .....	XX
Figure 2: Key steps in the qualitative data analysis process .....	23
Figure 3: Australia by areas of remoteness, ASGC classification .....	32
Figure 4: Gender breakdown – comparison of the Health Worker workforce and the Aboriginal and Torres Strait Islander population, 2006 .....	34
Figure 5: The conceptual map of the Health Worker scope of practice .....	54
Figure 6: Colour scale for Health Worker Scope of Practice Conceptual diagram .....	55
Figure 7: The National Health Worker scope of practice .....	56
Figure 8: Example – Health Worker contribution to the continuum of patient care .....	72
Figure 9: CS&HISC Health Worker qualifications framework .....	91
Figure 10: Current qualification types held by Health Worker survey participants .....	92
Figure 11: Variation of current ATSIHC qualifications – by jurisdiction .....	93
Figure 12: Variation of current ATSIHC qualifications – by jurisdiction – Certificate IV level and above .....	93
Figure 13: Variation of current ATSIHC qualifications – by remoteness .....	94
Figure 14: Intention to study in the next 5 years (n=351) .....	101
Figure 15: Number of respondents with an ATSIHC Certificate IV qualification (or equivalent) – today, in 2012 and 2016 (n) .....	102
Figure 16: Respondents from each jurisdiction who hold ATSIHC qualification at the Cert IV level – current and projected totals* .....	104
Figure 17: Types of workforces providing supervision to Health Workers as reported by survey respondents .....	123
Figure 18: Availability of supervision as reported by Health Worker survey respondents – Nationally .....	125
Figure 19: Reported frequency of face-to-face supervision by Health Worker survey respondents – Nationally .....	127
Figure 20: Recognising and empowering the Health Worker workforce – a virtuous cycle .....	165
Figure 21: Conceptualising workforce segments – an option for discussion .....	169

## List of tables

Table 1: Opportunities for transforming the Health Worker workforce: potential impact at the systemic, workforce and individual levels .....	22
Table 2: National Indigenous reform agreement targets.....	3
Table 3: Key participant groups .....	14
Table 4: Participant groups and the information collection method .....	15
Table 5: Summary of data-cleaning methods that led to final numbers of the survey respondent data pool.....	17
Table 6: Site visit activities .....	21
Table 7: Comparison of data relating to the size of the Health Worker workforce from 2006 to 2010.....	31
Table 8: Distribution by area of remoteness – comparison of the Health Worker workforce and the Aboriginal and Torres Strait Islander population, 2006.....	33
Table 9: Years Lived with Disabilities (YLD), Years of Life Lost (YLL) and Disability-Adjusted Life Years (DALYs) for top ten broad cause groups, Aboriginal and Torres Strait Islander population, 2003.....	40
Table 10: Example – Health Worker contribution to the continuum of patient care.....	72
Table 11: NCVER 2009 VET sector ATSIPHC qualification student numbers and completion numbers .....	96
Table 12: Proportion of respondents from each jurisdiction who hold ATSIPHC (Certificate IV): today, in 2012 and in 2016.....	104
Table 13: Opportunities for transforming the Health Worker workforce: potential impact at the systemic, workforce and individual levels .....	177

## 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)
ACCCHS	Aboriginal Community Controlled Health Sector
AGV	About Giving Vaccines
AHLO	Aboriginal Hospital Liaison Officer (also used interchangeably with "HLO" – Hospital Liaison Officer)
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)
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ANZCO	Australian and New Zealand Standard Classification of Occupations
APHCRI	Australian Primary Health Care Research Institute
ASGC	Australian Standard Geographical Classification
ATSIHRTONN	Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network
ATSIHWWG	Aboriginal and Torres Strait Islander Health Workforce Working Group
ATSIPHC	Aboriginal and Torres Strait Islander Primary Health Care
CARPA	Central Australian Rural Practitioners Association
COAG	Council of Australian Governments
CRCAH	Cooperative Research Centre for Aboriginal Health
CS&HISC	Community Services and Health Industry Skills Council
DALY	Disability-Adjusted Life Year
DEEWR	Australian Department of Education, Employment and Workplace Relations

DoHA	Australian Department of Health and Ageing
ERG	Expert Reference Group (for this project)
HLO	Hospital Liaison Officer (also used interchangeably with "AHLO" – Aboriginal Hospital Liaison Officer)
HWA	Health Workforce Australia
IOW	Indigenous Outreach Worker
JPG	Jurisdictional Planning Group (for this project)
MBS	Medicare Benefits Schedule
MSOAP	Medical Specialist Outreach Assistance Program
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
NATSIHWA	National Aboriginal and Torres Strait Islander Health Workers Association
NCVER	National Centre for Vocational Educational Research
NGO	Non Government Organisation
NIDDM	Non-Insulin Dependent Diabetes
NRAS	National Registration and Accreditation Scheme
OATSIH	Office of Aboriginal and Torres Strait Islander Health
PCCM	Primary Clinical Care Model
PHC	Primary Health Care
QAIHC	Queensland Aboriginal and Islander Health Council
RTO	Registered Training Organisation
SIDS	Sudden Infant Death Syndrome
USOAP	Urban Specialist Outreach Assistance Program
VACCHO	Victorian Aboriginal Community Controlled Health Organisation

VET	Vocational Education and Training
WIPO	Workforce Issues Policy Officers

## Executive summary

The aim of Health Workforce Australia's (HWA) Aboriginal and Torres Strait Islander Health Worker project is to identify how the Aboriginal and Torres Strait Islander Health Worker (or Health Worker) workforce can be strengthened to deliver care in response to the known burden and distribution of disease in the Aboriginal and Torres Strait Islander population.

This project, over 12 months and two phases, will develop a national picture of the Health Worker workforce. The picture will include location, role, skills, qualifications, and interface with other sections of the health workforce. It will also provide information to inform the development of national standards, scope of practice, workforce roles, career pathways, and optimal mechanisms for interaction with other health professionals.

## Approach to the project

The findings described in this report are based on the analysis of the quantitative data collected via a Health Worker and health manager survey (conducted in November and December 2010) and qualitative data collected during 64 community site visits across Australia (including interviews and focus groups with Health Workers, managers and other health professionals between October and December 2010). The qualitative analysis is also enriched by the themes arising from the key informant interviews with representatives from the jurisdictions, Aboriginal Community Controlled Health sector (ACCHS), and Health Worker education and training organisations.

This Interim Report needs to be read in conjunction with the Environmental Scan which provides a summary of the existing evidence base in relation to the development of the Health Worker workforce.

## Overview of the existing Health Worker workforce

### Defining the workforce

There is no nationally consistent definition of an Aboriginal and Torres Strait Islander Health Worker. As the workforce matures and expands, it will be necessary to develop such a definition to delineate the Health Worker workforce from other health professionals.

This project has developed a working definition for the Health Worker workforce as follows.

An Aboriginal and Torres Strait Islander Health Worker is a person who:

1. identifies as being of Aboriginal and/or Torres Strait Islander descent
2. holds an Aboriginal and Torres Strait Islander Primary Health Care qualification
3. adopts a culturally safe and holistic approach to health care.

This definition will be tested and developed during the second phase of this project, which will include national workshops with key stakeholders. These will take place between May and July 2011.

## Workforce size and demographic features

The absence of a nationally consistent Health Worker definition has contributed to the challenge of gaining an accurate and comparable understanding of what the existing Health Worker workforce looks like.

Nevertheless, using the best available data, the following key findings emerge:

- At a minimum, the total workforce is estimated at between 1007 (Australian Bureau of Statistics, 2006b) and 1600 (ATSIHWGG 2009) Health Workers.
- The Health Worker workforce represents 17% of the total Aboriginal and Torres Strait Islander health workforce (5,535 people) (Australian Institute of Health and Welfare, 2006b).
- There is a high concentration of Health Workers in remote areas (48%), while only 24% of the Aboriginal and Torres Strait Islander population is located in the same area (Australian Bureau of Statistics, 2006b).
- Only 30% of the Health Worker workforce is male, despite the fact that males comprise 50% of the total Aboriginal and Torres Strait Islander population (Australian Bureau of Statistics, 2009, Australian Bureau of Statistics, 2006b).
- There is substantial variation in remuneration for Health Workers across Australia, with the average weekly income ranging from \$363/week (reported in the Northern Territory, very remote location) to \$900/week (reported in New South Wales, very remote location) (Australian Bureau of Statistics, 2006b).

## The health and service needs of Aboriginal and Torres Strait Islander peoples

It is widely acknowledged that Aboriginal and Torres Strait Islander Australians experience higher levels of sickness, die younger, are more likely to experience the death of close friends and relatives, are more likely to experience assault, experience more emotional and mental stresses and are more likely to consume alcohol at risky levels and use other drugs than the general population of Australia. In addition, Aboriginal and Torres Strait Islander Australians carry a significantly higher burden of largely preventable chronic illnesses, particularly diabetes and respiratory diseases. Aboriginal and Torres Strait Islander children also experience much higher rates of morbidity than other Australian children.

Despite these facts, some evidence gives cause for optimism. According to a study conducted in the Northern Territory, the increase in death rates from chronic disease is slowing (Thomas et al., 2006); and there have been substantial improvements in infant mortality rates during the period from 1960 to 2004 (Robert Griew Consulting, 2008). Research suggests that these improvements are linked to increases in primary health care accessibility for Aboriginal and Torres Strait Islander Australians (Robert Griew Consulting, 2008).

Although there have been some improvements in health outcomes in recent years, many Aboriginal and Torres Strait Islander Australians continue to experience significant barriers when accessing health care services, such as:<sup>1</sup>

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<sup>1</sup> Environmental Scan (Chapter 4)

- lack of cultural safety (Williams, 1999, Hayman et al., 2006, Cass et al., 2006) and experiences of racial discrimination (Cutcliffe, 2004, Paradies, 2007, Steering Committee for the Review of Government Service Provision, 2009b)
- language barriers (Steering Committee for the Review of Government Service Provision, 2009b)
- transport barriers/geographic location of services (Australian Institute of Health and Welfare, 2006a)
- cost of health care (Australian Bureau of Statistics, 2001, Australian Institute of Health and Welfare, 2006a).

When Health Workers, managers and other health professionals were asked about the main barriers to health service access that Aboriginal and Torres Strait Islander people face, the overwhelming majority mentioned the lack of cultural safety. This was mentioned more frequently than any other access barrier identified above.

### The role of the Health Worker workforce

The impact of any workforce is maximised when it is appropriately aligned to the health and service needs of its target client group. To date, there has been no empirical examination of the alignment between the role of the Health Worker workforce and the health and service needs of Aboriginal and Torres Strait Islander peoples. This project will therefore provide the first evidence-based picture of the role of the Health Worker workforce as a foundation for future consideration.

### The existing scope of practice

According to the survey data, the elements of the Health Worker scope of practice that are performed most frequently by Health Workers across Australia are:

- culturally safe health care roles (eg advocating for Aboriginal and Torres Strait Islander clients to explain their cultural needs and ensure they are met by other health professionals)
- prevention and health promotion roles (eg running programs that raise awareness of health issues or target the social determinants of health).

In addition, there are key roles that contribute to the broader Health Worker scope of practice, but vary across the workforce. These include:

- the level of complexity of clinical roles (eg ranging from basic health checks to clinical interventions that involve breaking the skin or the risk of loss of life)
- areas of specific primary health care or clinical focus (eg a focus on chronic disease management, mental health, sexual health).

Factors which have the most significant impact on the variation in clinical roles include the number of years in a Health Worker role, Aboriginal and Torres Strait Islander Primary Health Care qualification, and jurisdiction of employment.

### Optimising the Health Worker workforce in the future

In the focus groups, Health Workers, managers and other health professionals demonstrated overwhelming support for the Health Worker workforce to perform a more significant role in responding to the health needs of their communities. Focus group participants believed that Health Workers were well positioned to target perceived health service gaps in relation to providing more:

- culturally secure health services

- prevention and health promotion programs
- holistic<sup>2</sup> approaches to health care.

However, Health Workers reported that certain barriers prevented them from performing larger roles, for example:

- insufficient recognition and support, which disempowers and demotivates Health Workers, thus limiting their potential
- limited opportunities for role and career progression
- limited access to more training which would equip them with more skills and thereby facilitate the expansion of their role
- insufficient resources to implement additional programs
- demands to perform clinical and administrative activities in clinics, reducing their availability for prevention and health promotion programs.

Addressing these barriers would help empower Health Workers to optimise the contribution they make to the health needs of Aboriginal and Torres Strait Islander people.

### Health Worker workforce models supporting health service delivery

The planning of any health workforce should be informed by an understanding of which deployment models are most effective for meeting the health needs of the target population.

Health Workers are one part of the broader health workforce that exists to respond to those needs.

A variety of models exist that use the Health Worker workforce in different ways to contribute to the full continuum of patient care. Some of the reportedly more effective models are:

- Health Worker-first policies, where Health Workers provide the first patient contact and initial assessment
- comprehensive primary health care approaches, where Health Workers facilitate a holistic approach to health care
- community-based service delivery models, where Health Workers use their local knowledge of health needs to inform and develop appropriate community-based health service responses
- outreach service delivery models, where Health Workers contribute to the provision of services in the homes or communities of clients (ie not in the clinic)
- prevention and health promotion programs, where Health Workers raise awareness of health issues and encourage preventative behaviours to reduce demand for health services
- acute care setting models, where Health Workers use their primary health care training to support the provision of acute care to Aboriginal and Torres Strait Islander patients.

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<sup>2</sup> As defined in Section 1.3.1.

There is limited evidence available to compare the impact of each model.

## Health Worker education and career pathways

The sustainability of any workforce is heavily dependent on the strength of the education and career pathways underpinning it. The stories told by Health Workers, managers and other health professionals around the country suggest that, to truly establish the Health Worker profession, these pathways must continue to be developed.

For this to happen, three key questions need to be addressed:

1. To what extent does the current qualification structure meet the needs of the Aboriginal and Torres Strait Islander population, particularly in relation to social and emotional wellbeing, chronic disease management and health promotion and prevention?
2. How will the future qualification and career pathway structures for Health Workers help enhance and build the workforce at all levels?
3. To what extent can the barriers to education and training be addressed?

Perspectives on these questions were collected throughout the project. It was generally agreed that the ATSIPHC, at a Certificate IV level, provides an appropriate skill level for Health Workers to meet the health needs of their communities – since all Health Workers should have a base level of clinical knowledge, regardless of whether their role involves clinical intervention activities.

The introduction of national registration for Health Practitioners in July 2012 will begin the process of 'segmenting' the Health Worker workforce; a process which has occurred in most professions as they begin to mature (eg nursing). As part of that process it will be necessary to develop:

- the range of other relevant Health Worker 'grades' within the workforce which will best meet the needs of the Aboriginal and Torres Strait Islander community
- complementary and nationally consistent levels of qualification and/or experience which will be relevant to each grade; currently, there is some concern that the ATSIPHC qualification is not delivered consistently across the states and territories as a consequence of the fragmented nature of the VET sector in Australia
- an expected or 'blueprint' career pathway for each grade including transition into management or other professions, both at the national and health service level
- a set of national practice standards to provide an overarching practice framework for the profession
- a strategy to address literacy and numeracy barriers to entry into the workforce or career advancement, given the varying literacy and numeracy levels across the country; this is a critical factor in the transition to new qualification arrangements to ensure that valuable and experienced members of the existing Health Worker workforce are not excluded.

The key message emerging in relation to education and training is that the right opportunities need to be provided at the right time, in the right place. A large proportion of Health Workers reported their interest in pursuing higher education. However, some are hindered by barriers that continue to exist. Reports suggest that there are not always enough course positions available in the right locations to meet regional demands. Courses that are available are not always tailored to the

educational needs of Health Workers. And finally, limited access to required funding, leave and family support can hinder educational goals.

### Professional development, supervision and safety

Participants in the Community Mapping focus groups emphasised the value of a range of professional development and support opportunities for Health Workers, including:

- opportunities for ongoing training and skills development in the workplace, in addition to formal education qualifications
- access to appropriate mentoring, which includes technical mentoring, career mentoring and cultural mentoring
- opportunities to network with other Health Workers and share knowledge about good practice
- access to appropriate social and emotional wellbeing support.

However, with the exception of some ongoing training, many reported limited access to the items listed above. Supervisors can play an important role in facilitating access to these opportunities; however, there currently appears to be minimal consistency in supervision practices in place across Australia.

Supervision performs an important function in ensuring the quality of Health Worker services to maintain patient safety. Again, there is a lot of variability in the approach to ensuring the quality and safety of Health Worker services.

### Underlying themes emerging from the analysis

Throughout the focus groups conducted with Health Workers, managers and other health professionals, a number of underlying themes emerged which have relevance across a number of the topics already discussed.

These issues have been categorised into three areas:

- empowering Health Workers in the workplace
- recruitment and retention
- systemic issues.

These issues were raised frequently in response to a broad range of questions and topics, demonstrating their significance to the development of the Health Worker workforce. For example, an enabling workplace environment can affect an individual Health Worker's scope of practice, learning and development trajectory, career pathway, and the level of supervision and support received. Each of these underlying themes is discussed below.

#### Enabling workers in the workplace

Health Workers work across Australia in different team environments at different workplaces, in which a range of interlinking issues and themes associated with team dynamics are present. These relate to the presence or lack of:

- empowerment, trust, respect and recognition within teams
- cultural security in the workplace
- leadership and management in the workplace.

Although these themes are difficult to measure, the fact that they were raised so frequently by Health Workers, managers and other health professionals alike suggests

they have a tangible impact upon the Health Worker workforce and the capacity of Health Workers to reach their full potential.

### **Recruitment and retention**

Health Worker recruitment and retention strategies are essential to workforce sustainability, yet this is a major issue for a large proportion of health services. For example, there are reportedly large numbers of positions vacant at any point in time. Some health services are finding it challenging to recruit appropriately trained Health Workers while others face problems with retention, attributed to 'burn-out' or exhaustion. A perceived lack of recognition and appropriate remuneration are also contributing issues.

Yet other health services face few of these challenges; indeed, some services report overwhelming interest from applicants. In these circumstances, promoting the organisation as a good place to work and building its reputation in the community were flagged as effective recruitment strategies. Also, increasing Health Worker job satisfaction through ensuring that they are consistently well supported and respected in their role was reported as being important for retaining Health Workers.

### **Systemic issues**

Health Workers, managers and other key informants also voiced major concerns about some systemic issues, including:

- the emergence of new workforces from the implementation of the COAG Closing the Gap initiatives; these new workforces have reportedly undermined the Health Worker workforce by
  1. contributing to confusion about the Health Worker workforce role and
  2. competing with the Health Worker workforce in the recruitment market
- a range of issues associated with training, including access, funding and comparability across jurisdictions – which is symptomatic of a fragmented system making it hard for Health Workers to navigate and progress
- the potential for Health Workers to be disadvantaged through their employment, as it may result in loss of entitlement to other benefits such as community housing
- the low pay levels for Health Workers generally when compared to other professions (eg enrolled nurses) and also the difference in pay between different sectors and geographic locations.

There is also a need for Health Workers to be considered within the broader health workforce, with regard to, for example:

- the role the Health Worker workforce performs in addressing workforce gaps in other health professions
- the implications of workforce shortages in other health professions on the Health Worker role – for example, the impact of "fly-in, fly-out" nursing and medical staff in remote areas.

### **Opportunities for action: where to from here?**

Information collected throughout this project contributes a new body of evidence to inform development opportunities for the Health Worker workforce. In addition, there are a number of key project findings that are complex, overlapping and interlinked. The

synthesis and interpretation of those findings has highlighted a number of opportunities for workforce development.

**First, the workforce’s contribution.** It appears that, although the Health Worker workforce is well-positioned to contribute to the health and service needs of Aboriginal and Torres Strait Islander Australians, this contribution is not currently being used to its maximum potential. There is therefore an opportunity to transform the workforce and enhance the role it plays in closing the gap on health inequality in Australia.

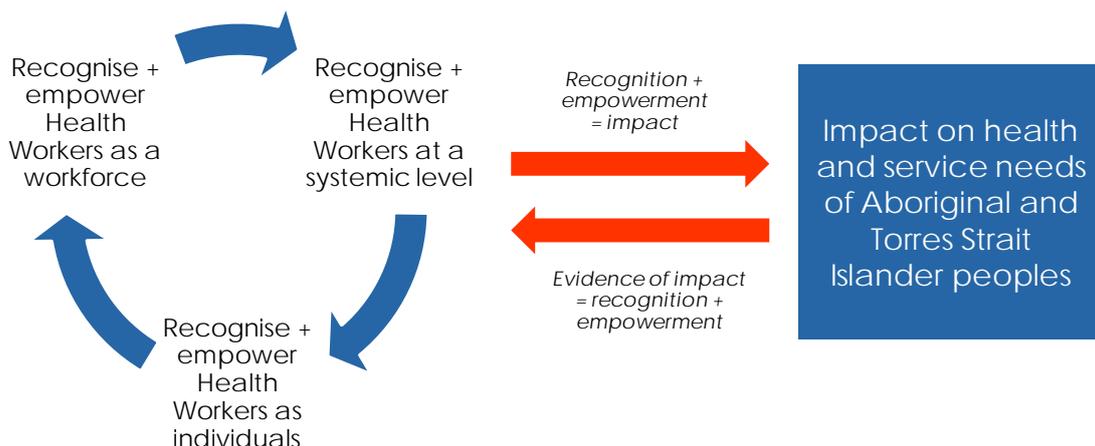
**Second, the workforce as a profession.** It seems that part of this process will involve establishing the Health Worker workforce as a distinct *profession*. However, it has yet to develop some of the attributes of a profession defined by the Australian Competition & Consumer Commission, such as practice standards and a unique and publicly accepted discipline or scope of practice (Australian Competition & Consumer Commission, 2011). The introduction of the HLT07 qualifications package represents a positive step towards the development of the Health Worker profession. However, Health Workers and managers continued to report that they would like the Health Worker workforce to be recognised as a distinct profession.

**Third, recognition and empowerment.** A common thread connects the various findings presented in this report. For Health Workers to have a greater impact on the health and service needs of Aboriginal and Torres Strait Islander Australians, they need to be more recognised and empowered.

Empowerment has been defined as relating to three levels: the individual level, the group level, and the systemic level (McEwan et al., 2009). In this context, recognition and empowerment at each of these levels has potential to generate a more significant impact on the health and service needs of Aboriginal and Torres Strait Islander people.

Progress at each of these levels is likely to be mutually reinforcing: the greater the impact on health and service needs, the more the workforce will be recognised, and the more it will be empowered to have a greater impact (Figure 1).

Figure 1: Recognising and empowering the Health Worker workforce – a virtuous cycle



Recognising the above, five key steps are proposed in order to continue the development of the workforce:

1. **Define the workforce** using nationally consistent titles, and by developing a national understanding of the Health Worker scope of practice.

2. **Clarify and strengthen education and career pathways** to ensure Health Workers have access to opportunities for career progression and recognition
3. **Build a systematic approach to workforce planning** to facilitate workforce development at the systemic level; for example by creating mechanisms to coordinate planned responses to workforce supply and demand issues.
4. **Create enabling workplace and community environments** to ensure that workforce policies designed to improve the system are also effective on the ground.
5. **Collect and share an evidence base** in future to evaluate the impact of the workforce, identify effective models of service delivery, and inform future workforce planning.

The opportunities for action identified within each of these steps are summarised in Table 1 of this Executive summary. Table 1 also frames each opportunity in terms of the potential impact it may have at the systemic, workforce and individual levels.

In short, the table summarises options for future consideration that have been developed after analysing the evidence presented in this report. These options are not prescriptive or definitive. Instead, they provide a foundation for the national workshops that are planned for Phase 2 of this project.

## Conclusion

The Health Worker workforce forms an integral part of the COAG Closing the Gap strategy to address Aboriginal and Torres Strait Islander disadvantage in health, education and economic outcomes.

This project highlights an opportunity to improve Aboriginal and Torres Strait Islander health outcomes by recognising and empowering the Aboriginal and Torres Strait Islander Health Worker workforce. However, such change will only occur if there is a joint and real commitment by all key stakeholders to do this. Stakeholders include Health Workers themselves, relevant government departments at all levels, the Aboriginal and Torres Strait Islander Community Controlled Health Sector, relevant professional associations, education and training organisations, and regulatory bodies.

Without this nationally consistent approach, there is a risk that the workforce's potential contribution to health outcomes may be undermined by the consequences of siloed or piecemeal initiatives. For example, although sharing the same objective, the new health workforces emerging from the COAG Closing the Gap strategy are currently perceived as undermining the development of the Health Worker workforce.

The challenge of developing a sustainable Aboriginal and Torres Strait Islander Health Worker workforce may seem daunting; but if successful, the benefits will be realised not only for Health Workers and their respective communities, but also for the wider Australian population. This is because the way Health Workers do business – which involves a comprehensive approach to primary health care – needs to be embedded in the whole health system to help, for example, manage the growth in chronic disease in a more cost-effective way.

Table 1: Opportunities for transforming the Health Worker workforce: potential impact at the systemic, workforce and individual levels

Five key steps	Opportunities for action	Potential Impact			
		at the systemic level	at the workforce level	at the individual level	
1. Define the workforce	1	Test, refine and agree on a nationally consistent definition of an Aboriginal and Torres Strait Islander Health Worker.	Facilitates workforce design and planning in response to health needs; facilitates national alignment of education, health and employment policies to support Health Worker workforce	Distinguishes and recognises the Health Worker workforce as a cohesive group that is clearly delineated from other health professions	Provides individual Health Workers with a clear understanding of their role and identity as part of the Health Worker workforce
	2	Review the Health Worker scope of practice to ensure the role of the Health Worker workforce is appropriately aligned to the health needs of Aboriginal and Torres Strait Islander people.	Enables the Health Worker scope of practice to better target gaps in the national response to the health and service needs of the target community	Distinguishes and recognises the Health Worker workforce as a cohesive group that is clearly delineated from other health professions	Provides individual Health Workers with awareness of their full scope of practice, within which they are able to choose career pathways and establish personal goals
	3	Explore options for identifying distinct categories within the Health Worker workforce (eg Health Workers with no formal qualifications, registered Aboriginal and Torres Strait Islander Health Practitioners).	Contributes to workforce planning: coordination of education and career pathways; and management of quality and safety risks	Enables workforce segments to develop more clearly defined areas of specialisation and expertise; strengthens career structure; fosters support networks within/across different levels of the workforce	Gives clarity concerning career pathways, providing opportunities for education and career progression within an aligned structure
	4	Review and determine the appropriate qualification requirements of the Health Worker career structure (in	Creates alignment between health, education and employment systems to optimise the workforce and maintain supply of appropriately qualified Health Workers; addresses public	Ensures that the Health Worker workforce is sufficiently equipped with the knowledge, skills and competencies required to	Provides clear educational pathways that are aligned to scope of practice and career structure
2. Clarify and strengthen education and career pathways	4	Review and determine the appropriate qualification requirements of the Health Worker career structure (in			

Five key steps	Opportunities for action	Potential impact		
		at the systemic level	at the workforce level	at the individual level
3. Build a systematic approach to workforce development	tandem with the ongoing development of career pathways for Health Workers).	safety risks by setting appropriate educational standards	support their role	Provides clear career pathways and opportunities, which are aligned to scope of practice and qualification requirements
		Helps to attract new recruits into the workforce by providing clear career pathways and appropriate entry points into the profession; helps retain Health Workers by providing opportunities for career progression	Facilitates development of fair and equitable remuneration structure; provides a tangible opportunity to promote Health Worker leadership and management roles in reflection of seniority and experience	
	Strengthen Health Worker career pathways by linking them to education, experience and individual choices – both within the Health Worker workforce and when transitioning into other health professions	Addresses public safety risks by minimising potential for harm to patients	Guides the scope of practice by establishing clear boundaries; helps protect the workforce from public safety risks	Guides personal development; protects Health Workers from situations outside their skill level through practice standards
	Develop national practice standards for the Health Worker profession.	Promotes workforce deployment models that are demonstrated to be effective in relevant contexts – thereby optimising impact of Health Worker workforce on health outcomes	Cultivates a better understanding of the role of the workforce and its position within the broader health system; may help to negotiate funding to address service gaps on the ground	Aims to ensure each Health Worker is empowered to perform to their full capacity
	Develop mechanisms that will enable a coordinated and strategic approach to workforce planning in response to demands for health services	Ensures ongoing supply of Health Workers that is sufficient to address the needs of Aboriginal and Torres Strait Islander people	Maintains a sustainable, skilled workforce with fewer recruitment and retention challenges	Facilitates smooth entry and exit points into the workforce for individuals; encourages appropriate recognition and
	Develop a coordinated and planned approach to ensuring a sustainable supply of Health			

Five key steps	Opportunities for action	Potential impact		
		at the systemic level	at the workforce level	at the individual level
4. Create enabling workplace and community environments	Workers			remuneration
	9	Support greater confidence in the implementation of policies that involve Health Workers as part of the response to Aboriginal and Torres Strait Islander health needs	Empowers the workforce to reach its full potential and work productively alongside other health professionals	Empowers individuals in the workplace – so that they might always feel culturally secure, supported, trusted and respected
	10	Contributes to supply and demand challenges by promoting the workforce in local communities where demands are high	Helps the workforce to grow from local areas – retaining local knowledge and support networks	Provides individual Health Workers with the community recognition, respect and support they deserve
5. Collect and share an evidence base	11	Provides an evidence-based view of the impact the Health Worker workforce has on Aboriginal and Torres Strait Islander health outcomes – this will inform ongoing workforce developments	Promotes respect as a unique and valued workforce distinct from other health professions; demonstrates the impact of the workforce; providing an evidence base for advocacy and support purposes	Values and recognises the individual's contribution; informs personal and professional development; promotes team relationships based on respect and trust
	12	Encourages optimal use of the Health Worker workforce by promoting innovative, evidence-based practice - across all jurisdictions, sectors and services	Helps to create a culture of continuous improvement, knowledge sharing, collaboration and support; thereby strengthening the workforce as a unified group of empowered individuals	Helps to provide individuals with the tools, insights and support they need to introduce new ideas, initiate change, and contribute to the best of their ability
		11	Develop a mechanism for measuring the impact of the Health Worker workforce at both the broader workforce and the individual level	
		12	Develop information sharing opportunities to encourage good practice and innovation (at all levels: peer-to-peer, service-to-service, jurisdiction-to-jurisdiction, sector-to-sector)	

## 1. Context for the project

Aboriginal and Torres Strait Islander Health Workers (Health Workers) have a very important role in helping to close the health outcomes gap between Aboriginal and Torres Strait Islander people and other Australians. Health Workers practise within a comprehensive primary health care model, promoting the cultural and social determinants of health.

Intrinsically, this project recognises the valuable contribution that Health Workers make to their communities and their people.

### 1.1 The project

The overarching aim of Health Workforce Australia's (HWA) Aboriginal and Torres Strait Islander Health Worker project is:

- to inform the development of policies and strategies which will strengthen and sustain the Health Worker workforce to deliver care in response to the known burden and distribution of disease in the Aboriginal and Torres Strait Islander population.

In particular, this project will develop a national picture of Aboriginal and Torres Strait Islander Health Worker workforce information such as location, role, skills, qualifications and interface with other sections of the health workforce. It will also provide information to inform the development of national standards, scope of practice, workforce roles, career pathways, and optimal mechanisms for interaction with other health professionals.

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

#### 1.1.1 Project structure and timelines

In order to achieve the project objectives, three project phases have been designed. The aims and activities of these three phases are as set out below.

<b>Phase 1</b> 'As is' September 2010 to March 2011	<p>Establish a clear understanding of the existing Health Worker workforce and the health status of Aboriginal and Torres Strait Islander peoples by conducting:</p> <ul style="list-style-type: none"> <li>➤ an Environmental Scan through a desktop literature search and key informant interviews: 1) of the existing health needs of Aboriginal and Torres Strait Islander people; 2) of the existing body of information relating to the Health Worker workforce</li> <li>➤ a survey of Health Workers and Health Worker managers and visits to community sites to map the existing Health Worker workforce and define current Health Worker roles, scope of practice and qualifications</li> </ul> <p>Three deliverables have been prepared as part of Phase 1:</p> <ul style="list-style-type: none"> <li>➤ the Environmental Scan</li> <li>➤ Preliminary Report for the National Registration and Accreditation Scheme (NRAS) subcommittee</li> <li>➤ Interim Report.</li> </ul>
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<b>Phase 2</b> 'To be' February 2011 to September 2011	<p>Develop a set of options for the future workforce design, roles and educational requirements to submit to governments for consideration.</p> <p>Findings from Phase 1 will be used to develop of a set of options for:</p> <ul style="list-style-type: none"> <li>➤ Health Worker role design and alignment to the health needs of the Aboriginal and Torres Strait Islander population</li> <li>➤ the development of national practice standards</li> <li>➤ recruitment and retention strategies.</li> </ul> <p>A core feature of Phase 2 is a series of national workshops to validate the findings of the Interim Report and discuss potential options.</p>
<b>Phase 3</b>	<p>Use supply and demand data to model the future Health Worker workforce.</p> <p>To be determined on the basis of results of Phase 1 and Phase 2.</p>

This project is a major workforce development initiative. The project will provide strategies for implementation by governments, health services and professional associations to assist in the future development of the Aboriginal and Torres Strait Islander Health Worker Workforce. The project has been conducted with the assistance of PwC and Shannon Consulting Services.

## 1.2 Background

### 1.2.1 Health needs of Aboriginal and Torres Strait Islander Australians

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 people. The reform process must therefore be informed by a sound understanding of the population demographics and their unique health needs.

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 people is comparatively very poor. Aboriginal and Torres Strait Islander people have a much higher disease profile than other Australians with regard to chronic disease, injury, social and mental wellbeing, and infant morbidity and mortality.

For example, according to the most recent burden of disease study conducted in 2003, 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).

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. Aligning the Health Worker workforce to the minimisation of these factors is likely to contribute to closing the health status gap. The Health Worker workforce can contribute both to health care availability and accessibility.

#### Availability vs. accessibility

The availability and accessibility of health services are two distinct concepts. Availability refers to the level and type of health services available and their geographic distribution. Aboriginal Community Controlled Health Services predominantly deliver primary health care services, while 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.

Data have shown that Aboriginal and Torres Strait Islanders in non-remote areas actually have a higher level of unmet needs 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, than 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 accessibility.

The Health Worker workforce has the capacity to improve the accessibility of services by breaking down some of the 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 across the Aboriginal Community Controlled, government and private sectors.

### 1.2.2 Policy context: existing policies and strategies

#### 'Closing the Gap' on health, education and employment

In response to some of these and other issues, 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 close the gap of Aboriginal and Torres Strait Islander disadvantage, covering a range of health, education and employment targets (Table 2).

Table 2: National Indigenous reform agreement targets

- Closing the life expectancy gap within a generation
- Halving the gap in mortality rates for Aboriginal and Torres Strait Islander children under five within a decade
- Ensuring all Indigenous four-year-olds in remote communities have access to early childhood education within five years
- Halving the gap for Aboriginal and Torres Strait Islander students in reading, writing, and numeracy within a decade
- Halving the gap for Aboriginal and Torres Strait Islander students in year 12 attainment or equivalent attainment rates by 2020
- Halving the gap in employment outcomes between Aboriginal and Torres Strait Islander and other Australians within a decade.

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 emphasises the importance of supporting Aboriginal and Torres Strait Islander people's transition pathways "into schooling and into work, post school education and training" (Council of Australian Governments, 2008).

A central element of the COAG framework is National Partnership payments, which are a mechanism to support the delivery of specified outputs or projects and to facilitate and reward those jurisdictions that deliver on nationally significant reforms. A number of

National Partnership Agreements have been signed to facilitate Closing the Gap reform<sup>3</sup>, which also relate to health workforce reform:

- Closing the Gap in Indigenous Health Outcomes, which includes: tackling smoking; healthy transition to adulthood; making Indigenous health everyone's business; primary health care services that can deliver and fix the gaps; and improving the patient journey
- Indigenous Economic Participation
- Remote Service Delivery
- Closing the Gap: Indigenous Early Childhood Development, which includes: child and family centres; antenatal, pre-pregnancy and teenage care; sexual and reproductive health; and maternal and child health services
- Remote Indigenous Housing
- Closing the Gap: Remote Indigenous Public Internet Access.

Taking the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* as an example, this resulted in \$1.57 billion in being committed over four years to improve Aboriginal health and wellbeing. This reform represents system-level change such as:

- national minimum service standards for all organisations providing primary health care services to Aboriginal and Torres Strait Islander populations
- improved quality of Aboriginal and Torres Strait Islander identification in demographic, health outcomes and administrative datasets
- infrastructure to support care transitions and linked records of Aboriginal and Torres Strait Islander patients between primary, in-patient and specialist services
- an increased number of Aboriginal and Torres Strait Islander people in the health workforce, and reforms and improvements to the supply of the health workforce generally including the adoption of complementary workplace reforms
- 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 funded a number of other Aboriginal and Torres Strait Islander health workforce initiatives:

- 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)
- 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

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<sup>3</sup> [http://www.federalfinancialrelations.gov.au/content/national\\_partnership\\_agreements/indigenous.aspx](http://www.federalfinancialrelations.gov.au/content/national_partnership_agreements/indigenous.aspx)

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. Whether this happens will be influenced by different qualification requirements, career pathway opportunities and relative salaries.

So, although the objectives of this project are aligned with the Closing the Gap strategy, other initiatives have resulted in some unforeseen consequences which will need to be considered as part of future workforce planning.

Other features of the current policy context are discussed below.

### [National registration and accreditation of Aboriginal and Torres Strait Islander Health Practitioners](#)

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 legislation is "to protect the public by establishing a national scheme for the regulation of health practitioners and students".

Some 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 legislation's principal purpose, it is likely that registration will only apply to Health Workers who perform services that carry a risk to public safety.

For Health Workers to be registered, a number of crucial steps must be completed. For example, the group of Health Workers that will be registered needs to be determined, and a regulatory body must be established. Although it is not within the scope of this project to determine the requirements for national registration, the body of evidence generated by the project will inform the steps towards registration of Aboriginal and Torres Strait Islander Health Practitioners in July 2012.

### [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. Titled *Building a 21st Century Primary Health Care System* (Commonwealth of Australia 2010), it 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:

- improving access and reducing inequity
- better management of chronic conditions
- increasing the focus on prevention
- improving quality, safety and performance.

All four areas are pertinent for primary health care provided to Aboriginal and Torres Strait Islander people. The strategy gives particular emphasis to improving Aboriginal and Torres Strait Islander people's 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:

- regional integration

- information and technology including eHealth
- skilled workforce
- infrastructure
- financing and system performance.

The definition of primary health care underpinning these reforms is provided below in Section 1.3.2.

*The Primary Health Care Reform in Australia Report* emphasised the importance of comprehensive primary health care 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 (Australian Government Department of Health and Ageing, 2009b).

### Preventative Health Care Strategy

The National Preventative Health Strategy (ie *Australia: The Healthiest Country by 2020*) was developed to improve Australia's approach to health promotion and prevention, with the long-term aim of reducing the strain on our acute health system and improving the health and lifestyles of all Australians (Australian Government - the National Preventative Health Taskforce, 2009). The strategy recognises the current inequities in the health system and in particular the disadvantages faced by Aboriginal and Torres Strait Islander Australians, which contribute to their current poorer health status and overall lack of access to health care

The strategy outlines seven strategic directions for action, one of which is to contribute to the overall Closing the Gap targets, particularly in reducing the life expectancy gap between Aboriginal and Torres Strait Islanders and other Australians.

Strategic Direction 1	<b>Shared responsibility – developing strategic partnerships</b> – at all levels of government, industry, business, unions, the non-government sector, research institutions and communities
Strategic Direction 2	<b>Act early and throughout life</b> – working with individuals, families and communities
Strategic Direction 3	<b>Engage communities</b> – act and engage with people where they live, work and play; at home, in schools, workplaces and the community. Inform, enable and support people to make healthy choices
Strategic Direction 4	<b>Influence markets and develop coherent policies</b> – for example, through taxation, responsive regulation, and coherent and connected policies
Strategic Direction 5	<b>Reduce inequity</b> through targeting disadvantage – especially low socioeconomic status (SES) population groups
Strategic Direction 6	<b>Indigenous Australians</b> contribute to ‘Closing the Gap’
Strategic Direction 7	<b>Refocus primary healthcare towards prevention</b>

Within these seven strategic directions, the strategy proposes to focus on three specific areas: reducing over time, obesity levels, tobacco consumption and alcohol consumption. The Taskforce believes this will have a significant impact on improving the overall health and wellbeing of Australians.

These issues also feature prominently in Aboriginal and Torres Strait Islander populations, and the strategy recognises that some of the necessary actions must be undertaken in conjunction with the support and aid of the Aboriginal Community Controlled sector.

It is worth noting some of the actions proposed involve the employment of Tobacco control workers within Aboriginal Community Controlled organisations. It is unclear when and how this action will be rolled out, but there may be an impact on the current Health Worker workforce in the form of overlap in scope of practice, as mentioned previously in Section 1.2.2. The impact of this is discussed further in Chapter 5.

Overall, this strategy would seem to be ambitious in setting targets for improvements across the three focus areas over the next few years; however, its impact on health outcomes has yet to be seen.

### Aboriginal and Torres Strait Islander Health Workforce Strategic Framework

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, 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:

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 Aboriginal and Torres Strait Islander and other 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 were being implemented by a range of actors at both the state/territory and national levels. For example, the CS&HISC developed the current Aboriginal and/or Torres Strait Islander Health Worker qualifications framework in 2007/8, which addressed the intended outcomes of Objective 2 in the Yellow Book.

A review of the 2002 Framework was conducted in 2008-2009 and the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2010-2015)* was released in 2011. This draft Framework was developed by ATSIHWWG and endorsed by AHMAC. It reflects an update in the content and structure following extensive consultation which identified a need to better align the original Framework to contemporary approaches and thinking (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2010). For example, since the original Framework was developed in 2002, a number of national policy and service delivery initiatives have altered the contextual environment (eg the Closing the Gap statement of intent, the COAG National Partnership Agreements, and NRAS).

The draft encompasses elements of reform required to improve the Aboriginal and Torres Strait Islander health workforce over the next five years and identifies five Key Priority Areas as listed below:

[National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework \(2010-2015\): Key Priority Areas](#)

Key Priority Area 1	Participation of Aboriginal and Torres Strait Islander people in the health workforce
Key Priority Area 2	Workforce capacity of the Community Controlled Sector including Aboriginal and Torres Strait Islander Health Workers
Key Priority Area 3	Competent health workforce to meet the needs of Aboriginal and Torres Strait Islander people
Key Priority Area 4	Leadership

(Aboriginal and Torres Strait Islander Health Workforce Working Group, 2010)

It is anticipated that through the implementation of the framework and its priority areas over the coming five years, there will likely be positive impacts in:

- the recruitment and retention of Aboriginal and Torres Strait Islander people in the health sector,
- the delivery of education and training to prepare them for work in the health sector along with increasing their skills and understanding to provide health services that meets the needs of the community they service.

### 1.3 Definition of terms

Below are definitions of the terms used frequently in this report.

#### 1.3.1 Holistic health

The concept of *holistic health* is central to the cultural belief system held by many Aboriginal and Torres Strait Islander peoples. Although Aboriginal and Torres Strait Islander peoples are culturally, linguistically and ethnically diverse, most share a holistic understanding of 'health'.

The definition of holistic health used in this report is drawn from the preface to the National Aboriginal Health Strategy (NAHS) published in 1989. The NAHS working definition of health includes:

*"Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life."*

(NAHS, 1989)

The above definition is informed by an additional explanation of the differences between Western medical ideology and the Aboriginal and Torres Strait Islander conceptualisation of health:

*"'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)

An understanding of the Aboriginal and Torres Strait Islander concept of holistic health is essential to the development of the Health Worker workforce because these cultural beliefs are embedded in the Health Worker approach. Sections 5.2 and 5.3 consider this further.

#### 1.3.2 Primary health care

*Primary health care* has two definitions: the narrow definition, referring to primary medical care; and the broader definition often described as *comprehensive primary health care* (Aboriginal Medical Services Alliance Northern Territory, 2010).

The definition of *primary health care* agreed by the World Health Organisation (WHO) in 1978 is:

*"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."*

(World Health Organisation, 1978)

These characteristics underpin the first Australian national primary health care strategy, published in May 2010 by the Australian Government Department of Health and Ageing. *Building a 21st Century Primary Health Care System* provides the roadmap to primary health care reform and the establishment of Medicare Locals (Australian Government Department of Health and Ageing, 2010a).

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, 2009a):

*"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."*<sup>4</sup>

*Comprehensive primary health care* builds on the definitions above. According to the Aboriginal Medical Services Alliance Northern Territory (AMSANT), primary health care is just one part of *comprehensive primary health care*, which is defined as:

*"...the broader, holistic approach to health problems. As well as primary medical care, comprehensive primary health care addresses a range of health concerns that have no specific medical intervention."*

(Aboriginal Medical Services Alliance Northern Territory, 2010)

### 1.3.3 Aboriginal and Torres Strait Islander primary health care

The definition of *Aboriginal and Torres Strait Islander primary health care* refers to two of the definitions above. Embedded in Aboriginal and Torres Strait Islander primary health care is:

- the Aboriginal and Torres Strait Islander concept of holistic health
- a comprehensive primary health care approach.

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<sup>4</sup> 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*.

This is reflected in the NACCHO definition of primary health care in the Aboriginal and Torres Strait Islander context, which is adapted from the WHO definition above:

*“Primary Health Care’ has always been a continuing integral aspect of our Aboriginal life, and is the collective effort of the local Aboriginal community to achieve and maintain its cultural well being. Primary health care is a holistic approach which incorporates body, mind, spirit, land, environment, custom and socio-economic status. Primary health care is an Aboriginal cultural construct that includes essential, integrated care based upon practical, scientifically sound and socially acceptable 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. The provision of this calibre of health care requires an intimate knowledge of the community and its health problems, with the community itself providing the most effective and appropriate way to address its main health problems, including promotion, preventative, curative and rehabilitation services.”*

(National Aboriginal Community Controlled Health Organisation, 2008)

It is reiterated in NACCHO’s definition of ‘Aboriginal health-related services’ below:

*“Aboriginal health related services’ means those services covered by the Aboriginal holistic definition of health including, but not restricted to, such services as health promotions and disease prevention services, substance misuse, men’s and women’s health, specialised services to children and the aged, services for people with disabilities, mental health services, dental care, clinical and hospital services and those services addressing, as well as seeking the amelioration of, poverty within Aboriginal communities.”*

(National Aboriginal Community Controlled Health Organisation, 2006)

Throughout this project, the term ‘Aboriginal and Torres Strait Islander primary health care services’ therefore reflects a holistic, comprehensive approach to primary health care.

### **1.3.4 Cultural safety, security and respect**

Terms like *cultural safety*, *cultural security* and *cultural respect* are often used interchangeably. Although this can be appropriate in certain contexts, their meanings vary.

In the context of health care, *cultural safety* is defined as:

*“The effective care of a person/family from another culture by a health care provider who has undertaken a process of reflection on their own cultural identity and recognises the impact of the health care professional’s culture on their practice. Unsafe cultural practice is any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual.”*

(The Nursing Council of New Zealand, 2002)

Culturally safe health care refers to the delivery of health services in a culturally safe way. For example, in the Aboriginal and Torres Strait Islander context, culturally safe health care should reflect the holistic conceptualisation of health as defined above.

*Cultural security* is similar in meaning but implies a greater sense of permanence or longevity. More specifically, *cultural security* has been defined as:

*‘...the capacity of a society to conserve its specific character in spite of changing conditions and real or virtual threats: more precisely, it involves the permanence of traditional schemas of language, culture, associations, identity and national or religious practices, allowing for changes that are judged to be acceptable.’*

(Weaver et al., 1993)

*Cultural respect* is defined as the “recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples” (Australian Health Ministers’ Advisory Council, 2004). Cultural respect is essential to the creation of culturally safe and culturally secure environments.

### 1.3.5 Profession

To understand what makes a profession a *profession*, as opposed to a *vocation*, the following definition is provided by the Australian Competition and Consumer Commission. A profession is:

*“A disciplined group of individuals who adhere to high ethical standards and uphold themselves to, and are accepted by, the public as possessing special knowledge and skills in a widely recognised, organised body of learning derived from education and training at a high level, and who are prepared to exercise this knowledge and these skills in the interest of others. Inherent in this definition is the concept that the responsibility for the welfare, health and safety of the community shall take precedence over other considerations.”*

(Australian Competition & Consumer Commission, 2011)

Consideration of this definition is relevant to the ongoing professionalisation of the Health Worker workforce.

## 1.4 The Interim Report

### 1.4.1 Objectives

The purpose of this Interim Report is to establish a clear understanding of the existing Health Worker workforce and the health status of Aboriginal and Torres Strait Islander people.

### 1.4.2 Scope of the Interim Report

The Interim Report builds on two previous publications: (1) the Environmental Scan; and (2) a Preliminary Report provided to the NRAS subcommittee.

#### Environmental Scan

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

- 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 focused 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; health needs of Aboriginal and Torres Strait Islander people; and the availability and accessibility of health services
- Health Worker-specific issues definition; scope of practice and role; distribution and demographics of the Health Worker workforce; quality and safety mechanisms; career pathways; education and training; and recruitment and retention.

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 Jurisdictional Planning Group and Expert Reference Group.

The Interim Report should be read in conjunction with the Environmental Scan.

#### Preliminary Report to the NRAS subcommittee

The Preliminary Report was prepared to meet HWA's commitment to provide timely information to help prepare for the registration of Aboriginal and/or Torres Strait Islander Health Practitioners under the NRAS. It provides information on the location, role, education and qualifications, and supervision of Health Workers, and was predominantly developed through analysis of the results of the Health Worker survey.

This Interim Report includes the qualitative information and thematic analysis of the Community Mapping site visits. Additional topics considered in this report are:

- further analysis of the Health Worker role and scope of practice including analysis of options and desire for expansion of the role
- examples of models of care where Health Workers contribute most effectively to health outcomes for their communities
- inter-professional relationships including enablers and barriers
- career pathways within the Health Worker workforce and into other health professions.

#### 1.4.3 Structure of this report

The remainder of this report is structured as following:

- Chapter 2: Approach to the project
- Chapter 3: The existing Health Worker workforce
- Chapter 4: The health and service needs of Aboriginal and Torres Strait Islander people
- Chapter 5: The role of the Health Worker workforce
- Chapter 6: Health Worker workforce models supporting health service delivery
- Chapter 7: Health Worker education and career pathways
- Chapter 8: Professional development, supervision and safety
- Chapter 9: Underlying themes emerging from the analysis
- Chapter 10: Opportunities for action: where to from here?

In addition, a series of appendices provide data analysis to supplement the content of certain chapters.

## 2. Approach to the project

### 2.1 Information collection

#### 2.1.1 Key participant groups

The four participant groups outlined in Table 3 were identified as critical for this project. These four groups were consulted at various points throughout the project via the most appropriate methods as determined by the project team.

Table 3: Key participant groups

Participant group	Sub-group
Aboriginal and Torres Strait Islander <b>Health Workers</b>	<ul style="list-style-type: none"> <li>➤ Aboriginal Health Workers (across the broad continuum of practice)</li> <li>➤ Torres Strait Islander Health Workers (across the broad continuum of practice)</li> </ul>
<b>Managers</b> of Aboriginal and Torres Strait Islander Health Workers	<ul style="list-style-type: none"> <li>➤ Aboriginal Community Controlled Health Service</li> <li>➤ Public/Private hospitals</li> <li>➤ Public/Private community health services</li> <li>➤ General Practitioners' Clinics</li> </ul>
Aboriginal and Torres Strait Islander Health Worker <b>employers and workforce representatives</b>	<ul style="list-style-type: none"> <li>➤ Aboriginal Community Controlled Health Organisations and Medical Services – Executive Staff</li> <li>➤ Workforce Issues Policy Officers (WIPOs)</li> <li>➤ Federal/Jurisdictional Health Workforce representatives</li> <li>➤ Relevant boards/Professional associations</li> </ul>
Health Worker education providers and agencies	<ul style="list-style-type: none"> <li>➤ Registered Training Organisations (RTOs)</li> <li>➤ Other relevant VET/tertiary education providers</li> <li>➤ Relevant education and government agencies</li> </ul>
Other relevant health professionals	<ul style="list-style-type: none"> <li>➤ General practitioners</li> <li>➤ Nursing professionals</li> <li>➤ Allied Health professionals</li> </ul>

#### 2.1.2 Information collection approach

Different methods of consultation were required for the consultation groups (eg interviews, surveys, site visits and focus groups). The project aimed to engage with as

many Health Workers as possible across Australia and a strategy was developed that took into consideration the size of the participant group and the best method of engagement. This is summarised in Table 4.

Table 4: Participant groups and the information collection method

Participant group	Information collection method		
	Key informant interviews	HW / HW manager surveys	Community Mapping activities
Aboriginal and Torres Strait Islander Health Workers		✓	✓
Managers of Aboriginal and Torres Strait Islander Health Workers		✓	✓
Aboriginal and Torres Strait Islander Health Worker employers and workforce planners	✓		
Health Worker education providers	✓		
Other relevant health professionals			✓

Each of these consultation methods is explained below.

## 2.2 Key informant interviews

### 2.2.1 Key informant interview methodology

Engagement of a number of industry leaders, including members of the Expert Reference Group, Aboriginal and Torres Strait Islander Health Worker employers, workforce planners and Health Worker education providers, was critical to the success of this project. Initial discussions with these people helped in the development of the framework for information collection.

The key informant interviews were largely conducted in a semi-structured way, with the project team seeking to promote discussions. They were conducted across Australia, by both HWA and PwC staff, between June 2010 and February 2011. A total of 138 interviews were conducted, and some of the key informants were also consulted in various meetings attended by the project team.

A profile of the key informants and stakeholders who have participated in the project to date is presented below. Additional details can be found in Appendix B.

- 138 individuals were consulted in 83 interviews.
- There was good representation across all jurisdictions, and, in addition, 18 key informants representing the Commonwealth or Commonwealth agencies, which provided a national perspective to the discussion.
- The majority of the key informants were either health workforce planners, policy makers.

- Most of the key informants were interviewed on a one-on-one basis; the others were consulted at meetings or group interviews. A number were engaged more than once, either in a follow-on interview or through participation in advisory groups/ meetings.

## 2.3 Health Worker and manager surveys

### 2.3.1 Survey methodology

#### Purpose

The purpose of the surveys was to collect predominantly quantitative information from Health Workers and managers across Australia. The information collected provided insights into potential workforce development options for the future.

#### Participants

In the absence of a nationally consistent definition of Aboriginal and Torres Strait Islander Health Workers, a working definition was developed to identify the survey target group. This included people who:

- identified as being of Aboriginal descent or of Torres Strait Islander descent (or both)
- considered themselves to fall within the broad definition of a Health Worker across the full range of practice across Australia; for example, a Health Worker with a specific clinical focus, such as vascular health or drug and alcohol.

As a result, the target group included all Health Workers along the broad spectrum of roles. This ensured a complete picture of the existing Health Worker workforce.

It may be the case that only a portion of respondents will be eligible for registration as Health Practitioners in 2012. Chapter 3 discusses the challenge of defining the Health Worker workforce in more detail, in light of the survey findings and the pending registration of Aboriginal and Torres Strait Islander Health Practitioners.

#### Sampling methodology: whole-of-population approach

Separate surveys were designed for Health Workers and for their managers. The surveys were open to any Health Workers and health managers who volunteered to participate, to ensure the survey population would be representative of:

- all jurisdictions in Australia
- remote, regional, and urban locations
- various employer organisations (eg ACCHO/government)
- gender.

Given the voluntary nature of the survey, some selection bias is likely. However, participation from a wide range of Health Workers was encouraged, as explained below.

First, potential barriers to participation were identified:

- lack of access to IT or internet
- low numeracy and/or literary levels
- proficiency in English language
- lack of time or motivation

- lack of awareness of opportunity to undertake survey.

To overcome these barriers, the following steps were taken:

- The survey was made available via two different channels: online or in person.
- A pilot was conducted to test for appropriateness of language and user-friendliness – in both the online and paper-based formats.
- A communication strategy was developed which included emails and presentations to the National Aboriginal Community Controlled Health Organisation (NACCHO) and its affiliates, managers of health services, jurisdictional representatives, and other relevant stakeholders, who gave valuable assistance by distributing information via their networks.
- A promotional activity was established whereby Health Workers who completed the survey were entered into a draw to win one of eight iPads.

### 2.3.2 Profile of survey participants

#### Health Worker survey sample group: total respondents

Total responses to the Health Worker survey were 392. These responses were ‘cleaned’ (as described below) to ensure that all participants fitted within the parameters of the defined target population.

On the basis of the working definition, the data-cleaning process involved:

- removing respondents who identified as being neither Aboriginal nor Torres Strait Islander
- removing respondents who identified as “other health professionals” (eg nurses, social workers)
- removing duplicate responses and those that were largely incomplete; ie responses with the name or location details but no other data.

This process resulted in 41 surveys being excluded from the analysis.

Table 5: Summary of data-cleaning methods that led to final numbers of the survey respondent data pool

Data validation stage	Number of respondents
1. Total survey responses received	392
2. Removal of Non Aboriginal and Torres Strait Islander people	(7)
3. Removal of respondents who identified as another type of health professional without also identifying as a Health Worker	(9)
3. Removal of duplicates	(23)
4. Removal of incomplete data (i.e. name/location provided but no other data included)	(2)
5. Final number of records	351

The total Health Workers who undertook the survey and were included in the data analysis were 351.

This equates to 35% of the total Health Worker workforce (n=1007) as defined by the ABS in 2006, or 22% of Health Workers when using the 2009 ATSIHWGG data (n=1612).

In relation to data extraction, for those surveys that were completed online, data was extracted directly from the survey database; however, there was a significant number of surveys completed manually and an extensive data entry exercise was conducted to input all the survey responses electronically to enable analysis.

#### *A valuable source of information*

These rates of participation provide a comprehensive source of information in relation to Aboriginal and Torres Strait Islander Health Worker self-reported employment information, particularly in comparison to past studies. For example, in the 1998-2000 National Review of Aboriginal and Torres Strait Islander Education and Training, almost 1400 Aboriginal and Torres Strait Islander Health Workers were estimated to be employed nationally across the government, NGO and other sectors. The review targeted a sample size of 200 of these workers (which was regarded as a representative sample) and sought their participation in completing a questionnaire through either face-to-face or telephone interviews. Of the 200 participants, 125 surveys were included in the final analysis, which represented a 62.5% response rate of the targeted sample. Although this is a high response rate, in actual terms less than 10% of the total population was surveyed.

In comparison, this project surveyed the total Aboriginal and Torres Strait Islander Health Worker population and received a response rate of between 35% (ABS 2006) and 22% (ATSIHWGG 2009). Given the range of factors associated with accessing the national Aboriginal and Torres Strait Islander population, along with factors that can negatively influence survey completion rates, a response rate that represents more than 30% of the total population is a considerable outcome.

#### *Statistical analysis of the results*

Statistical analysis was conducted to test the representativeness of the participant profile against the estimated Health Worker population. Tests were carried out by jurisdiction, remoteness, place of employment, age and gender.

Detailed results are presented in Appendix B, however a brief profile is provided below.

- When compared to the ABS 2006 Census data, respondents from NSW were over-represented – 59% of Health Workers in NSW completed the survey ( $p < 0.0001$ ); while respondents from the Northern Territory and Queensland were under-represented – only 17% of Health Workers in the NT and 23% of those in QLD completed it ( $p < 0.0001$ ).
- When compared to the ABS 2006 Census data, respondents from regional areas were over-represented – 47% of Health Workers from regional areas undertook the survey ( $p < 0.0001$ ), while those from remote areas are under-represented – only 16% of Health Workers in remote areas completed it ( $p < 0.0001$ ).
- When compared to the ABS 2006 Census data, respondents were representative on the basis of their employing organisation ( $p = 0.1213$ ).
- When compared to the ABS 2006 Census data, the respondent group was representative of the Health Worker population on the basis of gender; however, on the basis of age, the respondent group was not representative, with an over-representation in the 55 – 64 age groups ( $p = 0.0056$ ).

- Just over a quarter of survey respondents nationally had 11 or more years of service as a Health Worker.
- Compared to other jurisdictions, the NT and WA had the highest proportion of respondents with 11 or more years of service as a Health Worker, while Tas and NSW had the lowest.

#### Health manager survey sample group: total respondents

Similar to the Health Worker survey for those surveys that were completed online, data was extracted directly from the survey database; however, for those surveys that were completed manually an extensive data entry exercise was conducted to input all the survey responses electronically.

Once the survey data had been extracted, it was ‘cleaned’ before any data analysis was done. The total number of responses was 103, but after the data-cleaning process had excluded responses that were mostly incomplete, 3 surveys were excluded from the analysis.

Data validation stage	Number of respondents
➤ Total survey responses	103
➤ Removal of incomplete surveys	3
➤ Final number of records	100

Extensive data analysis was then undertaken on the final 100 responses, and the results are presented in subsequent sections of this report.

Below is a brief profile of the health manager survey participants. Additional detail can be found in Appendix B.

- The greatest proportion of health managers that responded to the survey were from NSW at 53%, followed by Queensland at 16%.
- When health manager survey respondents were profiled by area of remoteness, the highest proportion of respondents identified as coming from regional areas, followed by major cities. 15% did not identify where they were from.
- 62% of respondents indicated that they were employed in the government sector, followed by 13% who were employed in the Aboriginal Community Controlled Sector.

## 2.4 Community Mapping focus groups

### 2.4.1 Community Mapping methodology

The purpose of the Community Mapping activities was to:

- gain insights into how the health and service needs of Aboriginal and Torres Strait Islander peoples are currently being met – by both the Health Worker Workforce and the broader health system
- identify opportunities to develop the Health Worker Workforce so that it can better respond to the known causes and distribution of disease in the Aboriginal and Torres Strait Islander population

- provide an opportunity for a range of stakeholders to contribute to the project, including Health Workers, their managers, other health professionals, and Aboriginal and Torres Strait Islander communities and health service beneficiaries
- raise community awareness of and engagement with the Aboriginal and Torres Strait Islander Health Worker project.

The Community Mapping process targeted three key participant groups:

1. **Aboriginal and Torres Strait Islander Health Workers.** This group included those who:
  - identify as being of Aboriginal descent or of Torres Strait Islander descent (or both), and
  - considered themselves to fall within the broad definition of a Health Worker along the full spectrum of practice across Australia. For example, a transport officer that described him/herself as a Health Worker was included; as was a Health Worker with a specialist clinical focus, such as a Vascular Health Worker or a Drug and Alcohol Worker.
2. **Managers of Aboriginal and Torres Strait Islander Health Workers.** This group referred to the direct line managers of Health Workers, who often had different titles or belonged to different professions depending on the Health Service context. For example, in a hospital the Health Worker manager was a Nurse Unit Manager; in an Aboriginal Community Controlled Medical Service, the person in that role was the CEO of that service.
3. **Other relevant health professionals.** This group included other health professionals who worked alongside Aboriginal and Torres Strait Islander Health Workers at the site locations that were visited; for example, general practitioners, nursing professionals, and Allied Health professionals.

#### Overview of sites visited

During the Community Mapping exercise, a team of field workers visited 64 health facilities in 39 locations across Australia and conducted 127 interviews and/or focus groups with the above three participant groups. In total there were 389 participants in these interviews/focus groups, of which 264 were Health Workers, 100 health managers and 25 other health professionals.

All the site visits were conducted between October and December 2010.

The health facilities targeted were both Aboriginal Community Controlled Organisations and those provided by Commonwealth and/or State or Territory Governments.

Although there was a specific primary health care focus, some secondary and tertiary health institutions were included. Participating sites were based in remote, regional and urban areas to better understand differences across jurisdictions and geographic locations.

Three teams of field workers conducted the site visits across Australia in parallel. The field teams consisted of staff from Health Workforce Australia, Shannon Consulting Services Pty Ltd and PwC. Each field team leader had extensive experience in the Aboriginal Community Controlled Health Sector and working with Aboriginal and Torres Strait Islander communities and services.

### Site visit activities

While the site visits aimed to undertake a range of information collection activities, circumstances inevitably affected the ability to undertake each activity, the specific order of events, and the length of time it took to complete each activity. All the field teams therefore adopted a flexible and adaptable approach to these Community Mapping activities.

Table 6 broadly depicts the activities that were undertaken at each site visit. Where possible, each site visit began with an activity to introduce the project and allow the field team to confirm the availability of staff to participate, revise the pre-established plan for the day, and make any necessary logistical adjustments.

Table 6: Site visit activities

Activity	Description
Introduction	<ul style="list-style-type: none"> <li>➤ Group session with participants to provide an overview of the project and explain the importance of their contribution</li> <li>➤ Jointly delivered by the field team staff</li> </ul>
Opportunity for survey completion	<ul style="list-style-type: none"> <li>➤ Opportunities provided for Health Workers and managers to complete the survey. At least one field team member was available to provide support in case of language/literacy barriers</li> </ul>
Health Worker focus groups	<ul style="list-style-type: none"> <li>➤ Health Workers were interviewed in a small-group scenario where possible. Opportunities were provided for one-on-one interviews where required</li> <li>➤ Two team members participated in all interviews, one as the lead interviewer (which enabled better engagement) and the other responsible for taking notes throughout the interview</li> </ul>
Health Worker manager/ Other health professionals focus groups	<ul style="list-style-type: none"> <li>➤ Health Worker managers and other health professionals were interviewed in a small-group scenario</li> <li>➤ Two team members participated in most interviews, one as the lead interviewer (which enabled better engagement) and the other responsible for taking notes throughout the interview</li> </ul>

The time spent at each location varied depending on the number of Health Services offered and the number of staff who were willing to participate. In some cases, only one focus group or interview was conducted, but in sites with large numbers of participants, they were divided into smaller groups to enable the interviews to be run as effectively as possible. Some sites had up to three focus groups to accommodate the large number of participants.

### Community Mapping tools

Several tools were developed to facilitate the Community Mapping process and the collection of information during site visits, such as:

- storyboard to facilitate introduction/project overview for participants
- survey in paper-based form
- Health Worker interview template

- Health Worker manager interview template
- other health professionals interview template.

These can be found in Appendix B.

### Data analysis process

In recognition of the effort required to complete the extensive Community Mapping and survey exercises, the qualitative data analysis aimed for a balance of quality and efficiency. Therefore, certain critical factors were taken into consideration when developing the data analysis plan, including the need to:

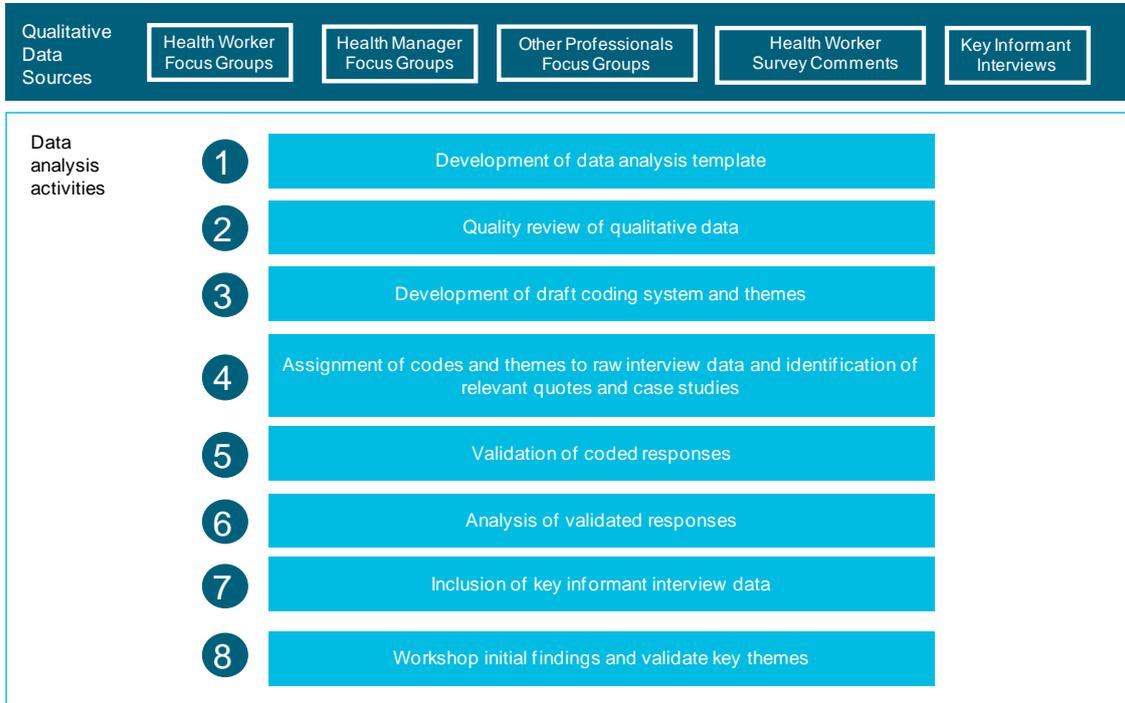
- recognise and maintain the richness of the qualitative information collected
- analyse the data as efficiently and effectively as possible without compromising the rigour or structure
- streamline the process to enable the sharing of activities across project team members while maintaining a high level of consistency and quality
- draw credible conclusions and findings that can be subject to scrutiny.

The aims of the analysis phase were to draw conclusions and findings to a sufficient level of detail that included:

- quantification of interview participants reporting certain themes, trends or observations under each of the key headings
- case studies and specific examples that can be used to illustrate or support major findings or themes
- interdependencies or impacts of different variables (such as geographical location, jurisdictional differences, service delivery model differences) on any of the key areas of investigation.

Figure 2 illustrates the key steps in the qualitative data analysis process.

Figure 2: Key steps in the qualitative data analysis process



### *Coding and validation of response themes*

First, key themes relating to each question in the interview were developed. Then each response to each question was coded according to those key themes. The coded responses were then validated by another team member checking them. Any disagreements about the coding of the key themes were recorded and reconciled. The validation process was applied to reduce the level of bias or error in this subjective exercise.

### *Analysis and key messages*

The themes were then analysed in terms of the variables such as jurisdiction, health service type and geographical location. Where appropriate, case studies or direct quotes from the interviews were included to further illustrate the messages. Finally, a workshop was conducted with the entire project team to agree on the results and key messages arising from the analysis. The results are presented in subsequent sections of this report.

## **2.4.2 Profile of focus group participants**

A profile of the Community Mapping focus group participants is summarised below. Additional details can be found in Appendix B.

### **Health Worker focus groups**

- 68 Health Worker focus groups were conducted across 64 sites, with 264 Health Workers taking part.
- Of the 68 Health Worker focus groups conducted, the greatest proportion were conducted in Queensland (32%), followed by Western Australia (22%) and the Northern Territory (16%).

- Just under half (47%) of all Health Worker focus groups were conducted in regional areas of Australia, followed by 29% in remote areas and 24% in major cities.
- The largest proportion of Health Worker focus groups were conducted with Health Workers from Aboriginal Community Controlled Health Organisations (47%), followed by those employed within State/Territory Community Health Centres and/or clinics (at 31%).
- Of the 264 Health Workers that participated, 81% identified themselves as Aboriginal, while 8% identified themselves as Aboriginal and Torres Strait Islander. A further 5% and 5% identified themselves as either Torres Strait Islander or Other respectively. 'Other' included those identifying as South Sea Islander.

#### Health Manager focus groups

- 47 health manager focus groups were conducted across 64 sites. The health managers interviewed were generally either direct line managers of Health Workers within the service or were managers of the service.
- Within those 47 focus groups, 100 health managers participated in the process. 30% of the health manager focus groups were conducted in Queensland, followed closely by the Northern Territory (26%). 4 health manager focus groups were conducted in each of New South Wales, South Australia and Victoria (11%).
- Just under half of the health managers focus groups were conducted with those from regional areas, followed by 36% from remote areas.
- 38% of the interviews were conducted with health managers employed by Aboriginal Community Controlled Health Organisations and 34% were employed by State/Territory Community Health Centre/Clinic.
- Of the 100 health managers who participated, 59% identified themselves as neither Aboriginal nor Torres Strait Islander. 21% identified as Aboriginal, followed by 13% who identified as both Aboriginal and Torres Strait Islander.

#### Other Health Professionals focus groups

- 11 other health professionals focus groups were conducted across 64 sites, with 25 other health professionals taking part.
- Just under half (45%) of the other health professionals focus groups were conducted in the Northern Territory.
- Of the 11 focus groups conducted, 6 were in regional areas, followed by 4 in remote areas.
- 8 of the 11 focus groups were with those employed by Aboriginal Community Controlled Organisations, with the remaining 2 and 1 with those employed by public hospitals and State/Territory Community Health Centres respectively.
- 80% (n=20) of the other health professionals focus group participants were nurses, followed by two medical specialists and one general practitioner.

### 3. The existing Health Worker workforce

## Key points

### Defining the workforce

There is currently no nationally consistent definition of an Aboriginal and Torres Strait Islander Health Worker. As the workforce matures and expands, it will be necessary to develop a nationally consistent definition that delineates the Health Worker workforce from other health professionals.

Providing a working definition of the Health Worker workforce is a key output of this project. The working definition is an Aboriginal and Torres Strait Islander Health Worker is a person who:

- identifies as being of Aboriginal and/or Torres Strait Islander descent
- holds an Aboriginal and Torres Strait Islander Primary Health Care qualification
- adopts a culturally safe<sup>5</sup> and holistic approach to health care.

This definition will be tested and developed during the second phase of this project, which will include approximately 13 national workshops with key stakeholders. These will take place between May and July 2011.

### Workforce size and demographic features

The absence of a nationally consistent Health Worker definition has contributed to the challenge of gaining an accurate and comparable understanding of what the existing Health Worker workforce looks like.

Nevertheless, using the best available data, the following key findings emerge:

- At a minimum, the total workforce is estimated at between 1007 (Australian Bureau of Statistics, 2006b) and 1600 (ATSIHWGG 2009) Health Workers.
- The Health Worker workforce represents 17% of the total Aboriginal and Torres Strait Islander health workforce (5,535 people) (Australian Institute of Health and Welfare, 2006b).
- There is a high concentration of Health Workers in remote areas (48%), while only 24% of the Aboriginal and Torres Strait Islander population is located in the same area (Australian Bureau of Statistics, 2006b).
- Only 30% of the Health Worker workforce is male, despite the fact that males comprise 50% of the total Aboriginal and Torres Strait Islander population (Australian Bureau of Statistics, 2009, Australian Bureau of Statistics, 2006b).
- There is substantial variation in remuneration for Health Workers across Australia, with the average weekly income ranging from \$363/week (reported in the Northern Territory, very remote location) to \$900/week (reported in New South Wales, very remote location) (Australian Bureau of Statistics, 2006b).

## 3.1 Context

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<sup>5</sup> Cultural safety is defined in Section 1.3.4. Cultural safety refers to "The effective care of a person/family from another culture by a health care provider who has undertaken a process of reflection on their own cultural identity and recognises the impact of the health care professional's culture on their practice." (The Nursing Council of New Zealand, 2002)

This chapter provides an overview of the current Health Worker workforce using the best available data. The following information contributes to this profile:

- the suggested working definition of an 'Aboriginal and Torres Strait Islander Health Worker' (Section 3.2)
- the size and geographic distribution of the Health Worker workforce (Section 3.3)
- the gender profile of the Health Worker workforce (Section 3.4)
- the Health Worker income scale (Section 3.5).

### 3.2 Defining the workforce

The Health Worker workforce has grown organically in response to contextual demands which vary between geographic location, workplace and community.<sup>6</sup> As this workforce has evolved, various titles and definitions have been used across the nation to describe the role.

Today, different role definitions are in use by state and territory government departments, agencies, peak bodies, organisations and Health Worker boards and associations. Even within each jurisdiction, the title of a Health Worker varies substantially depending on the workplace and context in which that person provides services.<sup>7</sup>

This story is not unique to the Health Worker workforce. Many established professions began in a similar way, evolving in response to local needs and gradually developing into a unique, nationally defined profession. The nursing and social work professions provide relevant examples for comparison.

To understand what makes a profession a *profession*, as opposed to a *vocation*, the following definition is provided by the Australian Competition and Consumer Commission. A profession is:

*"A disciplined group of individuals who adhere to high ethical standards and uphold themselves to, and are accepted by, the public as possessing special knowledge and skills in a widely recognised, organised body of learning derived from education and training at a high level, and who are prepared to exercise this knowledge and these skills in the interest of others.*

*Inherent in this definition is the concept that the responsibility for the welfare, health and safety of the community shall take precedence over other considerations."*

(Australian Competition & Consumer Commission, 2011)

This definition is relevant to the ongoing professionalisation of the Health Worker workforce. As the workforce matures, there will be a need to delineate Health Workers from other health professionals and recognise the unique Health Worker discipline. A nationally consistent definition will help to clarify particular characteristics of the Health Worker profession, including the specific knowledge and skill requirements<sup>8</sup>,

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<sup>6</sup> For more information on the evolution of this role, see the Environmental Scan (Section 6.4).

<sup>7</sup> These various definitions are presented in the Environmental Scan (Section 6.2).

<sup>8</sup> The CS&HISC national competency standards were based on extensive national consultation and are nationally agreed, contributing to the process of defining the workforce. CS&HISC are currently conducting a review of these national competency standards to maintain their currency given the ongoing development of the Health Worker workforce.

qualification and training requirements, career pathways, and practice standards. This issue is particularly relevant given the context of the NRAS, which will involve the registration of Aboriginal and Torres Strait Islander Health Practitioners in 2012. The Aboriginal and Torres Strait Islander registration Health Practitioner Board, once established, will be tasked with the development of a definition for Aboriginal and Torres Strait Islander Health Practitioners (Health Practitioners). These Health Practitioners are likely to comprise one part of the broader Aboriginal and Torres Strait Islander Health Worker workforce. A national definition of the general Health Worker workforce may therefore inform the definition of the specific segment of Health Practitioners. In recognition of the above, one of the key outputs of this project is to develop a working definition of the Health Worker workforce. This working definition will be tested and developed further in the second phase of the project, which will occur at national workshops taking place between May and July 2011.

### **3.2.1 The process for developing the working definition of an Aboriginal and Torres Strait Islander Health Worker**

The working definition was developed using a consultative and evidence-based process. The following activities contributed to this process:

- identification and analysis of definitions currently in use across Australia. This highlighted common characteristics of existing definitions<sup>9</sup>
- interviews with key informants across Australia. This contributed to the understanding of current definitions and the rationale underpinning them, also revealing different perspectives on what a national definition ought to include. Key informants included representatives from relevant employer organisations, education providers, workforce planners and policy makers, academics, peak organisations and other stakeholders from the government and the Aboriginal Community Controlled Health Sector
- Health Worker surveys. People considering themselves to be Health Workers reported their actual position title. This data contributed to the quantitative evidence base of position titles currently in use (results are listed in Appendix D).
- focus groups with Health Workers, managers and other health professionals. The focus groups included existing Health Workers, direct line managers and other health professionals. Similar to the key informant interviews, these focus groups provided insights into a range of perspectives relating to the definition
- Expert Reference Group (ERG) consultation. Evidence collected via the project was presented to the ERG. ERG members reached preliminary agreement on the working definition outlined below.

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<sup>9</sup> The various definitions are presented and commented on in the Environmental Scan (Section 6.2)

### 3.2.2 The working definition of an Aboriginal and Torres Strait Islander Health Worker developed via this project

#### Working definition

An Aboriginal and Torres Strait Islander Health Worker is a person who:

1. identifies as being of Aboriginal and/or Torres Strait Islander descent
2. holds an Aboriginal and Torres Strait Islander Primary Health Care qualification
3. adopts a culturally safe and holistic approach to health care.

The rationale underpinning each of these defining attributes of a Health Worker is explained below.

#### 1. A Health Worker is a person who identifies as being of Aboriginal and/or Torres Strait Islander descent.

Identification as an Aboriginal and Torres Strait Islander person was perceived to be a fundamental characteristic of Health Workers. This is because the cultural identity of Health Workers means that they are uniquely placed to bridge the cultural divide between Aboriginal and Torres Strait Islander clients and health professionals from other cultural backgrounds. This cultural divide has been highlighted as a key barrier to health care accessibility by relevant literature<sup>10</sup> and in focus groups conducted with Health Workers, managers and other health professionals during the course of this project (discussed further in Section 4.3.2).

#### 2. A Health Worker is a person who holds an Aboriginal and Torres Strait Islander Primary Health Care qualification.

The Aboriginal and Torres Strait Islander Primary Health Care (ATSIPHC) qualification refers to the Health Training Package HLT07 released by the Community Services and Health Industry Skills Council in 2008 (Community Services & Health Industry Skills Council, 2008). This qualifications framework was chosen as a reference point because it is a nationally endorsed qualification that reflects national occupational standards, encompassing the essential skills and competencies required of Health Workers to enable them to deliver comprehensive primary health care services.

The level of qualification has not been specified in recognition of the fact that Health Workers may pursue a career path that progresses through various qualification levels. Furthermore, the specific stream of the ATSIPHC qualification (Community Care and Practice streams are available at the Certificate IV level and above) has not been specified, reflecting existing variation in Health Worker areas of practice and education (explored further in Chapters 5 and 7, respectively).

#### 3. A Health Worker is a person who adopts a culturally safe and holistic approach to health care

In order to interpret this aspect of the definition, it is necessary to have a clear understanding of 'cultural safety' and 'holistic health care'. Each of these terms is defined in Section 1.3.

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<sup>10</sup> This literature is outlined in the Environmental Scan (Sections 3.2 and 5.2)

These terms have been used to define the Health Worker workforce after analysing other available definitions and the existing scope of practice (this evidence is presented in Chapter 5). A culturally safe and holistic approach to patient care was considered core to the Health Worker role by project participants.

These characteristics distinguish Health Workers from Aboriginal and Torres Strait Islander people working in other health professions. For example, the difference between a Torres Strait Islander nurse and a Torres Strait Islander Health Worker is that the nurse provides acute care that might target a specific illness, while the Health Worker provides holistic, comprehensive primary health care.

#### How the working definition corresponds to existing Health Worker position titles

The working definition is deliberately inclusive of a broad range of titles used to describe Health Worker roles. If a person is able to meet the above three criteria, they can be considered to be an Aboriginal and Torres Strait Islander Health Worker – regardless of the position description determined by their employer.

For example, the definition may include people who meet the three criteria and are employed under any of the following titles:

- Health Worker (Generalist)
- Outreach Worker
- Mental Health Worker
- Family Health Worker
- Sexual Health Worker
- Education Officer
- Hospital Liaison Officer
- Drug and Alcohol Worker
- Environmental Health Worker
- Community Worker
- Healthy Living Worker
- Vascular Health Worker
- Pharmacy Health Worker
- Maternal and Perinatal Health Worker
- Otitis Media Health Worker
- Nutrition Health Worker.

As the Health Worker workforce continues to mature, and as witnessed in many professions, divisions of the workforce may become more defined. The Health Practitioners who will be registered under NRAS in 2012 are one example of a potential workforce segment (Chapter 5 revisits this discussion in the context of the Health Worker scope of practice).

The definition of an Aboriginal and Torres Strait Islander Health Worker presented in this section is a work in progress. It is likely to continue to evolve during the course of the national workshops being undertaken in Phase 2. In the interim, it serves as a working definition framing this report.

### 3.3 Size and geographic distribution

There are a number of different data sets available to inform the national understanding of the size and geographic distribution of the Health Worker workforce. However, as there is no nationally consistent definition of a Health Worker, there are obvious issues in relation to the consistency and comparability of these data sets. Obtaining an accurate picture of the national Health Worker workforce therefore presents some challenges.

The following analysis uses the best available data to comment on the size and geographic distribution of the Health Worker workforce.

#### 3.3.1 Size of the Health Worker workforce

The national Health Worker workforce is estimated to be between 1007 and 1600 people. These figures, summarised in Table 7, have been informed by the following national sources of data:

- Australian Bureau of Statistics Census (ABS, 2006)
- Australian Institute of Health and Welfare -Health and Community Services Labour Force Survey (AIHW, 2006)
- Aboriginal and Torres Strait Islander Health Workforce Working Group estimates of current government and Aboriginal Community Controlled Health Organisation (ACCHO) employed Health Workers (ATSIHWWG, 2009)
- Northern Territory Aboriginal Health Worker Registration Board (2010).

Table 7: Comparison of data relating to the size of the Health Worker workforce from 2006 to 2010

Year	Source	Vic	WA	QLD	SA	NSW	ACT	NT	Tas	Total
2006	ABS Census of Population and Housing 2006	57	156	242	110	207	Not reported	224	11	1007
2006	AIHW Health and Community Services Workforce data	51	143	231	98	200	3	227	14	967
2009	ATSIHWWG estimates	76	260	492	133	346	9	287	9	1612
2010	Northern Territory AHW registration data	N/a	N/a	N/a	N/a	N/a	N/a	340	N/a	N/a

Each data set presented in Table 7 has its own strengths and limitations. For example, while the ATSIHWWG (2009) data are most recent and provide insights into the breakdown of the workforce by employer organisation, the 2006 ABS Census data enable a more detailed level of analysis (ie in relation to the geographic distribution of the workforce and its demographic characteristics). However, the ABS Census data lack currency and are self-reported, which may mean that the size of the Health Worker workforce is greater than the data suggest.

According to the AIHWs Health and Community Services data, the Health Worker workforce (967 people) represents 17% of the total Aboriginal and Torres Strait Islander health workforce (5,535 people) (Australian Institute of Health and Welfare, 2006b).

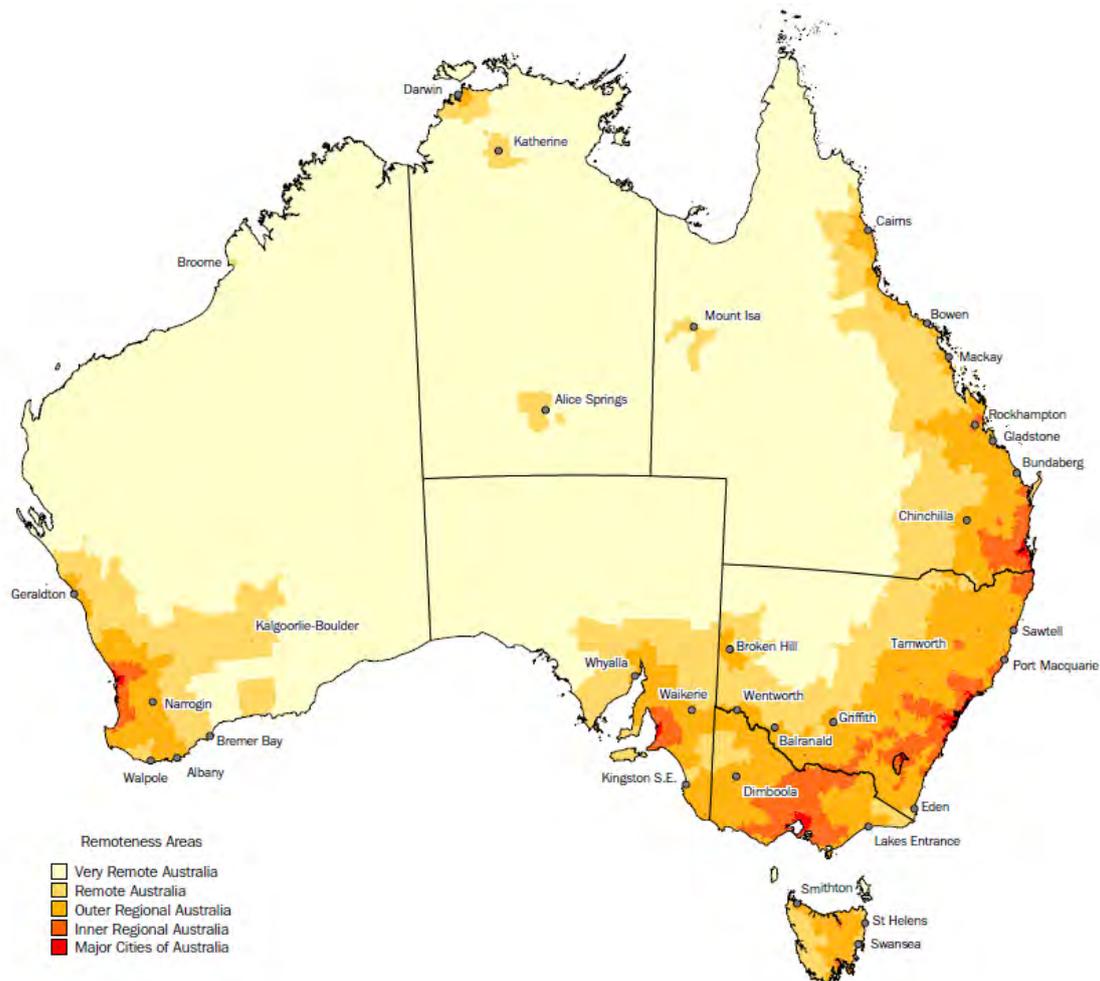
### 3.3.2 Geographic distribution of the Health Worker workforce

Information on the geographic distribution of the Health Worker workforce was sourced from the ABS Census data. These data were organised according to the Australian Standard Geographical Classification (ASGC) system, which includes the following five categories of remoteness:

- Major cities (eg Sydney, Brisbane, Melbourne, Adelaide)
- Inner regional areas (eg Hobart, Port Macquarie)
- Outer regional areas (eg Darwin, Tamworth)
- Remote (eg Alice Springs, Broome)
- Very remote (eg 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



A comparison of the distribution of the Health Worker workforce and the Aboriginal and Torres Strait Islander population by remoteness is presented in Table 8.<sup>11</sup>

Table 8: Distribution by area of remoteness – comparison of the Health Worker workforce and the Aboriginal and Torres Strait Islander population, 2006

	Number of Health Workers	% of total Health Worker workforce	Aboriginal and Torres Strait Islander population distribution	% of total Aboriginal and Torres Strait Islander population
Location - Australian Standard Geographic Classification (ASGC)	2006	2006	2006	2006
Major cities of Australia	177	18%	147,292	32%
Inner-regional Australia	146	14%	99,311	22%
Outer-regional Australia	200	20%	98,684	22%
Remote Australia	155	15%	39,403	9%
Very remote Australia	329	33%	68,737	15%
Migratory/No usual address	n/a	n/a	1582	0.4%
<b>TOTAL</b>	<b>1007</b>	<b>100%</b>	<b>455,009</b>	<b>100%</b>

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

According to the ABS Census data, in 2006:

- only one-fifth of the Health Worker workforce (18%) reported that they lived in major cities; in comparison, 32% of the Aboriginal and Torres Strait Islander population lived in major cities
- almost half the Health Worker workforce (48%) reported that they lived in remote or very remote areas; in comparison, only 24% of the Aboriginal and Torres Strait Islander population lived in the same remote and very remote areas (Australian Bureau of Statistics, 2006b).

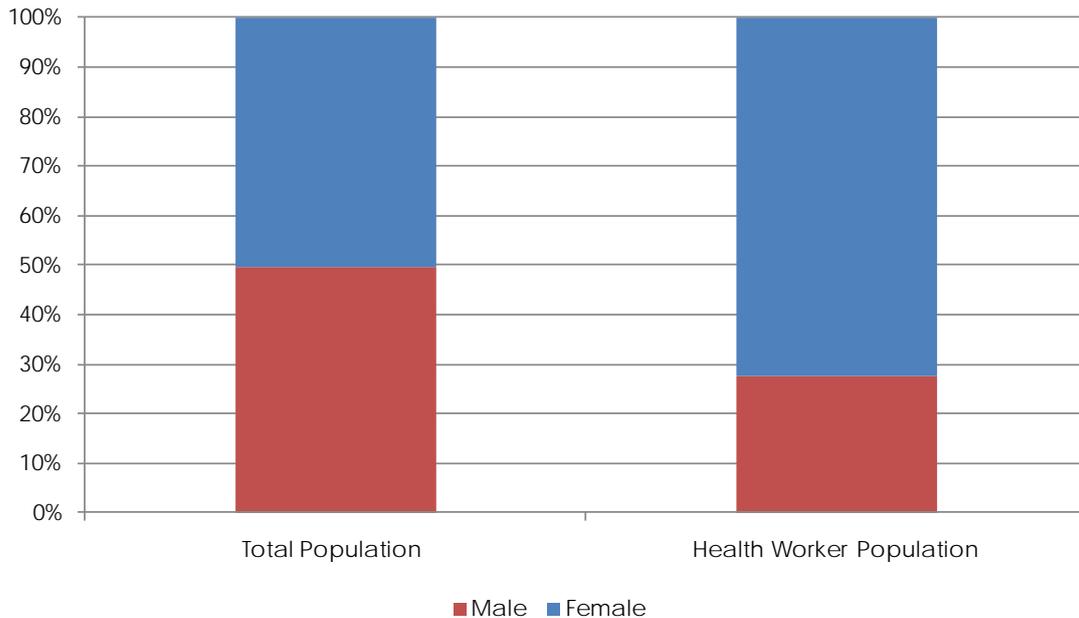
This evidence suggests that the distribution of the total Health Worker workforce does not currently align to the distribution of the Aboriginal and Torres Strait Islander population (Australian Bureau of Statistics, 2006b). However, given that there is no conclusive evidence regarding the optimum workforce/population ratio, the significance of this finding is not yet clear.

<sup>11</sup> Further information regarding geographic distribution from a jurisdictional perspective has also been provided in the Environmental Scan (Section 7).

### 3.4 Gender profile

There is a gender imbalance between the Health Worker workforce and the Aboriginal and Torres Strait Islander population (Australian Bureau of Statistics, 2006b). Figure 4 provides a comparison using ABS Census data (2006).

Figure 4: Gender breakdown – comparison of the Health Worker workforce and the Aboriginal and Torres Strait Islander population, 2006



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

As outlined in Figure 4, only 30% of the Health Worker workforce is male. This is comparable to the total Aboriginal and Torres Strait Islander population, which has an even gender split (50% male and 50% female) (Australian Bureau of Statistics, 2006b).

With the majority of Health Workers being female, gaps can arise in delivery of health care to the male population. This is a particularly important issue in the context of health service delivery to Aboriginal and Torres Strait Islander Australians. There are clear divisions between men’s business and women’s business in the traditional cultural beliefs of Aboriginal and Torres Strait Islander people. 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).

During the focus groups, many Health Workers mentioned that it is culturally inappropriate for female Health Workers to discuss health issues with male clients and vice versa. Some Health Workers reported they had been in situations which required them to provide services to the opposite gender, which had made both parties feel uncomfortable. Others reported Aboriginal and Torres Strait Islander clients had refused health services because a Health Worker of the same gender was not available. The gender breakdown of the Health Worker workforce is therefore an important consideration for workforce planning.

### 3.5 Health Worker income scale

Variation in the income levels of Health Workers across Australia is a theme that consistently emerged in focus groups with Health Workers, managers, other health professionals, and also in key informant interviews. There was reported variation between Health Workers employed by the government sector, and those employed by the Aboriginal Community Controlled Sector. There was also reported variation between Health Workers and other health professionals in comparable roles.

However, there is a limited evidence base available to provide an accurate picture of these potential income disparities. One source of information that contributes to this picture is the ABS Census data on average weekly income. However, this evidence is indicative only and has several limitations. For example:

- ABS data are self-reported, which may lead to over or under-reporting; actual income levels of respondents have not been validated
- ABS does not clearly define Aboriginal and Torres Strait Islander Health Workers; therefore, the sample group may include respondents who are outside the working definition of a Health Worker used in this project (or exclude potential respondents who meet the criteria in the working definition)
- in some jurisdictions or areas of remoteness the sample size is very small; this undermines the representativeness of the data
- the ABS data is from 2006, and therefore lacks currency
- the ABS data does not allow for comparison in wages between Health Workers employed in the Aboriginal and Torres Strait Islander Community Controlled Health Sector, and those employed in the government sector.

Regardless, the 2006 ABS Census data are the best available source of evidence regarding the weekly mean income of the Health Worker workforce. The data set includes a breakdown of data by jurisdiction and area of remoteness (using the ASGC system mentioned above), demonstrating income variation across Australia.

Analysis of the 2006 ABS data suggests that:

- **there is substantial variation in Health Worker wages across Australia;** the average weekly income ranges from \$363/week (reported in the Northern Territory, very remote location) to \$900/week (reported in New South Wales, very remote location) (Australian Bureau of Statistics, 2006b)
- **the average weekly income of a Health Worker varies substantially between jurisdictions;** for example, New South Wales recorded the highest average salary (\$748/week) and Tasmania recorded the lowest average salary (\$605/week)
- **the average weekly income of a Health Worker varies substantially by area of remoteness;** Health Workers living in major cities and/or inner regional areas recorded a higher median income than those working in remote and/or very remote areas (Australian Bureau of Statistics, 2006b). For example, at the highest end of the national scale, Health Workers in major cities reported an average weekly salary of \$746/week. At the lowest end of the national scale, Health Workers in remote Australia reported an average weekly salary of \$550/week. This variation was not only true at a national level but also in every individual jurisdiction

- the average weekly income of Health Workers increased between 2001 and 2006 in every state and territory, apart from the Northern Territory; although the reasons contributing to this exception are not clear.

In summary, it is clear that there is variation in remuneration levels across Australia, which validates some of the perceptions collected via focus groups with Health Workers and managers.

## 4. The health and service needs of Aboriginal and Torres Strait Islander people

### Key points

It is widely acknowledged that Aboriginal and Torres Strait Islander Australians are sicker, die younger, more likely to experience the death of close friends and relatives, more likely to experience assault, more emotionally and mentally stressed and more likely to abuse alcohol and other drugs than the general population of Australia. They carry a significantly higher burden of largely preventable chronic illnesses, particularly diabetes and respiratory diseases. In addition, Aboriginal and Torres Strait Islander children experience much higher rates of morbidity than other Australian children.

Despite these facts, some evidence gives cause for optimism. According to a study conducted in the Northern Territory, the increase in death rates from chronic disease is slowing (Thomas et al., 2006); and there have been substantial improvements in infant mortality rates during the period from 1960 to 2004 (Robert Griew Consulting, 2008). Research suggests that these improvements are linked to increases in primary health care accessibility for Aboriginal and Torres Strait Islander Australians (Robert Griew Consulting, 2008).

However, many Aboriginal and Torres Strait Islander people continue to face barriers accessing health care services. For example:

- cultural safety issues (Williams, 1999, Hayman et al., 2006, Cass et al., 2006) and experiences of racial discrimination (Cutcliffe, 2004, Paradies, 2007, Steering Committee for the Review of Government Service Provision, 2009b)
- language barriers (Steering Committee for the Review of Government Service Provision, 2009b)
- transport barriers/geographic location of services (Australian Institute of Health and Welfare, 2006a)
- cost of health care (Australian Bureau of Statistics, 2001, Australian Institute of Health and Welfare, 2006a).

When Health Workers, managers and other health professionals were asked in focus groups about the main barriers to health service, the overwhelming majority mentioned the cultural security<sup>12</sup> of health services. This was mentioned more frequently than any other access barrier identified in the literature.

There is an opportunity to optimise the contribution the Health Worker workforce makes to these health and service needs as part of the broader health care system. The specific role of the Health Worker workforce is explored in the following chapter.

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<sup>12</sup> See definition provided in Section 1.3

## 4.1 Context

The Health Worker workforce already makes a valuable contribution to the health and service needs of their communities. Yet there may be an opportunity to expand and develop the workforce to have an even greater impact upon Aboriginal and Torres Strait Islander health outcomes. This process must be informed by evidence relating to the health and service needs of Aboriginal and Torres Strait Islander Australians.

This report does not seek to duplicate existing research. Instead, it provides a summary of the key issues to contextualise the subsequent analysis of the Health Worker workforce and its role in responding to these health and service needs. Highlights from the Environmental Scan are supplemented by information collected via focus groups with Health Workers, their managers and other health professionals, and Health Worker and manager surveys. These views validate the existing burden of disease research, providing additional insights into the real-life scenarios that Health Workers are expected to deal with every day.

This includes the following areas:

- health needs of Aboriginal and Torres Strait Islander Australians
- health service needs of Aboriginal and Torres Strait Islander Australians.

Existing barriers to health care access for Aboriginal and Torres Strait Islander Australians are also explored in the health service needs section.

## 4.2 Health needs of Aboriginal and Torres Strait Islander peoples

### 4.2.1 Burden of disease and injury in the population: a scan of existing literature

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 people is comparatively very poor. Aboriginal and Torres Strait Islander people have a much higher disease profile than other Australians in relation to chronic disease, injury, social and mental wellbeing, and infant morbidity and mortality.

These findings are supported by evidence collected by a range of sources using various research methodologies.<sup>13</sup> 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.

To date, the most detailed Aboriginal and Torres Strait Islander burden of disease study using the DALY method was conducted by Vos et al in 2003. This study has not yet been repeated using the same methodology, yet continues to provide useful insights into the health status of Aboriginal and Torres Strait Islander people.

The study found that the Aboriginal and Torres Strait Islander population carried a disproportionate burden of disease in comparison to the total Australian population. Although Aboriginal and Torres Strait Islander people made up just 2.4% of the total Australian population in 2003, this group carried 3.6% of the burden of disease in

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<sup>13</sup> For further information on various methods of measuring the health status of populations, and discussion of the limitations of existing data sets, refer to the Environmental Scan (Section 4.2).

Australia (Vos et al., 2003). This means that the total burden of disease and injury for Aboriginal and Torres Strait Islander people was two-and-a-half times that of the general Australian population (Vos et al., 2003).

According to the evidence presented in Vos's report, in 2003:

- the Aboriginal and Torres Strait Islander population had a much higher rate of mortality and a much lower life expectancy than the total Australian population
- the majority of the absolute burden (number of DALYs) for Aboriginal and Torres Strait Islander peoples occurred in the middle-aged population, with a significant peak also occurring in the very young segment of the 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 (Vos et al., 2003) respectively.

#### Mortality rates of Aboriginal and Torres Strait Islander Australians

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).

More recent estimates state that, of the Aboriginal and Torres Strait Islander children born between 2005 and 2007, males can 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.

There are also much higher rates of infant and childhood mortality. 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 report of that study found that:

- 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)
- the main causes of mortality among Aboriginal and Torres Strait Islander infants were infection (29%), SIDS (27%), prematurity (16%) and birth defects (15%)
- the risk of death due to infection was 5.5 times higher for Aboriginal and Torres Strait Islander male children than for non-Aboriginal male children, and 6.5 times more likely for female children
- Aboriginal and Torres Strait Islander people aged between 13 and 23 were over five times more likely than non Aboriginal to commit suicide.

The evidence paints a stark picture of the status of Aboriginal and Torres Strait Islander health in comparison to that of other Australians.

Despite these facts, some evidence gives cause for optimism. According to a study conducted in the Northern Territory, the increase in death rates from chronic disease is slowing (Thomas et al., 2006); and there have been substantial improvements in infant mortality rates during the period from 1960 to 2004 (Robert Griew Consulting, 2008). Research suggests that these improvements are linked to increases in primary health care accessibility for Aboriginal and Torres Strait Islander Australians (Robert Griew Consulting, 2008).

## Causes of the disease burden experienced by Aboriginal and Torres Strait Islander Australians

In order to address this health inequality it is necessary to understand the factors that contribute to such high rates of death and illness. The 2003 burden of disease study identified the leading causes of illness in the adult Aboriginal and Torres Strait Islander population (Vos et al., 2003). In order of prevalence, these included:

- cardiovascular disease
- mental health disorders
- chronic respiratory disease
- diabetes
- intentional and unintentional injuries.

Collectively, these five broad categories account for 63.7% of the total disease burden experienced by the Aboriginal and Torres Strait Islander population, as demonstrated in Table 9 (Vos et al., 2003). Considering cancers contribute to 8.1% of the disease burden, the top six cause categories account for over 70% of the total burden of disease.

Any attempt to reduce the burden of disease experienced by the Aboriginal and Torres Strait Islander peoples must therefore target these leading causes of the disease burden.

Table 9: Years Lived with Disabilities (YLD), Years of Life Lost (YLL) and Disability-Adjusted Life Years (DALYs) for top ten broad cause groups, Aboriginal and Torres Strait Islander 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.

The Environmental Scan (Section 4.2.4) provides a more detailed discussion of the prevalence of each of the top five diseases in the Aboriginal and Torres Strait Islander population. Some of the key points raised in the Environmental Scan in relation to each of the top five causes of the disease burden are highlighted below.

#### *Cardiovascular disease*

- 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, 2006c).
- 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, and other diseases of the heart and circulatory system 1.2 times more common (Australian Indigenous Health Infonet, 2009).

#### *Social and emotional wellbeing*

- 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 mental health 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).
- 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 (Australian Bureau of Statistics, 2007).
- One-quarter experience an alcohol or drug-related problem, which is almost three times the proportion of the total Australian population (8.6%) (Australian Bureau of Statistics, 2007).
- The proportion that have witnessed violence, had trouble with police or been subjected to discrimination is approximately four times higher than for the broader Australian population (Australian Bureau of Statistics, 2007).

#### *Chronic respiratory disease*

- 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, 2006c).
- 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%).
- Asthma was the most commonly reported respiratory condition, and the second most commonly reported health condition. It 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).
- 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). This is largely due to overcrowded housing conditions, poor nutrition and poverty levels.

#### Diabetes

- Type 2 diabetes occurs at a much higher 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.
- Aboriginal and Torres Strait Islander people reported much higher rates of high-sugar levels than other Australians (Australian Bureau of Statistics, 2006c). For example, Aboriginal and Torres Strait Islander people aged between 25 and 34 reported 7.2 times the rate of high-sugar levels than other Australians in the same age group.

#### Injuries

- Assault was the most frequent external cause of hospitalisation for injury of Aboriginal and Torres Strait Islander people Australia-wide in the 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 – eight times higher for males and 35 times higher for females (Australian Indigenous Health Infonet, 2009).

#### Morbidity found in Aboriginal and Torres Strait Islander children

In addition to providing an overview of the morbidity experienced by the adult Aboriginal and Torres Strait Islander population, the Environmental Scan discussed morbidity found in Aboriginal and Torres Strait Islander children. It demonstrated that Aboriginal and Torres Strait Islander children experience very high rates of preventable morbidity. Some of the main reasons that children presented to clinics in a 2008 Northern Territory study were respiratory tract infections, skin sores and/or scabies, and diarrhoea (Clucas et al., 2008). These health issues are not typically found in children in a first world country. The health and wellbeing of Aboriginal and Torres Strait Islander children is therefore one of Australia's most important priorities.

#### Contributing risk factors

The high disease burden experienced by Aboriginal and Torres Strait Islander people is well researched and acknowledged. Some attempts to understand this health status gap go beyond simply describing the problem, targeting the root causes of the health issues that contribute to the poor health status of Aboriginal and Torres Strait Islander Australians.

A number of distinct risk factors have been identified as having a causal correlation to this burden of disease (Vos et al., 2003). Eleven 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 are:<sup>14</sup>

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<sup>14</sup> For more information and tables on these risk factors, see the Environmental Scan (Section 4.2.5)

- 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.

Most of these risk factors relate to lifestyle choices. Unsurprisingly, therefore, improvements in the lifestyle choices made by some Aboriginal and Torres Strait Islander people are likely to have a positive effect on the health status of the population (Vos et al., 2003).

Some of the reasons that poor lifestyle choices are made by some Aboriginal and Torres Strait Islander Australians may be (Productivity Commission, 2008):

- lack of awareness of the health consequences of their actions
- factors relating to the physical and social environments in which some Aboriginal and Torres Strait Islander people live
- conditions of social or economic disadvantage experienced by some.

As the following sections of this report discuss further, part of the role performed by many Health Workers is to encourage Aboriginal and Torres Strait Islander individuals to make healthier lifestyle choices. Health Workers also contribute to the early identification of diseases and the provision of appropriate treatment. In many cases, early intervention and treatment can help to prevent the premature incidence of mortality.

#### **4.2.2 Burden of disease and injury in the population: perceptions from focus groups**

Focus group participants were asked about the most common health needs they encountered in their communities. The views reported by Health Workers, managers and other health professionals are generally consistent with the burden of disease research provided in the literature. This section provides a snapshot of their experiences.

There was little variation between the responses collected at Health Worker focus groups and manager focus groups.<sup>15</sup> Across both participant groups, the most common category of health problem identified was chronic disease. Of the conditions that fall within that category, those most commonly referred to were diabetes, cardiac

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<sup>15</sup> Responses from the other health professionals' focus groups have not been analysed at the same level as those of Health Workers and managers due to the smaller sample size.

conditions (eg hypertension and heart attacks), renal conditions and cancers. These results support the findings published in the literature.

The quote below summarises the kind of response that was commonly received when focus groups were asked about the health needs of their communities, which often provoked a long list of illnesses:

“Diabetes, cardiac respiratory, mental health, smoking, substance abuse, otitis media, you name it. All the cancers you can think of. The related chronic diseases. Mental health issues attached to substance abuse. In this community, the three main areas for Healthy for Life after a clinical audit were diabetes, cardiac and respiratory. These were the three main issues that we found after doing a clinical audit of 1,000 clients. People need to learn how to start taking care of themselves better.”

(Health Worker)

In addition to chronic diseases, the other two common health problems most frequently identified by both Health Workers and their managers were in relation to social and emotional wellbeing and alcohol and other drugs.

For example, some Health Workers who mentioned the unique social and emotional wellbeing needs they encountered in their roles provided the following comments:

“People dying and community social and emotional wellbeing is bad. Three kids tried to commit suicide last year and Aboriginal Health Workers have to assist in management.”

(Health Worker)

“When it comes to our emotional needs, our grief, our loss, our Stolen Generation needs – mainstream services don’t address that well.”

(Health Worker)

“At a school education program we recently ran, 65% of the kids we talked to between the ages of 15-18 years old described having recently experienced a traumatic event.”

(Health Worker)

Examples of comments in relation to alcohol and other drugs issues include the following:

“The social and emotional issues around smoking and drinking is a major problem. When you ask a patient what is a standard drink and they say 1 carton or a box (24 beers), this is a problem.”

(Health Worker)

“Alcohol is often an issue in community even though it is a dry community. Alcohol is a major issue.”

(Health Worker)

“There’s the drug and alcohol problem here ... A lot of people won’t admit there is a problem – especially with the young people. As young as 10, 12, drunk on the street.”

(Health Worker)

Others also commented on the risk factors contributing to the prevalence of these diseases, particularly in relation to social determinants of health. For example:

“We see all these kids in nappies with coke and hot chips. Then we wonder why we are treating so many diabetics at 30.”

(Health Worker)

“Nutrition – because there is so much diabetes. This comes from poor finance for nutrition and poor housing, domestic violence – everything comes into it. If we see it when we go out we talk about it.”

(Health Worker)

“We see a lot of kids that don’t go to school because their parents don’t send them to school, or they haven’t got lunch, or they haven’t got clothes. We have a lot of head lice, scabies and boils, school sores; it’s a vicious cycle – the parents didn’t go to school, the kids won’t go to school. A lot of the adults need to take a lot more control over the health – eg they run out of tablets and only ring us a week later and get annoyed because they ran out.”

(Health Worker)

The comments above capture the individual experiences of Health Workers in relation to the community health needs that they respond to. Although they do not represent the experience of the entire Health Worker workforce, they provide some insights into the health needs that some Health Workers respond to on the front-line. These reported experiences are consistent with the existing body of literature on the health needs of Aboriginal and Torres Strait Islander peoples.

The Health Worker response to these health needs is only part of the solution to closing the health care gap between Aboriginal and Torres Strait Islander peoples and other Australians. It is therefore important to consider the health service needs of Aboriginal and Torres Strait Islander Australians to ensure health care is both available and accessible when needed. This will help to identify effective ways for the Health Worker workforce to contribute to the broader health system response. Consequently, the health service needs of Aboriginal and Torres Strait Islander peoples are discussed in the following section.

The following comment expresses one Health Worker's sentiments about the importance of the workforce to health outcomes.

"The government sees us [Aboriginal and Torres Strait Islander peoples] as stats but we are a dying race. They don't care what happens to us, we are just numbers. This is where the Health Worker comes in. We care. We are family. We want to make a difference to our lives"

(Health Worker)

### 4.3 Health service needs of Aboriginal and Torres Strait Islander peoples

The development of the Health Worker workforce provides an opportunity to strengthen the capacity of the health system to meet the health service needs of Aboriginal and Torres Strait Islander Australians. To understand these needs, it is necessary to consider two distinct concepts: the *availability* of health services; and the *accessibility* of health services.<sup>16</sup>

This section focuses on each of these aspects of service delivery respectively, providing an overview of the main barriers to health service access for Aboriginal and Torres Strait Islander people. Included are the perceptions of Health Workers, managers and other health professionals collected during site visits.

#### 4.3.1 Health service availability

The health services that are available to Aboriginal and Torres Strait Islander people are varied. As for other Australians, health services are available to Aboriginal and Torres Strait Islander people at different levels of the health system:

- comprehensive primary health care (eg health clinics, immunisations, prevention and health promotion programs)
- secondary care (eg smaller hospitals, specialist services)
- tertiary care (eg large hospitals, highly specialised services).

Some of these services are mainstream services. For example:

- GP clinics
- public and private hospitals.

Some are tailored specifically to Aboriginal and Torres Strait Islander clients. For example:

- Aboriginal Community Controlled Health Services
- Medical Specialist Outreach Assistance Program (MSOAP)
- Urban Specialist Outreach Program (USOAP).

Health Workers contribute to health service availability at various points within this broader network of available health services.

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<sup>16</sup> See the Environmental Scan (Chapter 5) for more comprehensive discussion of health and service needs.

One of the main considerations in relation to health service availability is whether there are services available in locations where Aboriginal and Torres Strait Islander people are concentrated. As demonstrated in Section 3.3, almost half (48%) of all Health Workers reported that they are working in either remote or very remote regions of Australia. In comparison, just 24% of the Aboriginal and Torres Strait Islander population is located in these areas (Australian Bureau of Statistics, 2006b)<sup>17</sup>.

There is a comparatively lower concentration of Health Workers in major cities. In major cities, there is one Health Worker for every 832 Aboriginal and Torres Strait Islander Australians; in remote and very remote Australia (combined), there is one Health Worker for every 223 Aboriginal and Torres Strait Islander Australians (Australian Bureau of Statistics, 2006b).

These data indicate some misalignment of the Health Worker workforce to the Aboriginal and Torres Strait Islander population, suggesting that a more coordinated approach to workforce planning would be appropriate. However, as yet there is no conclusive evidence in Australia regarding optimum workforce distribution models.

#### 4.3.2 Health service accessibility

Health service accessibility 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). According to ABS data, a higher level of unmet need has been reported by Aboriginal and Torres Strait Islander peoples in urban areas (Council of Australian Governments Reform Council, 2010, Australian Bureau of Statistics, 2006c). This is despite the fact that there are more mainstream health services available in these regions.

In fact, according to the National Aboriginal and Torres Strait Islander Health Survey conducted by the ABS in 2004/05, 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, 2006c, Steering Committee for the Review of Government Service Provision, 2009a).

Although those living in remote areas were more likely to receive health care, they were also less likely to seek it out when they needed it (2% in remote areas compared to 1.2% in non-remote areas) (Australian Bureau of Statistics, 2006c). This suggests that the health services that are available in remote areas are more proactive or more effective in meeting the needs of Aboriginal and Torres Strait Islander peoples than health services in non-remote areas.<sup>18</sup>

It is pertinent to consider why this is the case.

##### Possible reasons for greater availability/accessibility

One hypothesis is that services which specifically target Aboriginal and Torres Strait Islander peoples are better at meeting the needs of this population group than mainstream health services. This hypothesis is supported by the fact that there is a higher concentration of Aboriginal and Torres Strait Islander Community Controlled health services in remote and very remote areas, which specifically target Aboriginal and Torres Strait Islander needs (Australian Institute of Health and Welfare, 2010).

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<sup>17</sup> Also see Section 3.3

<sup>18</sup> A more comprehensive discussion of this information is provided in the Environmental Scan (Section 5.2).

A second hypothesis is that health service accessibility is positively influenced by the Health Worker workforce. This hypothesis is supported by the fact that there is a disproportionately high concentration of Health Workers in remote and very remote locations when compared to the distribution of the Aboriginal and Torres Strait Islander population (Australian Bureau of Statistics, 2006b, Australian Bureau of Statistics, 2006a, Australian Bureau of Statistics, 2003), and also by the fact that the Aboriginal and Torres Strait Islander Community Controlled Health Sector, which has more services located in remote areas, is the largest employer of Health Workers (National Aboriginal Community Controlled Health Organisation, 2010).

Further evidence is required to validate these hypotheses. Qualitative data collected from Health Workers, their managers and other health professionals around Australia during the project site visits contribute to this evidence base (discussed in Chapter 5).<sup>19</sup>

#### **4.3.3 Barriers to health care access for Aboriginal and Torres Strait Islander Australians**

The data presented above demonstrate that some Aboriginal and Torres Strait Islander peoples face barriers to accessing available health services. There is a large body of literature exploring the specific barriers influencing health care accessibility.<sup>20</sup> Some of the reported barriers are:

- cultural safety issues (Williams, 1999, Hayman et al., 2006, Cass et al., 2006) and experiences of racial discrimination (Cutcliffe, 2004, Paradies, 2007, Steering Committee for the Review of Government Service Provision, 2009b)
- language barriers (Steering Committee for the Review of Government Service Provision, 2009b)
- transport barriers/geographic location of services (Australian Institute of Health and Welfare, 2006a)
- cost of health care (Australian Bureau of Statistics, 2001, Australian Institute of Health and Welfare, 2006a).

During this project's Community Mapping activities, Health Workers and health service managers were asked what they believed were the main barriers preventing Aboriginal and Torres Strait Islander communities from getting the health care they need.

Interestingly, the responses from focus groups across Australia placed an overwhelming emphasis on cultural safety issues. Cultural safety was the access barrier identified most frequently by both Health Worker focus groups and manager focus groups.

The following quotes exemplify some of the perceptions held by staff at front-line health services in relation to cultural barriers:

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<sup>19</sup> When considering these hypotheses, it is important to remember that many of the leading causes of the Aboriginal and Torres Strait Islander disease burden have a higher prevalence in non-remote areas than in remote areas, as stated in Section 5.1.1. This also affects the high level of unmet need recorded in metropolitan areas.

<sup>20</sup> For a more detailed description of these barriers in the literature, see the Environmental Scan (Section 5.2.3)

“Mums and bubs never turn up to their [hospital] appointments because of the cultural barriers – they don't want to come in because of their dignity, the clinical smells, all of that is cultural stuff – they'd rather have their baby under a tree than see a hospital.”

(Health Worker – employed by government sector health clinic)

“Sometimes staff attitudes can be an issue ... clients don't feel comfortable with non-Indigenous staff.”

(Health Worker manager)

“I don't think that patients feel comfortable using \_\_\_\_\_ [mainstream health service]. Some refuse to go. They have an Aboriginal Mental Health Worker and another Aboriginal Health Worker and a receptionist who is Aboriginal. But they have a big swag of nurses. Because it's mostly white dominant, they don't feel as comfortable and don't trust them as much. There is a different environment to here. This is more relaxed.”

(Health Worker – employed in Aboriginal Community Controlled Health sector)

“It's funny because the blackfellas working for mainstream organisations bring their patients here anyway. A lot of \_\_\_\_\_ [Aboriginal language group] just rather come here.”

(Health Worker – employed in Aboriginal Community Controlled Health sector)

“If an Aboriginal and Torres Strait Islander person goes to a mainstream service and has a bad experience, then they won't go back to that service. Therefore they need to be culturally aware.”

(Health Worker – employed in Aboriginal Community Controlled Health sector)

These comments demonstrate perceptions of the cultural safety of a health service have a real impact on the decisions made by some Aboriginal and Torres Strait Islander individuals to use certain health services. According to many Health Workers and their managers, some Aboriginal and Torres Strait Islander people would rather go without health care than use a health service that does not feel culturally secure. This observation was made by participants who were employed by both the ACCHS and government health sector alike.

These interview data provide insights into some of the reasons why there is a higher level of unmet need in non-remote areas, despite the higher concentration of available mainstream health services in those locations. As hypothesised in Section 4.3.2, it can be at least partially attributed to the fact that in remote areas there are more health services that specifically target the needs of Aboriginal and Torres Strait Islander people; and there are also more Aboriginal and Torres Strait Islander Health Workers. According to focus group responses, both of these factors are likely to increase the perceived cultural safety of a health service.

Interestingly, other access barriers identified in the literature, such as geographic location and cost barriers, were not mentioned by Health Workers or their managers as frequently as cultural safety issues. This is worth noting because it suggests that, according to Health Workers and managers on the front line, these barriers are not as significant as cultural safety.

The role of the Health Worker workforce in addressing the health and service needs of Aboriginal and Torres Strait Islander communities is explored in the following chapter.

## 5. The role of the Health Worker workforce

### Key points

The impact of any workforce is maximised when it is appropriately aligned to the health and service needs of its target client group. To date, there has been no empirical examination of the alignment between the role of the Health Worker workforce and the health and service needs of Aboriginal and Torres Strait Islander people. This project therefore provides the first evidence-based picture of the role of the Health Worker workforce as a foundation for future consideration.

### The existing scope of practice

According to the survey data, the elements of the Health Worker scope of practice that are performed most frequently across Australia are:

- culturally safe health care roles (eg advocating for Aboriginal and Torres Strait Islander clients to explain and ensure their cultural needs are met by other health professionals)
- prevention and health promotion roles (eg running programs that raise awareness of health issues or target the social determinants of health).

In addition, there are key roles that contribute to the broader scope of practice, but vary in practice across the workforce. These include:

- the level of complexity of clinical roles (eg ranging from basic health checks to clinical interventions that involve breaking the skin or the risk of loss of life)
- areas of specific primary health care or clinical focus (eg a focus on chronic disease management, mental health, sexual health).

The variation in clinical roles is influenced by such factors as the number of years in a Health Worker role, Aboriginal and Torres Strait Islander Primary Health Care qualification, and jurisdiction of employment.

### Optimising the Health Worker workforce in the future

During the Community Mapping focus groups, Health Workers, managers and other health professionals demonstrated overwhelming support for the Health Worker workforce to perform a more significant role in responding to the health needs of their communities. Focus group participants believed that Health Workers were well-positioned to target perceived health service gaps in relation to providing more:

- culturally secure health services
- prevention and health promotion programs
- holistic approaches to health care.

However, Health Workers reported that certain barriers prevented them from performing larger roles. These include:

- insufficient recognition and support, which disempowers and demotivates Health Workers, thus limiting their potential
- limited opportunities for role and career progression
- limited access to training that would equip Health Workers with more skills and facilitate the expansion of their role

- insufficient resources to implement additional programs
- demands to perform clinical and administrative activities, reducing their availability for prevention and health promotion programs.

Addressing these barriers would help empower Health Workers to optimise the contribution they make to the health needs of Aboriginal and Torres Strait Islander people.

## 5.1 Context

One of the defining characteristics of a 'profession' is public acceptance that individuals belonging to a professional group "possess special knowledge and skills in a widely recognised, organised body of learning" (Australian Competition & Consumer Commission, 2011). Therefore, as part of the ongoing process of professionalising the Health Worker workforce, it is necessary to identify a nationally accepted understanding of the unique Health Worker scope of practice.

The scope of practice of a profession is distinct to the definition of a particular workforce. The definition of scope of practice, for the purpose of this discussion, is drawn from that used for nursing by the Queensland Nursing Council (Queensland Nursing Council, 2005). According to this definition, an overarching scope of practice is the range of activities and tasks a health professional is educated, competent and authorised to perform.<sup>21</sup>

A nationally recognised Health Worker scope of practice will:

- distinguish Health Workers from other health professionals
- facilitate the continued development of education and training requirements
- assist to identify agreed standards of practice.

Each of these activities is relevant to the establishment of any profession, in line with the definition of 'profession' provided by the Australian Competition & Consumer Commission (2011).<sup>22</sup>

A significant amount of work has already been invested in the process of defining a Health Worker scope of practice in specific jurisdictions and organisations. For example, the Health Worker scope of practice has been defined by:

- the Victorian Aboriginal Community Controlled Health Organisation (Victorian Aboriginal Community Controlled Health Organisation, 2010)
- the Northern Territory Aboriginal Health Workers Board (Aboriginal Health Workers Board of the Northern Territory, 2008)
- several jurisdictional health departments, including the Northern Territory Department of Health and Families, and the Queensland Department of Health (Queensland Health, 2007b).

In addition, the Community Services and Health Industry Skills Council developed a national qualifications framework to equip Health Workers to perform to their scope of practice (Community Services & Health Industry Skills Council, 2008). This qualifications

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<sup>21</sup> Further detail on the definition of a scope of practice is provided in the Environmental Scan (Section 6.3.2)

<sup>22</sup> Definition is provided in Section 1.3

framework is reviewed every three years as part of the CS&HISC's continuous improvement work plan, in accordance with the National Quality Council's Training Package development and endorsement process.

The different interpretations of the Health Worker scope of practice demonstrate there is substantial variation in the roles being performed by Health Workers across Australia. This variation has been confirmed by the evidence collected from Health Workers, managers and other health professionals via surveys and focus groups for the purpose of this project.<sup>23</sup>

Despite this variation, the evidence also demonstrates some common roles are fundamental to the Health Worker scope of practice. These are

- culturally safe health care roles (eg advocating for Aboriginal and Torres Strait Islander clients to explain their cultural needs to other health professionals)
- prevention and health promotion roles (eg running programs that raise awareness of health issues or target the social determinants of health).

In addition, key elements of the Health Worker role contribute to the definition of the scope of practice but vary across the workforce. These are:

- the level of complexity of clinical roles performed (eg ranging from basic health checks to clinical interventions that involve breaking the skin and/or the risk of loss of life or limb)
- areas of specific primary health care or clinical focus (eg a focus on chronic disease management, mental health, sexual health, etc).

These elements of the Health Worker scope of practice are defined and discussed in more detail below, using evidence collected during the course of this project.

First, an overview of the existing national scope of practice is provided; then each of the four defining characteristics listed above – the common roles and the key elements of the Health Worker role – is focused on individually.

## 5.2 Understanding the existing Health Worker scope of practice: overview of results

### 5.2.1 Introducing the conceptual map of the Health Worker scope of practice

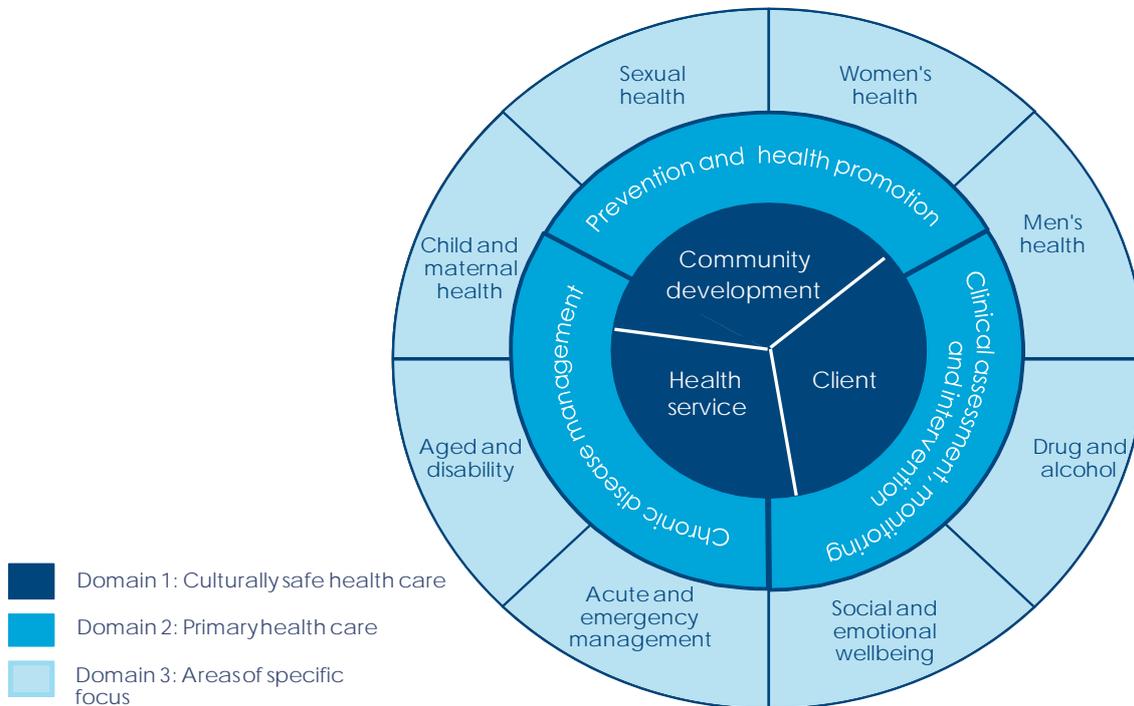
Before discussing the results in more detail, it is necessary to first introduce the conceptual map of the Health Worker scope of practice developed during this project.

The conceptual map (Figure 5) was developed in consultation with key stakeholders to guide the design of survey and focus group questions relating to the Health Worker scope of practice. It was endorsed by the Expert Reference Group, the Jurisdictional Planning Group and members of a meeting that included NACCHO and ACCHO workforce development representatives. (For more detail about the process, and a more comprehensive explanation of how each domain and element is defined, see Appendix E.)

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<sup>23</sup> See **Error! Reference source not found.** for additional data analysis demonstrating this variation.

Figure 5: The conceptual map of the Health Worker scope of practice



The conceptual map of the Health Worker scope of practice has three domain areas:

- culturally safe health care (defined in Section 1.3)
- primary health care (defined in Section 1.3)
- areas of specific focus (eg chronic disease, mental health or sexual health).

Each domain is divided into a number of elements which group similar types of activities performed by Health Workers.

This conceptual map not only framed the development of Health Worker survey questions, but has also been used to represent the results visually. A series of survey questions relating to specific health service activities were associated with each element on the conceptual map. Activities relating to some elements of the scope of practice were performed more frequently<sup>24</sup> by a larger number of Health Workers who responded to the survey. These elements are described as having a greater *intensity* in the Health Worker scope of practice. In other words, they are a more fundamental aspect of the Health Worker role than elements with a lower intensity on the conceptual map.

The intensity of each element within the scope of practice is depicted visually through a colour scale:

- the **darker** the blue, the more intense the element
- the **lighter** the blue, the less intense the element.

<sup>24</sup> 'Frequent' practice refers to activities that Health Workers reported performing 'most days', 'weekly' or 'fortnightly'; 'Infrequent' practice refers to those performed 'monthly', 'yearly' or 'never'.

The colour scale is displayed in Figure 6 (the methodology of the data analysis and visual representation is also explained in more detail in Appendix E)

Figure 6: Colour scale for Health Worker Scope of Practice Conceptual diagram

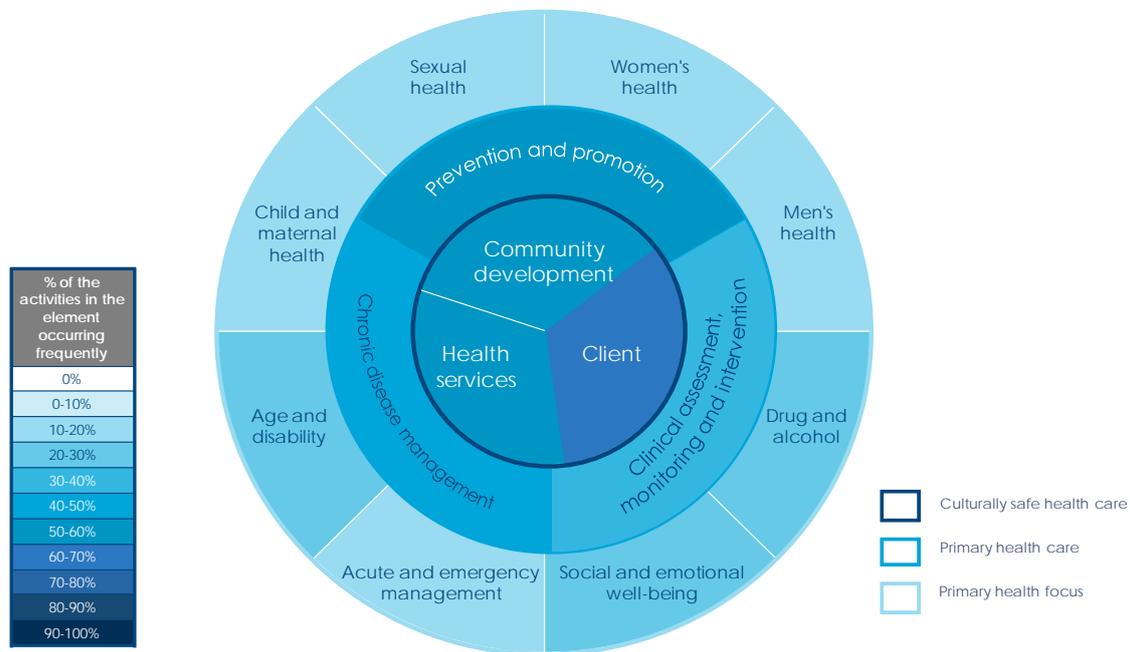
% of the activities in the element occurring frequently
0%
0-10%
10-20%
20-30%
30-40%
40-50%
50-60%
60-70%
70-80%
80-90%
90-100%

### 5.2.2 Results from quantitative data analysis: Health Worker surveys

During November and December 2010, 351 Health Workers completed the Health Worker survey. Of the total participants, 200 responded to the full set of questions in relation to scope of practice. This evidence base was used to create the national picture of the Health Worker scope of practice presented in this chapter. To date, this is the most comprehensive national body of evidence in relation to the Aboriginal and Torres Strait Islander Health Worker scope of practice.

The national Health Worker scope of practice results are visually represented below in Figure 7 (more detailed results are included in Appendix E).

Figure 7: The National Health Worker scope of practice



From this picture of the national Health Worker scope of practice, it is evident that:

- **culturally safe health care roles are a defining characteristic of the national Health Worker scope of practice.** The element of the Health Worker scope of practice that is most common and performed most frequently across Australia is the provision of direct cultural support to clients (the 'Client' element); activities that help to make health services more culturally secure, and relating to community development, are the second most common and frequent element of the Health Worker scope of practice (the 'Health services' and 'Community development' elements, respectively)
- **prevention and health promotion activities are a core part of the Health Worker role.** Activities contributing to this element ('Prevention and health promotion') are reportedly performed almost as frequently as those within the 'Culturally safe health care' domain
- **chronic disease management activities are frequently performed** (the 'Chronic disease management' element), although slightly less frequently than cultural safety roles and prevention and health promotion activities
- **at the national level, clinical assessment, monitoring and intervention activities are performed by Health Workers less frequently than other primary health care roles or culturally safe health care roles.**

The perceptions of Health Workers and managers reported during Community Mapping focus groups validate the survey data. When focus groups were asked how Health Workers contribute to the health and service needs of Aboriginal and Torres Strait Islander peoples, the two overarching themes that emerged were:

- the contribution made by Health Workers to making a health service culturally safe for Aboriginal and Torres Strait Islander clients

- the contribution made by Health Workers in delivering prevention and health promotion activities, and adopting a holistic approach to health care.

The quantitative and qualitative data presents a consistent message: core to the Health Worker scope of practice is a combination of culturally safe health care roles and prevention and health promotion activities. Other key roles involve clinical tasks and areas of specific primary health care focus, but these vary more noticeably across the workforce.

Each of these aspects of the Health Worker scope of practice is discussed in more depth in the following sections.

### 5.3 Culturally safe health care roles

'Culturally safe health care roles' refers to activities performed by Health Workers to improve health access for Aboriginal and Torres Strait Islander people by brokering and delivering culturally safe and appropriate health care. Data collected through the Health Worker surveys and in focus groups with Health Workers, managers and other health professionals emphasises the role Health Workers play in facilitating culturally safe health care.

Three components of culturally safe health care have been included in the conceptual map:

- **improving health and access through patient advocacy, communication and support.** For example, explaining medical terminology, medications and treatments in a way that is relevant to Aboriginal and Torres Strait Islander clients. (This is represented by the 'Client' element of the conceptual map)
- **improving health and access through a culturally safe and aware health service** For example, advising other health professionals on how health care should be provided to an Aboriginal or Torres Strait Islander client so it is culturally relevant, or educating other staff on Aboriginal or Torres Strait Islander culture (this is represented by the 'Health service' element of the conceptual map)
- **improving health through community wellbeing and development affecting social determinants of health.** For example, working with community Elders to develop solutions to environmental health issues in the community (this is represented by the 'Community development' element of the conceptual map).

The survey data relating to the Health Worker scope of practice revealed that:

- cultural brokerage and advocacy roles performed on behalf of the client were a frequent part of the national scope of practice (62% of the activities related to the 'Client' element in the 'Culturally safe health care' domain were performed frequently)
- 60% of the activities in the culturally safe health service ('Health service') element in the 'Culturally safe health care' domain were reported as a frequent part of the national scope of practice
- 51% of the activities in the 'Community development' element of the 'Culturally safe health care' domain were reported as being a frequent part of the national Health Worker role.

Interpretation of the focus group data suggests the culturally safe health care roles performed by Health Workers are a defining characteristic of the Health Worker workforce. No other health profession is currently perceived to perform a similar role in

cultivating culturally safe health services for Aboriginal and Torres Strait Islander peoples. In fact, when Health Worker focus groups were asked why community members might prefer to see them instead of other health professionals, the majority reported reasons related to cultural safety. Although some other health professionals might identify as Aboriginal and Torres Strait Islander (for example, an Aboriginal nurse), the roles performed by those health professionals are not specifically designed to ensure cultural safety in the way the Health Worker role is.

This is reinforced by the responses of Health Workers when they were asked in focus groups to comment on activities they perform as part of their usual job. Some of the activities commonly identified as an important part of the Health Worker role in Health Worker focus groups are:

- advising non-Aboriginal or Torres Strait Islander health professionals and managers how to best respond to the needs of Aboriginal and Torres Strait Islander clients
- liaising between Aboriginal and Torres Strait Islander communities and health services to help each party better understand the other and overcome cultural barriers
- encouraging community members to overcome fears of health clinics – for example by physically transporting clients to the health service, encouraging clients to avoid early discharge, or encouraging regular check-ups.

Examples of specific comments provided by some Health Workers in relation to culturally safe health care roles include:

“We are the shield between the community and the other health staff – especially the nurses.”

(Health Worker)

“As soon as the doctor starts saying more than 10 letter words to the patient, they’re lost – they can’t understand. We have to sit there and advocate for the patient, encourage the patient to do the right thing as the doctor says.”

(Health Worker)

“The Aboriginal and Torres Strait Islander people are frightened – they’re frightened of getting sick, frightened of the hospitals, frightened of the medication. They will discharge themselves. We have to make sure that if they do that, they stay on the right medication. There are not enough hours in the day for us to meet the needs of the community.”

(Health Worker)

“It’s a big plus for Aboriginal Health Workers to have acquired their cultural knowledge and it is not valued enough. It should be respected as intellectual property.”

(Health Worker)

The views of Health Worker managers reported in focus groups also emphasise the importance of this aspect of the Health Worker scope of practice. At the majority of manager focus groups, the two main reasons reported for employing Health Workers were:

- to ensure the cultural safety of their clients
- to provide a link between the Aboriginal and Torres Strait Islander community and their health service.

These two reasons combined were mentioned at 70% of the Health Worker manager focus groups that responded to the question of why they employ Health Workers. In comparison, primary health care skills were only mentioned at 10% of the manager focus groups in answer to the same question. This suggests the managers who participated in the focus groups place greater value on Health Workers' capacity to increase access to health services by bridging cultural divides.

Examples of comments made by the direct line-managers of Health Workers in focus groups include:

"They [Health Workers] are the face between the community and the health service"

(Health Worker manager)

"It is critical to remember that this generation is the stolen generation. As a result they [Aboriginal and Torres Strait Islander clients] are very un-trusting of the government and particularly white government workers. The Health Workers are the key to the Aboriginal and Torres Strait Islander community. Health Workers have been able to open doors to the community never opened before."

(Health Worker manager)

"It's just as important to acknowledge the cultural scope of practice as well as the clinical scope of practice. Even if a Health Worker doesn't have the clinical competence, some are excellent at mediating with the doctor and being a cultural advocate."

(Health Worker manager)

"Cultural consultancy is a major role [of Health Workers], not valued by other health professionals"

(Health Worker manager)

These comments are evidence of the importance of the culturally safe health care roles performed by Health Workers across Australia.

### Is community identity essential?

In investigating this role further, a pertinent question emerged – do Health Workers need to be of the same community as their clients in order to perform cultural safety roles effectively? This question is relevant considering the cultural differences that exist

between the diverse ethnic, linguistic and skin groups collectively described as “Aboriginal and Torres Strait Islander peoples”.

Some insights into this question were provided during the focus groups. Health Workers reported that they were from the same community as their clients in 85% of the focus groups. Being of the same community as their clients was identified as important because it ensures that Health Workers have the cultural knowledge required to meet the cultural safety needs of the client. This view was supported by some health service managers. For example, one health service manager in a remote health service made the following comment:

“Culture is very strong out here and it overtakes all other considerations. We cannot recruit Health Workers from other areas or send our Health Workers to other areas because the community culture requirements are so strong.”

(Health Worker manager, remote location)

However, other participants noted that being of the same community as the client is not a definitive requirement for overcoming cultural barriers. This view was usually only put forward alongside discussion of ensuring that Health Workers in these situations are provided with appropriate cultural mentoring and support. Examples of ‘appropriate mentoring and support’ suggested included mentoring from more senior Aboriginal or Torres Strait Islander staff from the community or community Elders.

This is reflected in the following comment:

“We want to grow local jobs with local people. We aren’t all one people. To really be effective as a primary health care giver, they need to be from that community. Community endorsing that person is vital for success. But if it’s two-way learning with those coming from other areas working with locals to get them up and trained with some of the health skills can help.”

(Health Worker manager)

Some Health Workers highlighted challenges associated with being of the same community as clients. In particular, many Health Workers referred to the risk of burn-out due to high community expectations. This issue is discussed further in Section 9.3.

Therefore, while most Health Workers and managers interviewed believe it is important for Health Workers to be from the same community as their clients, there are some mixed views. According to some participants, it is not a problem if Health Workers are from external communities as long as they are adequately supported from a cultural knowledge point of view. Further, being from the same community as their clients can place Health Workers in high-pressure situations that contribute to the risk of staff burn-out.

## 5.4 Prevention and health promotion roles

Prevention and health promotion activities are a crucial component of comprehensive primary health care approaches to health service delivery (Australian Primary Health Care Research Institute, 2005). They have also been identified as a core aspect of the

Health Worker scope of practice, as evidenced by both the Health Worker survey and focus group data sets.

In the Health Worker survey, questions relating to prevention and health promotion roles included the following activities:

- assessing a patient's health risk factors (eg weight, smoking, eating habits)
- talking to a patient about how to live a healthier life (eg losing weight, reducing alcohol consumption, quitting smoking, exercising)
- running group education sessions about healthy living
- running prevention or health promotion campaigns at community events (eg putting up a health stall or information poster at a football match)
- assessing the community and identifying aspects of the community that will make people unwell (eg the food in the stores, lack of exercise, smoking and drinking habits).

Many of these activities relate to the social determinants of health.

The results of the Health Worker survey found that 51% of activities in the survey relating to prevention and health promotion were reported as a frequent aspect of Health Worker scope of practice. This was a greater proportion than was reported for the other elements within the 'Primary health care' domain (44% of the activities relating to the 'Chronic disease management' element were reported as frequent; and 32% of the activities related to the 'Clinical assessment, monitoring and intervention' element were reported as frequent).

The thematic analysis of responses from both Health Worker and manager focus groups highlighted prevention and health promotion activities as a core aspect of the Health Worker role. The focus groups were asked about how the Health Worker workforce responds to community health needs. Prevention and health promotion was the dominant theme in both participant group categories, regardless of sector of employment.

The value of this role is emphasised in the comments below:

"A lot of Aboriginal people think that diabetes is just something that is going to happen because you've seen your aunts and uncles with it. They don't realise it is something preventable. If a nurse just gives them a script it is not teaching them that it is actually preventable."

(Health Worker)

"I deliver a few programs to the community, like a healthy cooking program, good food, simple first aid with the kids in the school, nose blowing and cleaning hands and faces, home hygiene, diabetes, teeth program, blood pressure program."

(Health Worker)

“Once a doctor gives an Indigenous person a tablet or some insulin, they think they can keep drinking and smoking and eating because the medicine will fix it. That is why we have to change their mindset. So that they understand why they also have to change drinking and smoking and eating.”

(Health Worker)

For many participants, the prevention and health promotion aspects of the Health Worker role were firmly rooted in the Aboriginal and Torres Strait Islander people’s cultural belief in the concept of holistic health.<sup>25</sup> Many Aboriginal and Torres Strait Islander people understand the concept of health to refer to total physical, mental, emotional, environmental and spiritual wellbeing (Devanesen and Maher, 2003). For Aboriginal and Torres Strait Islander people, the concept of ‘health’ is not “merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity” (NAHS, 1989). Many focus group participants suggested that the cultural values of Aboriginal and Torres Strait Islander Health Workers, emphasising holistic health care, better equipped them to perform prevention and health promotion roles in comparison to other health professionals.

For example:

“You find a lot of nurses have the acute approach to health care – it is different to Health Workers. We try to take a holistic approach, empower our clients, educate them so that they can address their own health issues. The program I run, Healthy for Life, is completely aligned with the Health Worker philosophy.”

(Health Worker)

“Health Workers work from a more holistic point of view. They see the person as a whole not just a disease process. For example, in comparison to Enrolled Nurses, Health Workers have a much greater and wider scope of practice.”

(Health Worker manager)

Although the cultural attributes of Health Workers may improve their capacity to deliver holistic prevention and health promotion initiatives, there is also a broader push across the Australian health care system to move towards prevention and health promotion models of care. The recent Australian Government health care reforms emphasise the importance of prevention and health promotion, particularly given the ageing population and increasing prevalence of chronic diseases (Australian Government Department of Health and Ageing, 2010a).

Therefore, the value of prevention and health promotion activities is recognised in the context of both mainstream and Aboriginal and Torres Strait Islander-specific health services alike. These activities, which include an emphasis on the social determinants of health, form a fundamental part of the Health Worker role.

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<sup>25</sup> The concept of holistic health is discussed further in the Environmental Scan (Section 3.2.1)

## 5.5 Variation in complexity of clinical roles

While cultural safety roles and prevention and health promotion roles are common to the Health Worker scope of practice, there is wide variation in the clinical roles being performed. For example, a registered Aboriginal Health Worker in the Northern Territory might perform more complex clinical tasks than a Health Worker in New South Wales. Similarly, a Health Worker located in a remote location might perform clinical activities that involve a higher level of complexity than would a Health Worker located in a city.

This variation in clinical activity reflects the organic development of the Health Worker workforce, where roles have often been shaped in response to specific contextual needs. If a community located in a remote area has limited access to other clinical practitioners, such as doctors or nurses, Health Workers in this community may develop more advanced clinical skills to address those gaps. Given Health Workers operate in a broad range of communities and health service settings, which may each have specific contextual needs, a degree of flexibility in the Health Worker scope of practice is both inevitable and required.

Evidence collected in the Health Worker surveys provide some insights into the variation of clinical roles performed by Health Workers. The survey was designed to collect information on a range of clinical activities potentially performed by Health Workers. These activities were divided into three main groups, defined as follows:

- **clinical assessment:** tasks carried out to determine the nature, cause, and potential effects of a patient's injury, illness, or wellness; no breaking of the skin, with minimal to any immediate risk to patient
- **clinical intervention:** tasks carried out to improve, maintain, or assess the health of a person in a clinical situation; breaking the skin is often involved, with an associated clinical risk present
- **acute and emergency management:** tasks carried out during an acute or life threatening episode; often breaking the skin is involved and a high risk to life is present.

For the purpose of data analysis, a clinical score metric was developed. This score indicates the percentage of Health Workers that frequently performed the tasks relating to each group of clinical activities above.<sup>26</sup> The clinical score metric enables comparison of the amount and type of clinical activity being performed by Health Workers across Australia (for more detail on the development of the clinical score metric and the data analysis methodology, see Appendix E).

### 5.5.1 Variables influencing clinical activity

Using the clinical score metric, the survey data was analysed to understand which variables influence the amount of clinical activity being undertaken by Health Workers.

The following variables were considered:

- jurisdiction of employment
- area of remoteness (using the Australian Standard Geographic Classification system)

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<sup>26</sup> 'Frequent' practice refers to activities that Health Workers reported performing 'most days', 'weekly' or 'fortnightly'

- frequency of supervision
- organisation of employment (ie ACCHO, government organisation, other)
- level of qualification (ie for Health Workers who held an Aboriginal and Torres Strait Islander Primary Health Care (ATSIPHC) qualification)
- gender
- age
- number of years in the Health Worker role.

The variables that seem to have the greatest influence on the national clinical score ( $p < 0.01$  is significant) are:

- the number of years in the Health Worker role ( $p < 0.0001$ ) that is, the data indicates the longer the Health Worker had been in their role, the higher their clinical score
- the ATSIPHC qualification ( $p = 0.001$ ) that is, the higher the qualification obtained, the higher their clinical score
- jurisdiction of employment ( $p = 0.0013$ ), that is the State/Territory in which the Health Worker is employed appears to influence their clinical score. The jurisdictional impact could be due to a number of factors such as differing registration requirements and/or the distribution of Health Worker across different areas of remoteness. For example, it was noted that the strong clinical results for the Northern Territory shown in Appendix E are consistent with reports collected during focus groups and key informant interviews. One of the factors contributing to this is the minimum requirement for registration as an Aboriginal Health Worker in the Northern Territory is Certificate IV (Practice). Further, there are more Health Workers located in remote areas in the Northern Territory than in other jurisdictions. As Section 5.5.2 below demonstrates, the more remote a Health Worker is, the more likely they are to undertake complex clinical activities.

See Appendix E for further detail.

### **5.5.2 Comparison of clinical activity: by level of remoteness and place of employment**

The above findings are generally consistent with responses from the focus groups. However, the focus groups also emphasised the impact of variables that were less significant in the survey data analysis. Two of these are the 'Area of remoteness' and 'organisation of employment' of Health Workers.

#### **Area of remoteness**

Focus groups emphasised that Health Workers in remote areas perform more complex clinical tasks than Health Workers in urban areas. Although the survey results show that there is a higher level of clinical activity in remote areas, this was not statistically significant. This may be due to Health Workers from very remote Australia being under-represented in the survey sample group.

#### **Organisation of employment**

In some Community Mapping focus groups, there was a perception that Health Workers employed by ACCHOs generally performed more complex clinical activities than Health Workers employed by the government health sector. As above, the difference in clinical activity by organisation of employment was not statistically significant.

However, the survey data do show that:

- the average total clinical score for Health Workers employed by ACCHOs is 31%; in comparison, the average clinical score for those employed at government health services is 26%
- there were higher clinical scores in the ACCHO sector across each of the three clinical activity groups – ie clinical assessment, clinical intervention, and acute and emergency activities.

This means that, at the local level, factors influencing the clinical activity Health Workers perform might be more obvious than the survey data suggests. Appendix E includes additional analysis of survey data on variation in clinical activity by level of remoteness and place of employment.

## 5.6 Variation in areas of specific focus

Some Health Workers choose to focus on specific areas of clinical or primary health care. Many Health Workers chose to develop skills in certain areas in response to the specific needs of the community they work in, in response to the provision of specific program funding, or to address gaps in available health services. So there is substantial variation in the specific areas of focus of Health Worker roles across Australia.

The specific areas of focus to which the survey questions related were:

- acute and emergency
- child and maternal health
- sexual health
- women's health
- men's health
- drug and alcohol
- social and emotional wellbeing
- aged and disability.

This is not an exhaustive list of areas of focus, but it incorporates some of the more frequently identified areas of specific practice. Some require more complex clinical skills; others are specific areas of primary health care that may not involve direct clinical intervention. Each requires a specific body of knowledge, regardless of whether complex clinical activities are being undertaken or not.

According to the Health Worker survey results, the most common areas of specific focus are:

- drug and alcohol (28% of activities reported as frequent)
- social and emotional wellbeing (27% of activities reported nationally as frequent)
- age and disability (24% of activities reported as frequent)
- acute and emergency management (18% of activities reported as frequent).

Less than 20% of activities in other elements were reported as being undertaken frequently.

In addition, some Health Workers choose to specialise as a generalist Health Worker and develop a broad skill set. 55% of Health Workers participating in the survey reported themselves to be generalist Health Workers.

## 5.7 Future opportunities: optimising the Health Worker workforce

In addition to current roles being performed by Health Workers, this project also collected information about the types of roles Health Workers could potentially play in future.

During focus groups, Health Workers, managers and other health professionals were asked whether they believed the roles of Health Workers should or could be expanded. They were also asked about the barriers that prevent Health Workers from performing bigger roles.

The results were definitive – an overwhelming majority of both Health Workers and their managers believed it would be possible for the Health Worker workforce to play a bigger role in responding to the needs of Aboriginal and Torres Strait Islander communities. This view was supported in 92% of the Health Worker focus groups and 96% of the Health Worker manager focus groups.

This section discusses these results and the perceived barriers to role expansion.

### 5.7.1 Existing health service gaps

Focus groups were first asked to identify the kinds of additional health services their communities needed, regardless of whether these should be performed by Health Workers. The purpose of this question was to gain insights into existing health service gaps that could potentially be targeted through the development of the Health Worker workforce.

The health service gaps identified by Health Workers most frequently, in order of frequency, were:

- social and emotional wellbeing services
- gender-specific services
- chronic disease services
- services relating to social determinants of health (such as welfare and environmental health services).

Prevention and health promotion activities, child and maternal health, and other specialist health services (eg eye and oral health) were also mentioned by Health Workers.

When the Health Worker managers were asked the same question, their responses were:

- Health Worker services in general
- Health Worker services at a higher skill/qualification level
- culturally appropriate health services.

These gaps were mentioned by managers more frequently than the need for additional clinical staff (such as doctors and nurses), additional specialist services, and more transport options.

These overarching health service gaps identified by Health Workers and managers highlight three themes:

- the need for culturally relevant health services;
- the need for more prevention and health promotion programs;
- the need for holistic approaches to health care.

### 5.7.2 The opportunity for the Health Worker to address health service gaps

According to focus group respondents in all participant categories, the Health Worker workforce is well-positioned to form at least part of the strategy to address the health service gaps.

In fact, manager focus groups identified insufficient numbers of Health Workers as the main health service gap, with insufficient numbers of more highly qualified Health Workers as the second largest health service gap. This shows there is support for expanding and developing the Health Worker workforce to better meet community needs.

Health Worker and manager focus groups were asked to explain how they believed the Health Worker workforce could specifically contribute to the health needs identified.

Two key areas identified by Health Workers as opportunities for their workforce to better meet the needs of communities were:

- delivering more prevention and health promotion programs
- providing more home-based or community-based health services.

Some Health Workers commented that their clinic-based responsibilities were increasing and this was preventing them from delivering enough prevention and health promotion programs in communities. These clinic-based responsibilities reportedly included both clinical practice and administrative tasks.

For example:

“The volume of work and number of patients stops us program people making a major difference. We need more Health Workers in the prevention stream of this service. For example in Child Health we have one Health Worker to 1,700 children: what can be done really?”

(Health Worker)

These sentiments were reflected by the Health Worker managers. The main themes emerging from manager focus groups (in response to the question of how Health Worker roles could change to better meet the needs of their communities) were:

- more community engagement, outreach and program-based work (eg health promotion programs and home visits)
- more clinical roles.

Examples of managers' comments in relation to program-based work include:

“We would like Health Workers to develop some of the community programs. At the moment they partner with programs that are already up and running. We would like Health Workers to drive these going forward.”

(Health Worker manager)

“Health Workers need more time to do programs – it’s what they want to do.”

(Health Worker manager)

The manager responses highlighted the tension between program-based work and clinical responsibilities, mirroring Health Worker comments. According to both participant groups, there is a fine balance between these two aspects of the Health Worker role that is not always managed appropriately.

This tension is highlighted by the following comment:

“We used to do a lot of health promotion in schools and the like. Health Workers didn’t have the same clinical role then. We now have a combination of community [clinical] needs and community health promotion. We are understaffed, our workforce is stressed, they are tired – we don’t have the capacity to deliver everything. We need more health promotions people.”

(Health Worker manager)

### 5.7.3 What barriers currently prevent Health Workers from performing this larger role?

The evidence outlined above demonstrates support for the expansion of the Health Worker workforce’s role. Health Workers and managers were invited to give their views on what factors currently prevent Health Workers from performing the larger roles they identified.

The four barriers mentioned most frequently in the Health Worker focus groups were (in order of frequency):

- insufficient recognition and support from managers and other health professionals
- limited opportunities for career progression
- a need for more training
- insufficient resources.

Some of the comments from Health Workers indicate they believe they are trained and capable of performing certain functions, but are held back from working to their full capacity as a result of some or all of the four factors listed above.

For example:

“I want to do more things in my role! Like those Health Workers in the NT, and we want to get more training opportunities. I’m not able to do a lot of the things I am trained to do, for example venipuncture, because of the rules around what Health Workers can and can’t do. We want more support to update our skills with training, and to develop our skills in the workplace too. A lot of short courses are targeted toward nurses, or are just a waste of time.”

(Health Worker)

[Interviewer: “What would it take to change the situation so that you could have a bigger role?”]

“Recognition of the skills that we have; and allowing us to do what we are trained to do. Stop holding us back if [we are] trained and competent to do it.”

(Health Worker)

The barriers identified in the manager focus groups were largely consistent with those mentioned by the Health Workers, with particular emphasis on the need for more support, recognition and training of Health Workers.

Many of the Health Workers and managers interviewed believed that, if these barriers were addressed, Health Workers would be more empowered to adopt a larger role in response to community health needs.

## 6. Health Worker workforce models supporting health service delivery

### Key points

The planning of any health workforce should be informed by an understanding of effective models of workforce deployment which best meet the health needs of its target population. Health Workers are one part of the broader health workforce that exists to respond to these needs for Aboriginal and Torres Strait Islander people. A variety of models exist that use the Health Worker workforce in different ways to contribute to the full continuum of patient care.

The Community Mapping site visits provided some insights into those various models. Although different models are appropriate in different health service settings, some that were reported as effective are:

- Health Worker-first models, where Health Workers provide the first patient contact and initial assessment
- comprehensive primary health care models, where Health Workers facilitate a holistic approach to health care
- community-based workforce models, where Health Workers use their local knowledge to inform and develop community-based health service responses
- outreach models, where Health Workers contribute to the provision of services in the homes or communities of clients (ie not in the clinic)
- prevention and health promotion program-based models, where Health Workers raise awareness of health issues and encourage preventative behaviours to reduce demand for health services
- models used in acute health care settings, where Health Workers use their primary health care training to support the provision of acute care to Aboriginal and Torres Strait Islander patients.

There is currently limited evidence comparing the impact of each model. The collection and sharing of this type of information could therefore assist health services to optimise the contribution made by Health Workers to patient care.

## 6.1 Context

A range of workforce models exist which use the Health Worker workforce in different ways to support health service delivery to Aboriginal and Torres Strait Islander people. Some of these models involve Health Workers at all stages of the patient journey; others emphasise the Health Worker contribution to patient care during specific points of the patient's broader experience in the health system. Other workforce models use Health Workers to target Aboriginal and Torres Strait Islander people *before* they become patients of a health service, in an effort to prevent illness and promote healthy lifestyles.

Different health care settings use different workforce models. For example, the model used in a comprehensive primary health care clinic is likely to differ from the one used in an acute care hospital; and that which is used in a remote location is likely to differ to those used in urban settings. This variation reflects contextual circumstances, such as the availability of other health professionals, the type of community demands for health services, and the geographic proximity to other health services that may also contribute to the patient journey (eg hospitals).

There is currently no evidence to demonstrate which models of Health Worker workforce deployment in each setting most effectively contribute to improved health outcomes for Aboriginal and Torres Strait Islander people. However, the Community Mapping site visits provided some insights into several models that were *perceived* to be effective in interviews with Health Workers, managers and other health professionals.

These models, which are discussed in more detail later in this chapter, are:

- Health Worker-first models
- comprehensive primary health care models
- community-based workforce models
- outreach models
- prevention and health promotion program-based models
- Health Worker models used in acute health care settings.

Case studies have been included to give some real-life examples of models that were reported during the Community Mapping site visits as representing good practice. However, in many instances there is limited data available to evaluate the actual impact of these approaches on health outcomes; this is partly due to the fact that the direct impact can be difficult to measure and attribute to specific workforce models alone. Therefore, patient outcomes resulting from the case studies have not been assessed in this project.

The case studies have been selected as examples only – other services may use workforce models involving Health Workers that are equally effective. Health services that feature in the case studies have given their approval to be identified to share their experiences with other Health Workers and health services.

To set the scene for a discussion of the different models of workforce deployment, an example of a patient journey is provided below. This illustrates the different ways in which a Health Worker might contribute to the broader continuum of patient care.

## 6.2 The continuum of patient care

Health Workers may feature at numerous points throughout the patient journey, as demonstrated by the example below (Figure 8). The example is not a real case, but is a representation based on stories heard during the Community Mapping process. So the

example patient journey is illustrative only – it does not take into account all the roles performed by Health Workers.

Each step of the process is described in detail in Table 10.

Figure 8: Example – Health Worker contribution to the continuum of patient care

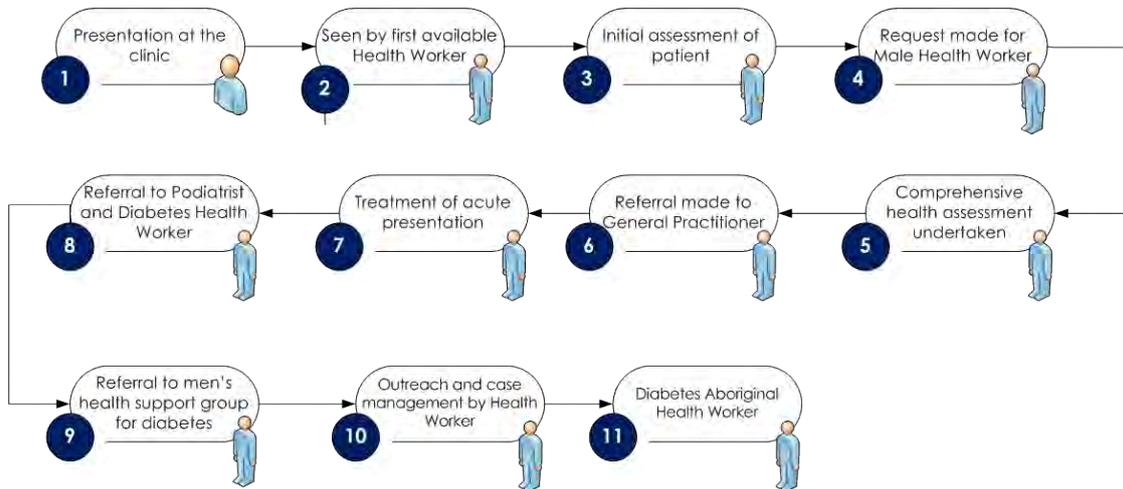


Table 10: Example – Health Worker contribution to the continuum of patient care

Activity	Description
1. Presentation at clinic	A 60-year-old Aboriginal man presents at the clinic complaining of sore feet. He is also has a diagnosis of non-insulin dependent diabetes (NIDDM) but has not been managing his condition appropriately.
2. Seen by the first available Health Worker (refer to Section 6.3 )	The clinic has a well developed Health Worker-first policy. Upon presentation at the clinic, the patient is seen by the first available Health Worker, who is female.
3. Initial assessment of patient	The Health Worker performs an initial assessment of the patient's condition to ensure that it does not require an emergency response. She completes a brief assessment of the patient and records his vital observations. The patient is febrile and has a red, swollen and painful foot. She triages him to the primary care clinic. Given her understanding of his culture, she offers the patient the option of consulting a male Health Worker to continue his care, which the patient happily accepts.
4. Request made for male Health Worker	A request is made for a male Health Worker to take over the care of this patient. Even though the patient has to wait a short while for the male Health Worker to be available, he states he is happy to wait as this Health Worker is from the patient's local community and has knowledge of the relational and cultural needs of the patient. The male Health Worker has completed a Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care.
5. Comprehensive health assessment	Once the male Health Worker is available, he meets with the patient and reviews the initial assessment made by his colleague. He then

Activity	Description
undertaken  (refer to Section 6.4 below)	<p>conducts a comprehensive health assessment with the patient, to address both his immediate acute presentation of sore feet and his underlying issues relating to diabetes. He tests the patient's blood sugar and takes blood and wound swabs to be sent away for pathology testing. The patient's blood sugar is 15.7, when the normal range should be between 4 to 6.</p> <p>During this assessment, the Health Worker assesses that the reason for the sore feet is ulcers as a result of the patient's diabetic condition. While talking to the patient, he also discovers that the patient:</p> <ul style="list-style-type: none"> <li>➤ is not eating healthily</li> <li>➤ is drinking and smoking heavily</li> <li>➤ has recently lost his job.</li> </ul> <p>All of these factors have had an impact on the patient's relationship with his family, which is now strained. In summary, the Health Worker notes that the patient does not appear to be coping, is presenting as quite depressed as a result of his job situation, and consequently is not managing his diabetes well.</p>
6. Referral to General Practitioner	<p>The Health Worker notes all of this in the patient's case file, but in the first instance refers the patient to the General Practitioner to treat his foot ulcers.</p> <p>The GP makes an assessment and recommends appropriate treatment, as follows:</p> <ul style="list-style-type: none"> <li>➤ requests that the Health Worker dress the patient's ulcers</li> <li>➤ prescribes oral antibiotics</li> <li>➤ suggests that a podiatrist may be able to help the patient to prevent a further occurrence</li> <li>➤ suggests a referral to the Aboriginal Health Worker who is a diabetic consultant at the local hospital and an expert in wound management and hyperbaric treatment of leg ulcers.</li> </ul>
7. Treatment of acute presentation  (refer to Section 6.8 below)	<p>The Health Worker administers the antibiotics and teaches the patient about the importance and method of taking the medication. Wound management of the patient's foot is completed and followed up by the Health Worker 3 days later to re-dress the wound. He liaises with the local podiatrist and arranges a consultation.</p>
8. Referral to Podiatrist and Diabetes Health Worker	<p>An appointment is made for the patient to consult with the podiatrist two days later. The Health Worker gives the podiatrist and the Diabetes Aboriginal Health Worker the results of the comprehensive assessment, with the patient's consent.</p>
9. Referral to men's health support group for diabetes  (refer to Section 6.7 below)	<p>Before concluding the patient's visit, the Health Worker encourages the patient to attend a men's health support group on a weekly basis. The Health Worker explains that this group includes many other men from the community who have similar conditions. As part of the management plan, the Health Worker :</p>

Activity	Description
	<ul style="list-style-type: none"> <li>➤ develops a plan for the patient’s daily routine, including recommended alcohol intake</li> <li>➤ provides guidance on healthy eating plans and exercise</li> <li>➤ makes an appointment for the patient to see him again to address some of the social and emotional wellbeing aspects of his condition</li> <li>➤ provides guidance on services that could help the patient in his job-seeking activities.</li> </ul>
<p>10. Outreach and case management by Health Worker (refer to Section 6.6 below)</p>	<p>Three days later the Health Worker visits the patient in his home to attend to his dressing and assess his home environment. The Health Worker notices empty fast-food containers and no fridge. On a weekly basis, the Health Worker follows up with the patient and encourages him to attend the men’s health support group, which the patient agrees to do. With the patient’s consent the Health Worker updates the comprehensive care plan and liaises with the men’s health group. The clinic arranges to take the patient to the group.</p>
<p>11. Diabetes Aboriginal Health Worker (refer to Section 6.8 below)</p>	<p>The clinic transport officer takes the patient to the diabetes clinic at the local tertiary hospital. The Diabetes Aboriginal Health Worker in this acute setting conducts a review in collaboration with an endocrinologist. The Diabetes Aboriginal Health Worker then facilitates hyperbaric wound management treating and adjustment of medication. The diabetic Aboriginal Health Worker provides support and education during the treatment process and liaises with the clinic Health Worker to provide specialist input to the care plan.</p>

The following sections describe specific aspects of the models involving Health Workers who feature throughout the patient journey.

### 6.3 Health Worker-first models

Health Worker-first models are practised by many health services throughout Australia. This approach involves appointing Health Workers as the first points of contact and triage for all patients entering the health service. Following initial assessment and triage, Health Workers refer patients to other health professionals (eg doctors, Allied Health professionals) who are then responsible for managing specific health needs, while Health Workers maintain their role as the primary point of contact for the client.

At one of the health manager focus groups, when asked which models of care are most effective for Aboriginal and Torres Strait Islander people, one participant stated:

“Aboriginal people looking after Aboriginal people – where the Health Worker is the first point of contact and hence Aboriginal people feel comfortable accessing the Health Service. The philosophy of Health Workers is: ‘We will help you help yourself’.”  
(Health Worker manager)

The Health Worker-first approach was valued by participants in focus groups because it helps to ensure continuity of care throughout the broader patient journey. This means that Aboriginal and Torres Strait Islander clients are supported while navigating the complex health service environment.

Focus group respondents stated that having the same Health Worker consistently treating and supporting a patient throughout their experience helps to develop respect and trust from the community and builds rapport. This in turn was reported to increase access to health care services. The following comments collected via Community Mapping focus groups demonstrate support for this approach:

“Where Aboriginal people are part of treating their own people – this builds trust and engagement.”

(Health Worker)

“The best model is our model of Health Workers being the front line: they are the permanent staff and hence have the history and knowledge of the community needs as they are the community.”

(Health Worker)

## CASE STUDY 1: Health Worker-first model

### Description of the service

**Name of Service:** Wurli Wurlinjang Health Service

**Location of Service:** Katherine, Northern Territory

**Type of Service:** Aboriginal Community Controlled Health Organisation

### Key features of the service

Wurli Wurlinjang Health Service has operated for many years with a registered Health-Worker first model of care. Every patient presenting, regardless of cultural identity, is initially treated by an Health Worker. The clinic works in a multi-disciplinary context with medical and Allied Health staff present. Referrals to other health professionals are made by Aboriginal Health Workers after an initial consultation. Aboriginal Health Workers then follow the patients through their journey within the health service. Services offered at Wurli Wurlinjang include clinical service delivery (including emergencies) and program-based services such as sexual health, women's health, maternal and child health, and men's health.

### What is working well

The interface between Aboriginal Health Workers and other health professionals in the service is very strong, partly due to the registered Aboriginal Health Worker-first model in place. The board and management team ensure that all new staff are briefed, at the outset, on the importance and role of Aboriginal Health Workers in the service. This process is supported by the clinic coordinator, who is an experienced Aboriginal Health Worker. The clinic coordinator has established a strong succession plan so that, during times of leave or absence, Senior Aboriginal Health Workers act in the role of the clinic coordinator. In turn, less experienced Aboriginal Health Workers act in more senior roles. The management team believes that:

*"... the present system of a Health Worker focused system is the best way of meeting the needs of the community".*

Wurli Wurlinjang has an on-site training delivery program, with staff dedicated to help with on-the-job training. When Aboriginal Health Workers return from block education sessions away from the community, they are supported in applying their newly acquired skills in their role. This less formal process engenders a two-way process of learning and skills exchange between Health Workers and other health professionals:

*"We learn a lot from the doctors and they learn a lot from us. We help the new registrars to learn how to deal with the Aboriginal community. Mostly we learn so much more on the job than we can ever learn in the classroom".*

### Challenges

A shortage of qualified Aboriginal Health Workers presents a significant challenge for Wurli Wurlinjang. Despite strong retention, credited to the Aboriginal Health Worker-focused workforce model, there is a shortage of Aboriginal Health Workers to fill advertised positions. This is discussed further in Section 9.3.

## 6.4 Comprehensive primary health care models

Comprehensive primary health care is defined as:

*"...the broader, holistic approach to health problems. As well as primary medical care, comprehensive primary health care addresses a range of health concerns that have no specific medical intervention."*

(Aboriginal Medical Services Alliance Northern Territory, 2010)

Although comprehensive primary health care models are not confined to the Aboriginal and Torres Strait Islander health sector, they are commonly adopted by ACCHOs. In this context, comprehensive primary health care has been described as 'Aboriginal and Torres Strait Islander primary health care'.<sup>27</sup> According to the definition endorsed by the NT Aboriginal Health Forum, 'Aboriginal primary health care services' refers to all services delivering health care in accordance with the holistic definition of health, and includes the following core services:

- clinical services
- social preventative programs
- primary health care support
- advocacy (Aboriginal Medical Services Alliance Northern Territory, 2010).

Health Workers are often integral to the delivery of comprehensive primary health care to Aboriginal and Torres Strait Islander clients, given the contribution they are able to make in each of the core services listed above. As Chapter 5 demonstrated, the existing national Health Worker scope of practice spans clinical activities, prevention and health promotion programs, roles supporting other health professionals, and advocating on behalf of clients.

Perceptions shared during focus groups suggest that Health Workers' holistic approach to health care should give them a central role in the provision of comprehensive primary health care. This is demonstrated in the comments below:

"I had Elders that wanted to talk about the trauma from the Stolen Generation, but they wouldn't fit into the mainstream box of mental health services. They needed to be able to talk to me and look at the holistic view of their health care – total physical, emotional, mental wellbeing. As an Indigenous Health Worker, we know that. We identify and work within ourselves to address that, but mainstream health services don't support us to provide holistic care. They tell me I'm not a counsellor; I'm not there to do that. But it is an inevitable part of our role."

(Health Worker)

"Health Workers work from a more holistic point of view. They see the person as a whole not just a disease process."

(Health Worker manager)

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<sup>27</sup> See Section 1.3.1 for the definition of holistic health, and Section 1.3.3 for more information on Aboriginal and Torres Strait Islander Primary Health Care.

“Today there is not one specific health problem that stands out. In a holistic health manner one should and does not stand out. I get tired when people talk about specific health problems as all health problems and needs in our community is a concern.”

(Health Worker)

Comprehensive primary health care models were being used at most of the ACCHOs that participated in the Community Mapping process, and also at some government-run health services. This widespread adoption suggests the comprehensive primary health care approach is an effective way of using Health Workers to influence health outcomes for Aboriginal and Torres Strait Islander clients. Qualitative data collected throughout the project has supported this claim.

However, it is difficult to measure the actual impact of this approach on health outcomes, in comparison to alternative approaches. Relevant outcomes-based evidence has not been identified in this project. The absence of such data does not mean this approach does not deliver tangible outcomes; simply that there are limited mechanisms for collecting and sharing information at this stage.

## 6.5 Community-based workforce models

Community-based workforce models involve building on the Health Workers' local knowledge to adopt a community-centric approach to health care. Many Health Workers are from the target community of the health service that employs them, and so they have a good understanding of local health needs. This understanding extends beyond health status alone – it includes the social determinants of health in that community (such as environmental factors, availability of nutritional food, employment,, etc) and the specific cultural and relational context (for example, family relationships, sorry business, community politics). Adopting a holistic approach to health care requires community factors like these be considered and responded to by health services.

Some health services incorporate Health Workers' community knowledge more proactively than others, providing opportunities for Health Workers to share their insights with other health professionals and/or contribute to decision-making. Some Health Workers provide a leadership role by sitting on community health boards or local land/shire councils and advising on strategies to mitigate the social determinants of poor health in their community.

They offer a unique community-centric perspective for health services, which can only be provided by a person who belongs to that same community. This view is evident in the following comment made at a focus group with other health professionals:

“Health Workers are fundamental to our service delivery model ... A large portion of the Health Workers that work here are of the community – they have relationships and are able to communicate with the community members in a way that we cannot. They are vital in making sure that people come to the health service, stick to their care plans, etc. Also in feeding back to the service and telling us the community needs and how to respond to them. They are very much on the ground and operating and keeping the service alive.”

(Other health professional)

The community-based approach enables health services to be more responsive to local health needs, based on information provided by Health Workers. For example:

“Chronic disease is getting higher. Our younger ones have diabetes; it's getting more and more. We're addressing that. One program we have is about finding what we had to do for our mob, and we have someone from our community to help deliver that program. And now, most of the people on that program, their weight and sugar levels are coming down”.

(Health Worker)

## CASE STUDY 2: Community-based model

### Description of Service

**Name of Service:** Wuchopperen Health Service

**Location of Service:** Cairns, Queensland

**Type of Service:** Aboriginal Community Controlled Health Organisation

### Key features of the service

Wuchopperen offers health services and programs to Aboriginal and Torres Strait Islander people through a number of health clinics located throughout far north Queensland. It provides programs in the following areas: women's health; ante/post natal; child health; men's health; over 50s health; diabetic health; eye health; hearing health; cardiac rehabilitation; and sexual health. Additionally, Wuchopperen Social Health offers a range of services including counselling, family support and a cultural program.

Aboriginal and Torres Strait Islander Health Workers at Wuchopperen provide a holistic approach to health care which includes hands-on clinical work, prevention and health promotion, and community engagement. The Health workers are part of a multi-disciplinary team which includes doctors and nurses within the clinic as well as Allied Health professionals and other medical specialists.

### What is working well

Health Workers at Wuchopperen form part of a holistic, community-based approach to primary health care. They consider the social, emotional and physical wellbeing of their clients within the context of the clients' broader community. They build on local knowledge to design programs that are tailored to local health needs.

Their skills enable them to help communities develop healthier lifestyles and to diagnose and treat a range of common medical conditions. In addition, the Health Workers play an important role in providing the cultural safety and brokage role between the health service and the community. This allows the community to feel safe in approaching the health service and have comfort in the fact that they are being treated by their own people. At the same time, Health Workers assist other health professionals to understand the local community, its culture, its specific health needs, the social determinants contributing to poor health, relationships within the community and appropriate ways of interacting with clients.

### Challenges

Chronic disease and social and emotional wellbeing are just some of the challenges the health service is currently facing. Men's health is also a major concern, particularly as there are no specific men's health services or programs being offered despite a significant need.

Health promotion and prevention at the community level was also noted as an issue for a number of Health Workers. Most of them are based at the on-site clinic where they have a high workload, and therefore do not have much opportunity to go out into the community.

Workforce issues are another challenge, in terms of the recruitment of Aboriginal and Torres Strait Islander Health Workers as well as providing them with appropriate training and skills. Due to staff shortages, Health Workers are required to perform multiple duties ranging from clinical work to reception work and even client transportation to and from appointments.

## 6.6 Outreach models

The outreach model of care is based on the physical location of service delivery. While many health services offer their services within a clinic, a number offer them outside the clinic. Using Health Workers to perform such outreach activities facilitates service delivery in people's homes, in public spaces and in other locations outside the traditional clinic setting.

The general principle underpinning this model is to improve access to health services. Some Aboriginal and Torres Strait Islander clients do not feel comfortable in health service environments, and are hesitant to turn up to appointments. This can be exacerbated by some common perceptions reported to exist, such as the perceptions of some males that a clinic is a space for the women; or fears arising from common associations between death and traditional clinic or hospital settings. There are other barriers that can make health services less accessible for some clients, such as transport availability and cost. These access barriers are discussed further in Section 4.3.2.

To overcome these barriers, many Health Workers take health services to the clients, to environments in which they feel safe – like their own homes. This can increase the comfort level of many patients and encourage them to present to health services again. It can help to ensure that people who refuse to physically approach health services still receive the health care they need.

Many health services visited during the Community Mapping process use Health Workers in outreach service models.

## 6.7 Prevention and health promotion program-based models

Prevention and health promotion models focus on the primary health care core value of 'preventing the illness' compared to the acute model value of 'treating the illness'. Programs are set up with a long-term view that focuses on preventing illness and promoting wellness.

Almost all health services that took part in the Community Mapping activities recognised prevention and health promotion is a critical part of their everyday function. This was demonstrated by the support for prevention and health promotion programs referred to in Sections 5.4 and 5.7. These sections describe the perceived value of program-based activities, and the opportunity for Health Workers to contribute to these programs.

However, as noted in Section 5.7, Health Workers have reported they are often removed from prevention and health promotion programs to work in the clinic because of limited funds and availability of other health professionals. For example:

"We used to do a lot of programs, and you would work on whatever you were specialised in, like the women do the women's business and the men would do the men's programs, camps and sexual health and all that. There is not enough staff now so they just put us back in the clinic".

(Health Worker)

This raises the important question of how to best use the Health Worker workforce – is their impact on health outcomes likely to be greater if they are responding to existing health problems, or preventing future health problems? This question is also currently

being grappled with in the mainstream health environment, as Australia moves towards a more prevention-focused approach to health care.

The case studies below provide two innovative examples of prevention and health promotion programs identified during Community Mapping exercises. They demonstrate the value of programs designed and/or delivered by Health Workers for their communities. There are many different kinds of programs targeting different diseases; these two case studies are examples that have been reported to be effective in their specific setting.

## CASE STUDY 3: Program-based model

### Description of the service

**Name of Service:** Aboriginal and Torres Strait Islander Community Health Service Mackay

**Location of Service:** Mackay, Queensland

**Type of Service:** Aboriginal Community Controlled Health Organisation

### Key features of the service

The Aboriginal and Torres Strait Islander Community Health Service Mackay (ATSICHS Mackay) is an Aboriginal Community Controlled Health centre located in North Queensland. They provide services to the local Aboriginal, Torres Strait Islander and South Sea Islander communities in Mackay, Sarina, Bowen, Proserpine and Clermont.

ATSICHS Mackay provides comprehensive primary health care, including clinical services, allied health services, health education and promotion programs, and social health services. Clinical services are provided by a multi-disciplinary team of Aboriginal and Torres Strait Islander Health Workers, Registered Nurses, GPs and other medical specialists. The service features a flat organisational structure and a "Health-Worker first" approach that is respected by all health professionals employed at the service.

### What is working well

This case study aims to highlight an effective chronic disease program being implemented at ATSICHS Mackay- the Which Way One Way Healthy Way (WWOW) program. The WWOW framework was based on the personal journey of an experienced Health Worker, Uncle Poi Pensio, and further modified by management and staff at ATSICHS Mackay. Uncle Poi has conducted similar programs have also been implemented throughout the Torres Strait Islands.

The WWOW program provides a framework for the culturally appropriate management, intervention and prevention of chronic diseases. WWOW uses a holistic approach that focuses on three key areas:

1. the body (e.g. physical risk factors, symptoms, or illness; clinical activities)
2. the mind (e.g. social and emotional wellbeing; environmental factors)
3. the spirit (e.g. religious beliefs; cultural beliefs; spiritual beliefs).

The program is grounded in a family-based philosophy that considers each person within the context of his/her family and community. Each family is enrolled in the program for an eighteen month period.

The first six-month period involves assessing and diagnosing the family in each of the three areas above, developing an educational plan which is tailored to the specific needs of that family. This educational plan is designed to help the family understand lifestyle choices that increase the risks of chronic disease, and learn about the physiological causes and consequences of chronic disease.

The second six-month period involves delivering the education plan and, as the family's awareness of chronic disease increases, supporting the family to develop a family care plan for clinical health and wellbeing (well-being relates to six key areas: physical, spiritual, environmental, mental, cultural, economic, and family). This includes the development of an action plan for changing relevant lifestyle habits

and behaviours.

The third six-month period involves supporting the family to implement their action plan and overcome the challenges associated with changing their lifestyle habits.

Health Workers are fundamental to the delivery of the WWOW program. They are supported by a multi-disciplinary team that includes GPs, nurses, Allied Health professionals, counsellors, dieticians, community Elders and spiritual/religious leaders.

ATSICHS has reported that the WWOW program achieves sustainable outcomes for the families that are enrolled, with many families changing their lifestyles to reduce the risk of chronic disease, or receiving timely and appropriate treatment for chronic disease as required. Data is collected to demonstrate improvements in the health of those enrolled – including both the clinical indicators and emotional wellbeing outcomes (measured using the Warwick Edinburgh Mental Well-being Scale (WEMWBS)).

According to both management and Health Workers at ATSICHS Mackay, the success of the WWOW program is directly related to the fact that ATSICHS Mackay cultivates an enabling workplace environment for Health Workers. The service's approach to recruitment and retention is of particular relevance. Health Workers are recruited through a two-year traineeship, with clearly defined educational milestones and timeframes established before they commence the role. This provides a platform for their career development. The recruitment of any Health Worker is therefore conditional on a two-way commitment between management and the Health Worker to his/her education and career pathway.

Furthermore, ATSICHS Mackay adopts a Health Worker-first model that all health professionals employed by the service must understand and respect as a condition of employment. ATSICHS Mackay report that they implement a "reverse-training model" in which Health Workers train other health professionals how to provide health care in communities, using their community knowledge and health knowledge obtained through Aboriginal and Torres Strait Islander Primary Health Care qualifications. While Health Workers learn from other health professionals in the clinic, other health professionals learn from Health Workers in the community. This is an integral and accepted part of the ATSICHS Mackay work environment.

Both management and Health Workers at ATSICHS Mackay emphasise that the WWOW program would not be successful without the recruitment, retention and employment strategies described above. They believe that the capacity for Health Workers to influence health outcomes via programs is clearly linked to the empowerment of Health Workers in the workplace.

### Challenges

One of the key challenges that the health service is currently facing is an increasing number of clients presenting to the service with chronic diseases such as diabetes, high blood pressure, hypertension and obesity. These new clients have an impact on existing resources and create demand for the expansion of programs like WWOW. However, there are limited resources available to do this (eg funding for Health Workers to coordinate programs and program costs). There are also challenges recruiting male Health Workers, who are required to address demand for the provision of more men's health services and programs.

## CASE STUDY 4: Program-based model

### Description of the service

**Name of Service:** Coomealla Health Aboriginal Corporation

**Location of Service:** Dareton, New South Wales

**Type of Service:** Aboriginal Community Controlled Health Organisation

### Key features of the service

Coomealla Health Aboriginal Corporation (CHAC) delivers a wide range of health-related services to the Greater Sunraysia area of NSW and Victoria. Those services include clinical services, health promotion activities, and health programs in nutrition, diabetes, immunisation, substance abuse, men's health, women's health, hearing health and sexual health. CHAC had 22 staff at the time of the focus group in 2010 (16 full-time equivalent positions). CHAC uses a Health Worker-first model – all clients, including non-Aboriginal and Torres Strait Islander clients, are triaged by a Health Worker before seeing other health professionals.

### What is working well

CHAC takes an innovative approach to encouraging child and adult health checks. The health check program involves using a portion of the Medicare rebates the service receives for Aboriginal and Torres Strait Islander health checks and investing it in toys and gifts for 'the Magic Toy Room'. Children and adults are invited to choose a toy or gift from the Magic Toy Room when they have their regular health check-up each year. Many of the prizes for adults also serve a dual purpose – they not only encourage health checks, but also promote healthy lifestyles. For example, food steamers and slow cookers promote healthy eating habits. CHAC also runs child health check days every school holidays, featuring barbeques, jumping castles and the Magic Toy Room, in an effort to increase chronic disease prevention.

This approach provides an incentive for children and adults to be more proactive in booking health checks and turning up for appointments. CHAC recognises that, by targeting children through the Magic Toy Room, they are also harnessing the children's ability to influence their parents to have health checks as well.

The impact of this program on the local community was summarised by one Health Worker during the Community Mapping process:

*"We have queues out the street. We had two kids come in last week who knew that their nine months were up [since the last check-up] so they convinced their mothers to bring them up here. So we have no trouble bringing clients in, we just have to make sure the doctor is there to treat them.*

*The thing you have to understand is that Aboriginal kids run their own life. The parent has no chance in hell trying to get their kids to come in. But if we make the kids want to come in, then they do. Even if the parent is sitting there waiting, bored and wanting to go home, they have no chance in hell leaving until the kid has their toy. The Magic Toy Room works."*

The program resulted in substantially increased numbers of adult and child health checks at CHAC. More health checks have also led to increased treatment and management of illnesses which were identified during the health checks. For example, according to the CEO of CHAC, "four years ago we had 22 diabetic clients; we've now got 93."

The success of the health checks program has also been recognised through the

NSW Health Aboriginal Health Awards in both 2009 and 2010. Most recently, CHAC won the 2010 *Excellence in Program and Service Delivery Award* for "Checking the Mob: Extending the Health Check Program".

### Challenges

Some of the main challenges identified by CHAC staff related to the social determinants of health, particularly those that contribute to chronic diseases. For example, staff referred to hygiene and nutrition issues, substance abuse and a lack of personal responsibility/ownership of health, as some of the key challenges in the community.

## 6.8 Health Worker models used in acute health care settings

While the majority of Health Workers work in a primary health care environment, some work in an acute care setting. These Health Workers demonstrate that Health Workers are employed at all stages of the patient journey, across different levels of health care.

However, workforce models involving Health Workers in a primary health care environment are not necessarily appropriate in an acute care setting. Although Health Workers employed in an acute care setting often report using primary health care skills, the way in which they contribute to the acute health service and its team is adapted in order to be contextually appropriate. It is therefore important to recognise that different models of Health Worker workforce deployment can be more or less appropriate in a given setting.

As yet, there does not appear to be evidence demonstrating the impact of Health Workers in an acute care environment. Despite this, the Community Mapping focus groups that were conducted in acute care health services emphasised the value of Health Workers in this setting. This was reiterated in key informant interviews.

The following case studies demonstrate two different ways in which Health Workers contribute to acute care health services.

### CASE STUDY 5: Health Worker models in an acute care setting

#### Description of service

**Name of Service:** Aboriginal Maternal and Infant Care Workers, Port Augusta Hospital

**Location of Service:** Port Augusta, South Australia

**Type of Service:** Government Health Service

#### Key features of the service

Port Augusta Hospital began using Health Workers in acute care as part of the development of its Maternal and Infant Care service. This initiative formed part of a project that was developed and trialled across Whyalla and Port Augusta Hospitals in collaboration with local ACCHOs and Divisions of GPs. The model is now being used in other areas of South Australia, including large acute hospitals in metropolitan areas.

Over the past eight years, the Aboriginal Maternal and Infant Care (AMIC) workers at Port Augusta Hospital have come to be seen as a distinct group of health professionals in their own right, with their speciality being the provision of culturally safe care and health services. AMIC workers work in collaboration with midwives in both the community and the acute care setting to facilitate continuity of care when a mother

presents to hospital.

#### What is working well

The aim of the project is to make the hospital a centre of excellence for Aboriginal people. The AMIC workers are part of making that vision a reality for women accessing maternal and infant services. Like all the health professionals working in maternity care, each patient is given time with the Health Workers to ensure their hospitalisation is not just of high medical quality but culturally safe and relevant. For example, expecting mothers once seen by the midwife, now have more time with the Health Workers, who walk them through the hospital journey using verbal and non-verbal language.

The AMIC program began as a pilot program nearly seven years ago. Given its success, it was rolled out across the region in 2010. The AMIC workers are incorporated into the broader hospital workforce and are treated like every other employee (for example, they are expected to attend mandatory training). On a daily basis, the AMIC workers work in close collaboration with midwives on the wards as well as Allied Health staff.

#### Challenges

Recruitment and retention issues are a major challenge for the hospital. It was stated during the interviews that there are barriers hindering Aboriginal and Torres Strait Islander people from entering the Health Worker workforce, limiting the workforce supply.

For example, in South Australia there is only one Registered Training Organisation. Due to funding limitations, there is not a sufficient number of training positions available to meet demand from people who wish to become Health Workers, or existing Health Workers hoping to further their education. Cultural and family commitments also serve as a barrier to education.

Another factor affecting retention is the contractual nature of the role. Health Workers are often employed on short-term contracts, which are contingent on recurrent funding. These contracts do not provide job security, which obviously has an impact on recruitment and retention.

## CASE STUDY 6: Health Worker models in an acute care setting

### Description of service

**Name of Service:** Royal Darwin Hospital

**Location of Service:** Darwin, Northern Territory

**Type of Service:** Government Health Facility

### Key features of the service

Royal Darwin Hospital has two Health Workers, one of whom has the role of 'cultural broker' in the diabetes service. This Health Worker conducts diabetes education both within the acute care hospital setting and in remote clinics. She has also been trained in hyperbaric therapy to provide the cultural link between treatment and the community. This role is a critical part of the total diabetes service.

### What is working well

As a valued member of the team, the Health Worker is seen as a specialist in her own right, adding to the value of the total service. The medical specialists in the service believe the Health Worker role – of education and cultural broker – is invaluable and they often defer to her for advice.

The Royal Darwin Hospital is an example of the way Health Workers can make an impact in an acute care health setting using primary health care training. This example demonstrates that Health Workers are not limited to working only in primary health care clinics but also within any service where Aboriginal and Torres Strait Islander people seek care. Essentially, this demonstrates the importance of cultural understanding and supportive multi-disciplinary teams, regardless of the context.

### Challenges

The recognition of skills and ability is a challenge faced by the Health Worker. While she is a valued member of the team, she is not recognised externally as a diabetes educator. The Australian Diabetic Association (ADA) does not recognise Health Workers as official diabetes educators. There are currently five professions that can be credentialled: doctors, dietitians, registered nurses, pharmacists and podiatrists. A credentialled Diabetes Educator can claim an MBS item for a group session.

The Health Worker has a passion for diabetes education and has self-funded all her education. To function at the specialist level, she had to add to her Certificate IV qualification and undertake an additional course – a Graduate Certificate in Health (Diabetes Management and Education). Financial barriers had to be overcome in order to obtain this extra qualification. However, despite her commitment, her experience and skills continue to go unrecognised by professional associations.

## 7. Health Worker education and career pathways

### Key points

The sustainability of any workforce depends on the strength of the education and career pathways underpinning it. The stories told by Health Workers, managers and other health professionals around the country suggest that in order to establish a true Health Worker profession these pathways must continue to be developed. As the workforce continues to mature, the following questions will arise:

- What type of qualification is appropriate to equip Health Workers with the necessary skills to meet the health and service needs of their communities?
- What level of qualification is appropriate as a minimum requirement to ensure quality of care?
- What barriers must be addressed to enable the Health Worker workforce to progress their education and career goals?

While work has been done on developing a qualification pathway for Health Workers, inconsistencies still exist across jurisdictions regarding the minimum qualification level. Participants in this project generally agreed that the ATSIPHC at a Certificate IV level is an appropriate skill level, since all Health Workers should have a base level of clinical knowledge regardless of whether their role involves clinical intervention activities.

The introduction of national registration for Health Practitioners in July 2012 will begin the process of 'segmenting' the Health Worker profession; an event which has occurred in most professions as they begin to mature (eg nursing).

A large proportion of Health Workers have high educational ambitions, yet a number of barriers to pursuing those continue to exist. In large part this is due not to inadequacies in qualifications structures, but rather to issues in education and training delivery. Anecdotal evidence suggests there are not always enough course positions available in the right locations to meet regional demands. A lack of critical mass of enrolments is one of the barriers that prevent education providers from delivering courses in rural areas. Courses that are available are not always tailored to the educational needs of Health Workers. In addition, limited access to required funding, leave, and family support can hinder educational goals.

Some of the Health Worker participants expressed a desire to move into other health professions, but have found that the opportunities to do so are mixed. For example, they are not given recognition for their existing skills or current competence, which makes it difficult to pursue additional education. This is often a deterrent to moving into other professions.

## 7.1 Context

As the Health Worker workforce continues to mature as a profession it is important to consider the education needs of the workforce as well the existing career pathways. This is important because the current career pathway of a Health Worker, although varied across jurisdictions, is heavily dependent on the qualifications framework. This section will address these issues while also discussing:

- the education and career pathways available to Health Workers including qualification types and levels held by survey participants
- what these pathways ought to look like; drawing upon perceptions collected via focus groups with Health Workers, managers and other health professionals
- the roadblocks standing in the way of education and career advancement for Health Workers – barriers that need to be overcome
- the opportunities to move into other professions and the barriers currently existing for Health Workers who seek to do so.

## 7.2 Existing education and career pathways

Significant effort has been invested in strengthening the education and career pathways available to Health Workers across Australia.<sup>28</sup> These efforts culminated in the development of the first nationally consistent, cross-sector Health Worker qualifications framework which was released by the Community Services & Health Industry Skills Council (CS&HISC) in 2008.

This laid the foundation for a nationally consistent approach to the ongoing development of training courses and career structures in each jurisdiction. For example, the Aboriginal and Torres Strait Islander Primary Health Care (ATSIPHC) qualification was established as a result of the framework. In Queensland, the development of the framework was used as the basis of the Aboriginal and Torres Strait Islander Health Worker Career Structure in 2007 (Queensland Health, 2007a).

This section discusses the education profile of the Health Workers who took part in the survey and provides a snapshot of the courses currently available.

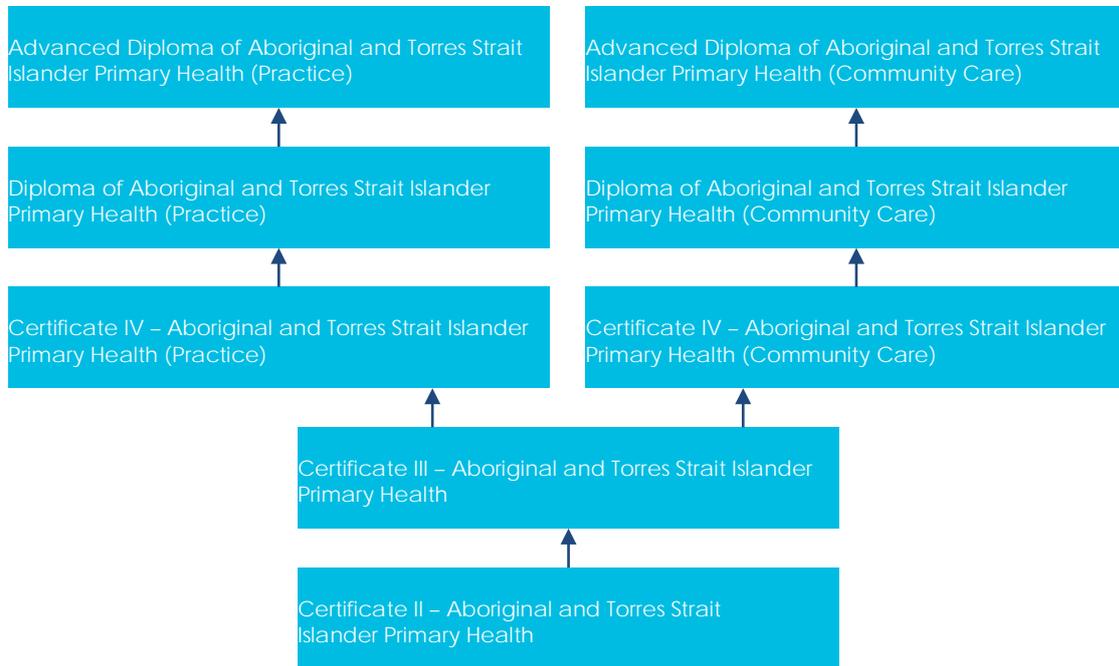
### 7.2.1 The national Health Worker qualifications framework

The qualifications framework (Figure 9) was created to guide Health Worker education and career pathways.

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<sup>28</sup> See the Environmental Scan (Chapter 10)

Figure 9: CS&HISC Health Worker qualifications framework



(Community Services & Health Industry Skills Council, 2008)

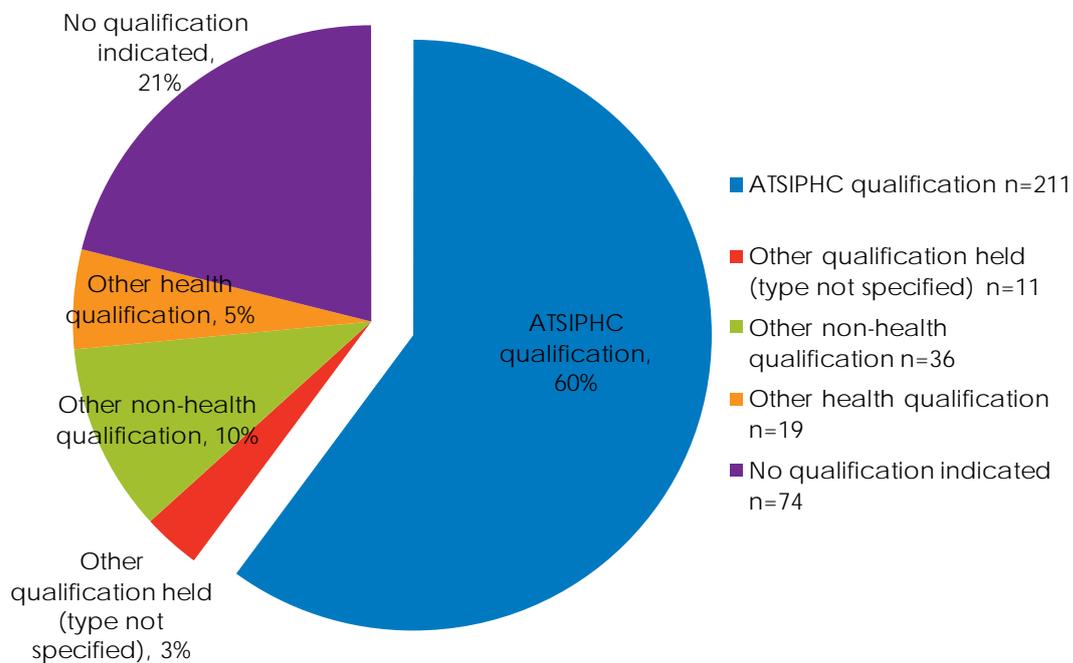
As Figure 9 shows, there is one curriculum at the Certificate II and Certificate III level. At the Certificate IV level, Health Workers may choose from two pathways: the community care stream or the clinical practice stream.

The reason for the two streams, as revealed in interviews with key informants, was to recognise the national variation in clinical roles and ensure that Health Workers who performed more complex clinical tasks would have appropriate training and competencies. So clinical practice stream standards have a stronger focus on clinical roles and competence and the community care stream standards focus more on community health promotion aspects of service delivery.

### 7.2.2 Current qualification profile of the workforce

The Health Worker survey asked participants a series of questions about the types of qualification they currently held. The types of qualifications held by survey participants are represented in Figure 10 below.

Figure 10: Current qualification types held by Health Worker survey participants



Of the 351 Health Worker survey participants:

- 60% currently hold an ATSI PHC qualification (n=211)
- 5% hold another type of health qualification (eg qualifications in Nursing, Social Work, and Mental Health) (n=19)
- 10% hold a qualification that is not health related (examples of other qualifications specified are plumbing, management, and hairdressing) (n=36)
- 21% did not indicate that they have any form of qualification (n=74).

The responses of the 211 (60%) Health Workers who reported having an ATSI PHC qualification were further analysed to determine the level of ATSI PHC qualification, focusing on the highest level of achievement. The results showed that:

- 20% of the total respondents have ATSI PHC Certificate III as their highest qualification (n=72)
- 23% of the total respondents have ATSI PHC Certificate IV as their highest qualification (n=81)
- 17% of the total respondents have the ATSI PHC Diploma or Advanced Diploma as their highest qualification (n=58).
- Note: this does not specify which stream the respondent has studied.

Survey responses were assessed by jurisdiction and area of remoteness. The results are displayed in Figure 11 (variation by jurisdiction), Figure 12 (variation by jurisdiction – Certificate IV level and above) and Figure 13 (variation by area of remoteness). Additional data on jurisdictional differences can be found in Appendix F.

Figure 11: Variation of current ATSIHC qualifications – by jurisdiction

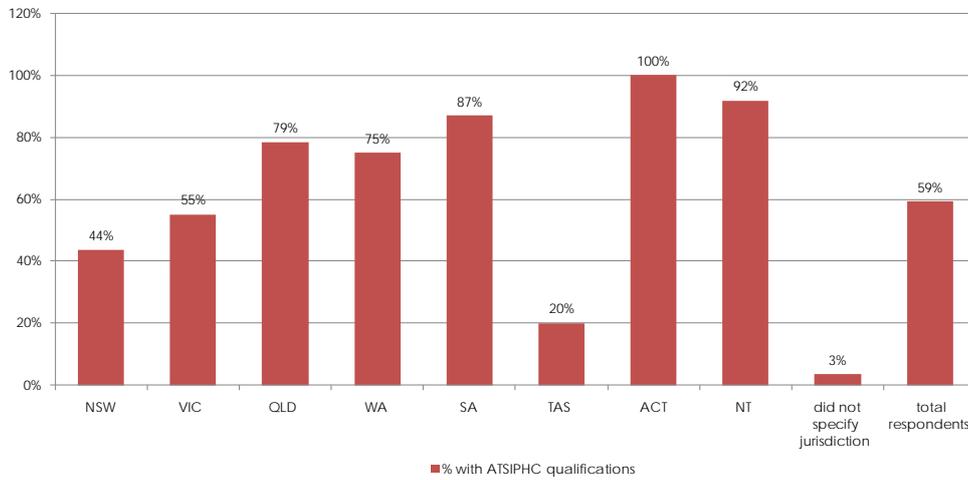


Figure 12: Variation of current ATSIHC qualifications – by jurisdiction – Certificate IV level and above

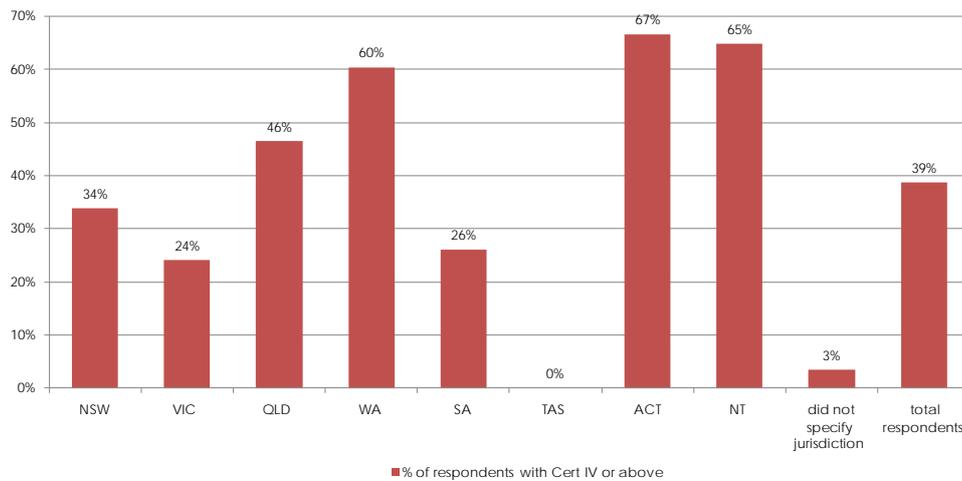
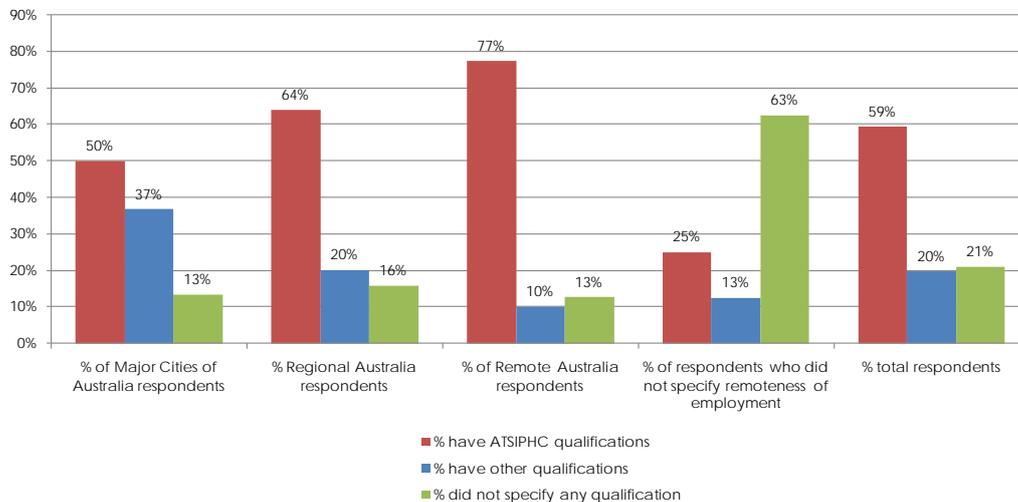


Figure 13: Variation of current ATSIPHC qualifications – by remoteness



Several key findings are revealed in these figures:

- a significantly higher proportion of respondents from the Northern Territory have ATSIPHC qualifications: 92%, with much lower numbers in other jurisdictions (eg 45% in NSW). This can be at least partially attributed to the Northern Territory being the only jurisdiction that regulates the workforce, with strict minimum qualification requirements for employment and registration
- Northern Territory survey participants also have higher levels of educational achievement than in other jurisdictions. 65% have ATSIPHC qualifications at Certificate IV or above; other jurisdictions have much lower proportions (eg 24% of Victorian participants)
- the more remote the location, the more likely the Health Worker is to have an ATSIPHC qualification.

### 7.2.3 Available educational opportunities

Health Workers can only obtain the ATSIPHC qualification if they can access educational opportunities. This section provides an overview of the courses available and their distribution.

#### VET sector educational opportunities

Most ATSIPHC courses are provided by the Vocational Education Sector (VET). The majority of VET training occurs within Aboriginal and Torres Strait Islander Community Controlled Registered Training Organisations (RTOs), with a small selection of states and territories supporting or considering training through general VET sector providers.

According to the CS&HISC website, there are currently 33 RTOs providing training to the sector (Community Services & Health Industry Skills Council, 2010). Of these, 15 are Aboriginal Community Controlled Sector organisations and form part of the Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network.

The CS&HISC publishes information on the courses within the scope of each RTO (Community Services & Health Industry Skills Council, 2010). This does not necessarily mean the courses are definitely available to Health Workers; it means that the training

organisation is registered to deliver the course if it chooses to offer it in a given academic year.

Examination of the courses available found: <sup>29</sup>

- The majority of RTO's provided training for Certificate III and IV level only, however only 11 RTO's offer higher qualifications for Health Workers and only 2 RTO's offer Advanced Diplomas, these are located in Queensland and Western Australia.
- NSW has the highest number of RTO's (10)
- In Victoria there are no RTO's offering Health Worker courses at a level higher than Certificate IV
- In Tasmania there is only 1 RTO offering courses for Health Workers, the highest level of qualification is Certificate IV

This demonstrates that the distribution of RTO's nationally is not consistent and there are limited opportunities available for advanced Health Worker education. This was one of the key issues raised by Health Workers during the survey and focus groups, as a significant barrier to continuing education.

#### Current VET ATSIPHC qualification student numbers.

The numbers of students undertaking Aboriginal & Torres Strait Islander Primary Health Care qualifications in 2009 has been reported by the National Centre for Vocational Educational Research (NCVER), and are reported in in Table 11. When interpreting this data, it is important to keep the following points in mind:

- The relatively short time since the introduction of these qualifications in 2007; this is particularly relevant when comparing 2008 and 2009 data as completion numbers are likely to be lower in 2008.
- Completion rates cannot be derived by comparing the number of students who complete with the numbers studying, for example; many courses require more than one year to complete and some students defer courses to complete at a later date. Consequently there is presently not enough data to calculate valid completion rates.
- Students who undertake the qualification do not necessarily become Health Workers or even aim to be a Health Worker, the courses may be undertaken by students who wish to pursue a range of careers.
- Students who undertake the qualification are not necessarily new recruits into the health workforce, some may already be practicing as Health Workers, or other health professionals are undertaking further education concurrently.
- NCVER reports on publically funded training, such as places funded through state training or by the government. Therefore the data does not reflect places that are paid for directly by the employers such as ACCHO health providers who do not access public funds.
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<sup>29</sup> More information is provided in the Environmental Scan (Chapter 10)

Table 11: NCVET 2009 VET sector ATSIPHC qualification student numbers and completion numbers

VET Certificate/Jurisdiction	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total studying 2009	Total completion 2008
HLT21307 - Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care	41	-	-	-	-	-	24	-	65	1
HLT33207 - Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care	52	39	232	57	34	-	17	-	431	33
HLT43907 - Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)	11	-	19	23	27	-	65	-	145	49 (24 NSW & 25 WA)
HLT44007 - Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health (Community Care)	32	21	89	3	-	-	1	-	146	2
HLT52107 - Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)	-	-	-	-	7	-	-	-	7	4
HLT52207 - Diploma of Aboriginal and/or Torres Strait Islander Primary Health (Community Care)	-	-	31	-	-	-	-	-	31	0
HLT61307 - Advanced Diploma of Aboriginal and/or Torres Strait Islander Primary Health (Community Care)	-	-	1	-	-	-	-	-	1	0
<b>TOTAL</b>	<b>136</b>	<b>60</b>	<b>372</b>	<b>83</b>	<b>68</b>	<b>0</b>	<b>107</b>	<b>0</b>	<b>826</b>	<b>89</b>

Source: National Centre for Vocational Educational Research 2010. VET Provider Collection - data request.

- Table 11 shows that in 2009 there were 826 students undertaking the Aboriginal & Torres Strait Islander Primary Health Care (ATSIPHC) qualifications within the VET sector. The jurisdiction with the highest number of students was Queensland. Data was requested by NCVET in relation to the number of students who completed the ATSIPHC qualification in 2009, the total was 242 (National Centre for Vocational Educational Research, 2010). Although comparison of these two figures does not provide an accurate course completion rate, it is clear that the number of students, who completed their ATSIPHC qualification in 2009, was relatively low.



- Consequently during the Community Mapping focus groups, it was reported that there are limited positions available in the ATSIPHC courses, additionally some Health Workers reported having to wait up to 24 months to be accepted into a course, as a result of high demand.

### Tertiary educational opportunities

A small number of tertiary institutions provide higher education relating to the area of Aboriginal & Torres Strait Islander Health Worker practice. These courses are in addition to the Community Services and Health Industry Skills Council (CS&HISC). There is limited undergraduate courses focusing specifically on Aboriginal & Torres Strait Islander Health

- There are two undergraduate courses that specifically target Health Workers; the University of Wollongong, NSW (Stein and Gluck, 1995) and Curtin University, WA (Curtin University, 2010). Furthermore there is a major currently offered at the University of Queensland (University of Queensland, 2010).
- The course offered by the University of Queensland and Curtin University both emphasise the practical training components within the program and requires much of the course work to be completed in community clinics (University of Queensland, 2010 - Curtin University, 2010). These places are eligible for financial assistance from the Commonwealth and are made available for specifically for Aboriginal & Torres Strait Islander people (Curtin University, 2010).
- There is one course offered at Charles Sturt University, NSW which is specifically designed for Mental Health Workers; Bachelor in Health Science (Mental Health) degree (Charles Sturt University, 2010).

While many of the subjects offered in these courses may be undertaken by students of other related programs, it is important to note that a small number have been developed specifically to address the need for further and formal qualifications for Aboriginal Health Workers.

Beyond the courses specifically targeting Health Workers, there are a range of University courses that are relevant to the Health Worker workforce. However, there has not been any attempt as yet, to map the Health Worker qualifications to these courses in a systematic way to facilitate career pathways.

### 7.3 Observations on what these pathways should look like

As the workforce continues to mature, many stakeholders are questioning how these pathways could be strengthened, two significant questions which are fundamental to this are:

- What type of qualification is appropriate to equip Health Worker with the necessary skills to meet the health and service needs of their communities?
- What level of qualification is an appropriate minimum requirement to ensure quality of care?

#### 7.3.1

What type of qualification is appropriate?

The Health Worker scope of practice is broad and unique. Chapter 5 highlights common elements of the national scope of practice, including provision of culturally safe health care and prevention and promotion activities. Other key elements of the Health Worker scope of practice are prone to variation across the workforce, for example there is significant variation in the complexity of each Health Workers clinical role, and in their chosen areas of specific focus.

The continuing development of the Health Worker workforce involves assessing the type of education which will best enable Health Workers to fulfill their scope of practice as several themes emerged from interviews with key informants and focus groups with Health Workers, managers and other health professionals.

First: **promotional and cultural skills training**. There is a perception that Health Workers need to be sufficiently trained in the skills required to conduct prevention and health promotion activities and cultural safety roles effectively. According to some participants, prevention and health promotion training modules tend to focus on the content of the programs to be delivered. They do not necessarily equip Health Workers with the skills required to deliver program activities, such as public speaking, public awareness campaigns, and effective communication and presentation techniques. Some Health Workers reported that these activities were outside their comfort zone. Some also stated that cultural competencies are just as important to the Health Worker role as clinical competencies. This is exemplified in the following comment:

“The most important thing about the Health Worker role is cultural brokerage. Having that understanding is a qualification in its own right. There is an assumption that just because you are Aboriginal or Torres Strait Islander then you will have that understanding and you can go into any community. I get annoyed when people are turned away because they don't have the piece of paper but they have cultural competency. You need local cultural competency not just generic cultural competency because you are Aboriginal and Torres Strait. Understanding of local community and valuing different types of knowledge is important – it can't be measured or put on a piece of paper but it needs to be recognised and valued. Not limited to the piece of paper qualification.”

(Health Worker)

Second: **clinical knowledge**. Some key informants and focus group participants observed Health Workers require a base level of clinical knowledge, regardless of the amount of clinical assessment or intervention work each Health Worker actually undertakes as part of their everyday role. Clinical knowledge better equips Health Workers to perform prevention and health promotion activities effectively.

Third: **counselling skills**. Some Health Workers mentioned the need for more training in counselling skills, given social and emotional wellbeing is often a large part of the provision of holistic health care to Aboriginal and Torres Strait Islander clients.

"Sometimes we have to do things that are outside our scope of work and there is no one to refer to [so] mostly we don't. [For] example: [when] trying to take blood from a mental health patient [we] have to sit down and chat and make them feel comfortable [and use] soft skills like counselling. [For] social problems [we] refer them to other NGOs, agencies."

(Health Worker)

"The needs of mental health patients are making us need more training, like mental health first aid and more workshops on how to deal with mental health."

(Health Worker)

Some young mums are having relationship problems and want someone to talk to. So we have to do counselling that we haven't really been trained in. There's that stigma about going to mental health. And they want to talk to an Aboriginal person, in their own home. So we end up doing lots of counselling when we're out there.

(Health Worker)

Trainees have been put under pressure to help outside their role like [providing] social services [such as] social and emotional support.

(Health Worker manager)

### 7.3.1 What level of qualification is appropriate?

Currently, Certificate III in Aboriginal and Torres Strait Islander Primary Health Care is the minimum qualification requirement for employment as a Health Worker in the majority of states and territories, with the exception of the Northern Territory. As part of the Northern Territory registration process, the minimum qualification is a Certificate IV (Practice). However, the Northern Territory Registration Board has not excluded those with prior learning at Certificate III level (if completed through accredited Northern Territory providers) and has established supported programs to transition those Health Workers to the Certificate IV (Practice) level in order to achieve registration (Northern Territory Health Practitioners Act, 2004)

The Community Mapping focus groups explored the question of what the minimum requirement should be in future. Participants were asked what they believed the appropriate level of qualification would be to enable Health Workers to meet the needs of their communities. The majority of both Health Worker and manager focus groups supported a minimum standard of Certificate IV in the ATSIPHC qualification. This is demonstrated in the following comments:

"Certificate IV is quite sufficient. It covers a bit of everything. Any more and you'd be a nurse. Nurses we know think we learn more than they do. We gain a wealth of knowledge."

(Health Worker)

“For liaison roles Certificate III, for clinical roles they need Certificate IV”.  
(Health Worker manager)

In fact, some focus group participants believed an even higher qualification would be preferable. For example:

“Minimum of Cert IV, Diploma is best”.  
(Health Worker)

Certificate IV qualifications were considered necessary to enable Health Workers to work in more autonomous roles. For example:

“You can work at a Cert III, but those people need supervision – so why wouldn't you train a HW up to a Cert IV and have them able to work independently?”  
(Health Worker manager)

It was evident that there was broad support within focus groups for a Certificate IV qualification as a minimum requirement for the Health Worker role. As described in section 7.2.2 (and above) 23% of the survey respondents hold an ATSI PHC qualification at a Certificate IV level; and 17% hold the ATSI PHC qualification at a Diploma or Advanced Diploma level.

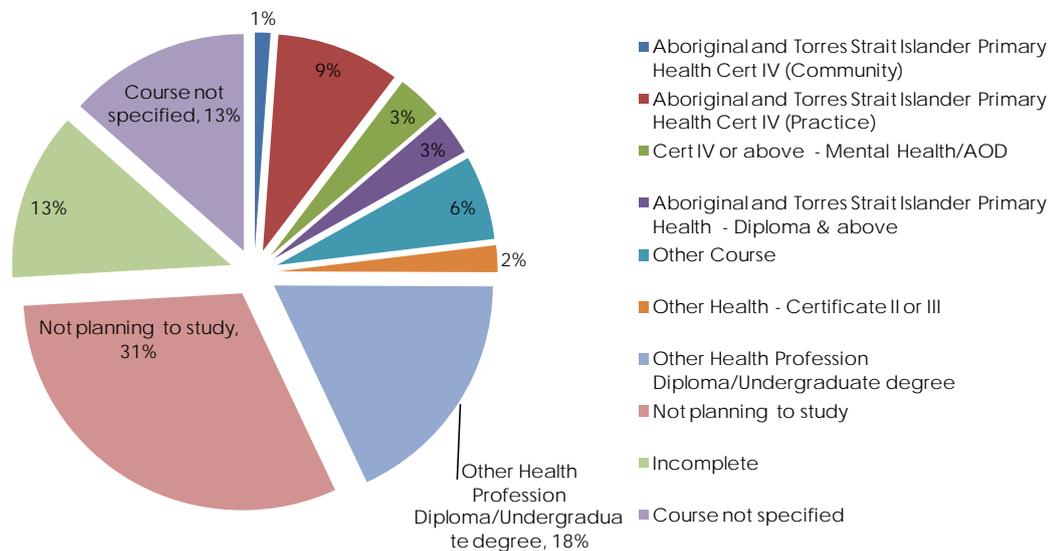
Using the survey sample group as an indicator of broader workforce trends, a large proportion of the workforce is yet to obtain a Certificate IV qualification or above. However, the survey also revealed that participants have high educational goals. These are presented below.

### **7.3.2 Educational goals: aspirations and projections**

#### **Educational aspirations of Health Worker survey participants**

The educational intentions of Health Workers in the next five years were assessed (presented in Figure 14). These data help to provide an evidence base for future projections of the educational profile of the workforce.

Figure 14: Intention to study in the next 5 years (n=351)



The results in figure 14 shows:

- approximately one-third of the respondents do not intend to undertake further study
- the intention to undertake further study varied between place of employment; 38% of ACCHO employed Health Workers and 51% of government employed Health Workers, who had already completed a primary health care certificate said they did not intend to undertake further study.
- 18% reported an intention to undertake a degree or diploma in another health professional stream; the majority of these were Enrolled Nursing followed by Registered Nursing, Social Work and Medicine
- of the 9% currently studying reported an intention to complete the Certificate IV in ATSI PHC (Practice) and 2% reported an intention to undertake a Certificate IV or above qualification in Alcohol and Other Drugs and/or Mental Health.

The profound aspirations of the many Health Workers responses were reflected by their responses within the focus groups. At almost all of the focus groups, Health Workers indicated they would like to pursue further training. Among the motivating factors described, there was a desire to improve their current skill-set, along with career progression. A small portion indicated a desire to move into more specialised areas.

“There is so much training I want to do! I want to do everything. I've had my calling later in life, I used to be a receptionist. But now I know this is the way I want to go.”  
(Health Worker)

When asked if Health Workers wanted improved access to further learning and development opportunities, the results were overwhelmingly positive, with a small portion of Health Workers indicating a desire to pursue undergraduate or postgraduate qualifications in medicine and nursing. These sentiments however, were accompanied by concerns about the lack of funding for training courses, as well as the lack of

organisational support for Health Workers to pursue training (barriers to education are discussed further in Section 7.4).

### Projecting the possible pool of Certificate IV trained Health Workers

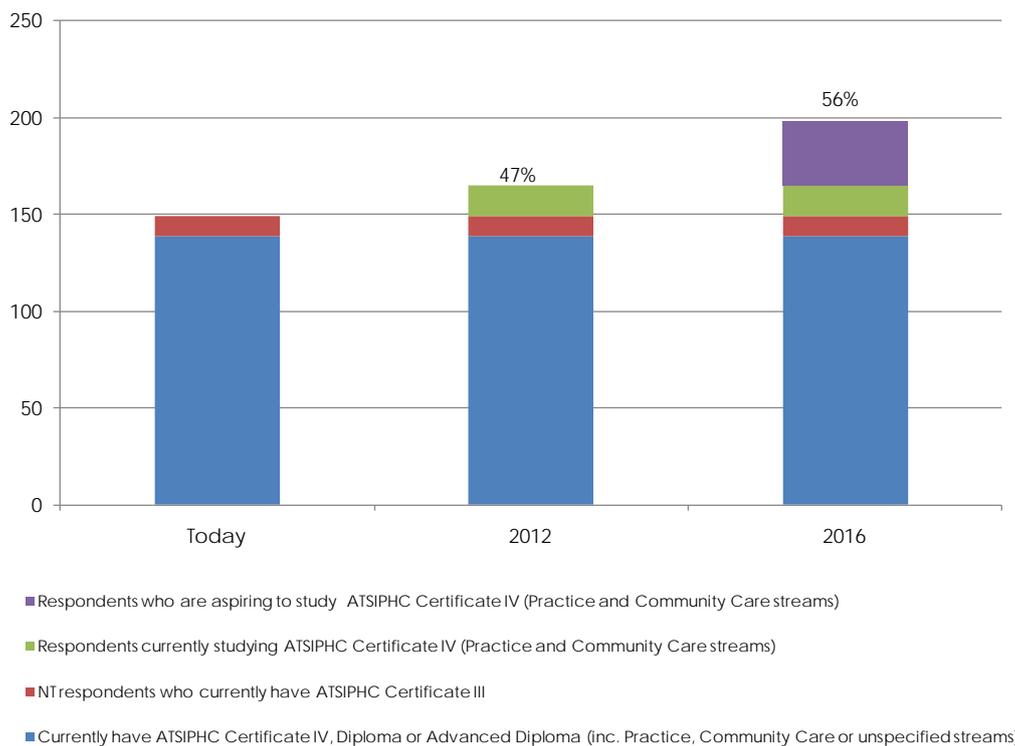
Collecting data on the educational aspirations of Health Workers enables some preliminary projections of the potential pool of Certificate IV trained Health Workers, if this were to be accepted as the minimum requirement.

The analysis used a combination of the Health Worker survey results for completed, currently studying or intending to study Certificate IV or above. Some caveats on these projected figures need to be noted:

- this analysis assumes that all Health Workers who reported currently studying and aspiring to study at this level will complete their education
- the analysis does not specify the Community or Practice streams and assumes that bridging mechanisms could be used, if required, to upskill Health Workers from one stream to another.

The results are presented in Figure 15.

Figure 15: Number of respondents with an ATSI/PHC Certificate IV qualification (or equivalent) – today, in 2012 and 2016 (n)



According to these projections: <sup>30</sup>

- today, 42% of survey respondents have the ATSIPHC Certificate IV qualification (including respondents from the Northern Territory who currently have ATSIPHC Certificate III)
- by 2012, it is likely that up to 47% of survey respondents may have an ATSIPHC qualification at the Certificate IV level (including respondents who currently have ATSIPHC Certificate IV level and above; respondents from the Northern Territory who currently have ATSIPHC Certificate III; and respondents who are currently studying ATSIPHC Certificate IV level)<sup>31</sup>
- by 2016, it is likely that up to 56% of survey respondents may have an ATSIPHC qualification at the Certificate IV level (including respondents who currently have ATSIPHC Certificate IV level and above; respondents from the Northern Territory who currently have ATSIPHC Certificate III; respondents who are currently studying ATSIPHC Certificate IV level; and respondents who are aspiring to study ATSIPHC Certificate IV level in the next five years)<sup>32</sup>.

Projections were also made at a jurisdictional level to understand variations across Australia. The jurisdictional comparison is shown in Figure 16. The red bar in the graphic indicates the total survey respondents from each jurisdiction. This has been included to give a sense of the respondents who have obtained/aspire to obtain the ATSIPHC Certificate IV qualification as a proportion of the total respondents from each jurisdiction. These proportions are also presented in Table 12.

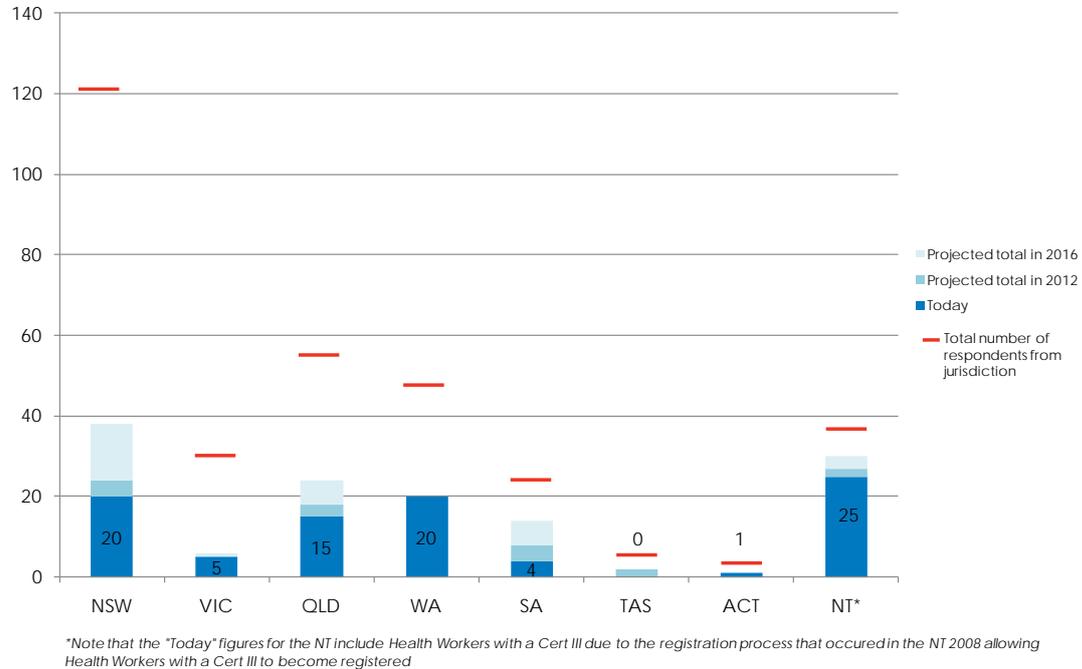
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<sup>30</sup> Projections are based on the assumption that courses currently being studied, or planned in the next five years will be completed.

<sup>31</sup> Respondents who are currently studying or intending to study ATSIPHC Diploma and Advanced Diplomas have not been included in this analysis as there is a risk that this will over-represent the total pool due to potential double-counting. Respondents who indicated that they were "currently studying" at the Certificate IV level but had already obtained a Certificate IV or above qualification were also excluded to avoid double-counting.

<sup>32</sup> See preceding footnote.

Figure 16: Respondents from each jurisdiction who hold ATSIPHC qualification at the Cert IV level – current and projected totals\*



\*Note: this graph focuses on the ATSIPHC Certificate IV level only. Respondents who specified that their highest qualification was the ATSIPHC Diploma/Advanced Diploma level have been excluded from this graph to avoid double-counting in projected figures. However, some of these respondents who have ATSIPHC Diplomas/Advanced Diplomas might also meet registration requirements.

Table 12: Proportion of respondents from each jurisdiction who hold ATSIPHC (Certificate IV): today, in 2012 and in 2016

Jurisdiction	NSW	VIC	QLD	NT**	SA	WA	TAS	ACT
<b>Today</b>	17%	17%	27%	68%	17%	42%	0%	33%
<b>Projected total in 2012</b>	20%	17%	32%	73%	35%	42%	40%	33%
<b>Projected total in 2016</b>	31%	21%	43%	81%	61%	42%	40%	33%

\*\*Northern Territory figures include those with ATSIPHC Certificate III.

The key findings from this data are as follows:

- The Northern Territory has the highest proportion of respondents who have already obtained the ATSIPHC Certificate IV qualification (68%, or 25 respondents). This is not surprising given the Northern Territory is the only jurisdiction that registers Aboriginal Health Workers.
- Both Western Australia and New South Wales have 20 survey respondents qualified at the ATSIPHC Certificate IV level. This represents 42% of the total respondents from Western Australia, but only 17% of the total respondents from New South Wales.

Additional data on jurisdictional differences can be found in Appendix F.

## 7.4 Roadblocks: barriers to education and career progression

The results of the Health Worker and health manager focus groups emphasise the motivation and desire shared by many Health Workers to attain higher qualifications. This could lead to significantly upskilling the current workforce, encouraging new recruits and enabling more Health Workers to be eligible for registration. Continuing education would also help Health Workers to progress their careers as they gain more educational and practical experience.

However, these goals can only be achieved if Health Workers can overcome the barriers reported to exist. Some of these barriers affect entry to the workforce. For example obtaining the initial qualification while others relate to continuing education which would enable career progression.

In summary, the right educational opportunities need to be provided to Health Workers at the right time, in the right place.

### 7.4.1 Barriers to education

From a systemic perspective, the common barriers to obtaining minimum level qualifications for employment, as reported through the Community Mapping focus groups, are:

- lack of availability of training courses
- inflexibility of the mode of training delivery
- lack of funding to support education
- family and community responsibilities
- pre-vocational numeracy and literacy issues
- perceived lack of career progression opportunities
- release from employers and the challenge of 'back-filling' positions.

Each of these barriers is explored below.

#### Lack of availability of training courses

Some key informants reported that there was a shortage of Registered Training Organisations (RTOs) available to deliver the required training. For example:

"I had prior learning that wasn't recognised by \_\_\_\_ - they said it was nil and void [due to introduction of new national qualifications framework]. So I asked what course I could start straight away, and they said Certificate IV. I asked when I could start and they said in two years in 2012 – because all the positions were full."

(Health Worker)

While this may be the case, without actual evidence of over-subscription it remains a perception only. Over-subscription of courses was not raised often as an issue in interviews with training providers and other key stakeholders.

However, the issue of appropriate training models in locations accessible by both students and training providers was reported frequently by the majority of health managers and key informants, which leads to the next barrier.

### Inflexibility of the mode of training delivery

It was reported that funding and resourcing for regional and remote training was limited. Key informants from education organisations reported funding models require training to be provided in the most cost-effective location which limits their ability to train and assess in community or remote locations.

The majority of Health Workers noted the impact of travel to centralised locations, requiring leaving both their duties and their family support structures. Block training also means leaving family and community responsibilities and was reported to cause stress within family units.

Training courses therefore need to be more accessible, with more flexible modes of delivery, so that Health Workers who live and work in remote areas can complete them in a way that is suitable for them.

“Can the training come to us so we stay in our community? We don’t want to leave our families, our communities, our jobs. We need more opportunities for scholarships, especially to do a specialty so we’re funded to do it. ABSTUDY isn’t enough when you’ve got a family”

(Health Worker)

“Training in the community where you live – too hard to go into town and leave the little ones”

(Health Worker)

“In addition, there needs to be a flexible delivery method. A lot of single mothers can’t leave to do the training in a city. Furthermore, people that want to do the training but live and grew up in a rural town don’t want to leave home to go to a city and do the training.”

(Health Worker manager)

Other Health Workers mentioned the importance of delivering training courses using methods that were more closely aligned to the learning style of Aboriginal and Torres Strait Islander Health Workers. For example, many referred to the value of hands-on experience with more practical components or clinical placements.

“Not so much book work. It needs to be hands-on at least every second block. Even visiting other services. Like going to \_\_\_\_\_ - like a sharing of knowledge. They took us to the library – what do we need to go to the library for? If you’re studying to be a teacher or a nurse you have to do rural and remote placements. This could be the same for Health Workers.”

(Health Worker manager)

### Lack of funding to support education

It was frequently reported in the focus groups that the financial constraints of undertaking further education are a major barrier. For example, many Health Workers have to take unpaid leave to undertake their education. As many of them have families to support, the financial assistance provided through the government study scheme ABSTUDY was reported to be inadequate.

“ABSTUDY is not enough to pay people to train – AHW have responsibilities to family and their community – how can they meet those responsibilities and take on extra training on that wage?”

(Health Worker manager)

“Financial barriers – too expensive to study, they are also supporting families. The Government should put in sponsorships for people to go through – they won’t go through now because of the money, it is too expensive for Health Workers”

(Health Worker manager)

These funding constraints apply not only to the cost of the courses and transportation, but also to ‘back-filling’ Health Worker positions at health services while staff are away undertaking training. Health Workers are integral to the daily operation of health services, and in many cases there are limited resources to fill in for them while they undertake courses. Where casual or part-time staff are available, there are additional salary costs. This creates a disincentive for some health services to release Health Workers for education purposes.

### Family and community responsibilities

The majority of Health Workers commented on the financial constraints on training and education often when they are working to support their family or extended family. There are also constraints in terms of family and community ties. Most Health Workers are responsible for looking after their family, elders and other members of their community. Family support was constantly raised as a significant barrier.

“No incentives or funding to go away from home to learn more. Family structures prohibit them from leaving, especially with kids and elders to care for. They could study online if they had more computer training and we could teach more here if we were funded to do it. We need to form partnerships with RTOs to do this better.”

(Health Worker manager)

“Time away from family and work affects people’s motivation to upskill”

(Key informant)

“Family support or lack of family support is the number one barrier or enabler to education”

(Health Worker manager)

### Pre-vocational numeracy and literacy barriers

Many courses require literacy and numeracy skills which prevent some Health Workers from undertaking the course unless adequate support is in place. This was often noted as an issue in relation to the recruitment of adequately qualified Health Workers.

“When people are coming out of year 12 unable to read and write well enough to write a letter, there are serious issues. The need for regionalised support so that people are there in community helping our students to deal with the literacy issues, so that this isn’t a barrier to our people doing health training ...”

(Health Worker manager)

“The single biggest barrier here to education is that of numeracy and literacy levels. Most of our Health Workers have not graduated from high school and both their verbal and written English levels are very low.”

(Health Worker manager)

“Accessing appropriate training at their literacy/numeracy level is also proving to be a stumbling block.”

(Health Worker manager survey)

“Hard for people to get education due to numeracy and literacy – hard to do Certificate IV”

(Health Worker)

There are a number of programs available to assist Health Workers in meeting literacy and numeracy requirements. DEEWR funds programs and services to support and improve literacy and numeracy skills assisting both individuals and organisations. These include a language, literacy and numeracy program to assist individuals to perform in training or in the workforce. There is a Workplace English Language and Literacy program to assist organisations to provide literacy and numeracy training for workers.

### Perceived lack of career progression opportunities

The opportunity for career progression was identified as an incentive for Health Workers to obtain further training. Some Health Workers noted the positive support of leadership and management and their willingness to facilitate access to training. On the other hand, a number of focus groups reported the perceived lack of career progression opportunities was often a deterrent to Health Workers obtaining further qualifications.

“The ‘why bother syndrome’ if they are at the top of the level anyway and cannot progress further or get better pay.”

(Health Worker manager)

“There needs to be a better career structure with future possibility of career progression”

(Health Worker)

The issues concerning career progression are explored in more detail in Section 7.4.2.

#### Release from employers and the challenge of ‘back-filling’ positions

There were many reports from focus groups and in key informant interviews with Health Workers of a lack of access to back-up staff if the Health Worker was attending training, or even taking a day of sick leave. This lack of back-up is a barrier to attending education courses because, in some cases, if a Health Worker was to attend training the Health Service would need to be closed.

“One of the problems is that for us to go to study we need other Health Workers to be able to work in our place so we need more Health Workers in our service.”

(Health Worker)

“Sometimes the training that is available you can't go to – I would love to do suicide prevention but they won't let me because there aren't enough staff.”

(Health Worker)

“We need more time, support from the service [to access training]. One barrier is the ability to get back-fill or be released from work to attend. We want access to more leaning and development – but need temp staff to allow this to happen.”

(Health Worker)

#### 7.4.2 Barriers to career progression

Given the limited information available on the workforce career pathways, it was important to examine Health Worker and health manager views. As part of the community mapping exercise, their perceptions on whether there was a clear structure for career progression and if so, what opportunities existed for them to progress in particular, were sought.

Broadly, Health Worker managers listed a range of organisational structures involving Health Workers, and they were often described as being at the bottom of the structure in almost one-fifth of the focus groups. When Health Worker managers were asked what opportunities Health Workers have for career progression at their health service, in half of the focus groups it was reported there were no opportunities or that opportunities were limited. Opportunities for progression into management roles were mentioned at

only 15% of the Health Worker manager focus groups. For example, one of the health managers in the focus groups commented:

"I don't think there really is a structure for career progression at the moment. If I had the power and the money, this is what I would set up!"

(Health Worker manager)

Progression into other positions or senior clinical roles was mentioned at even fewer focus groups. These findings demonstrate that opportunities for Health Workers to progress are currently limited.

"Unless they go to do nursing there is no career progression. Some of our staff have degrees, diplomas, and even a PHD and yet they are still at the HW ceiling."

(Health Worker manager)

"No pathway for progression. All the positions are created. Once they are created that is the end of it."

(Health Worker manager)

When asked whether there was a clear career structure for Health Workers, just under half the health managers from the focus groups stated there was either no career structure or a very limited career structure. Health managers mostly indicated the career structure was very much centred on qualification levels which could mean Health Workers could only progress if they obtained higher qualifications.

"Today the career structure for HW's is very limited as soon as you become a Senior HW it stops. The career path is very limiting and hence people leave."

(Health Worker manager)

"Further study will increase what level you can be paid at, but the job is mostly the same. I encourage all the AHLOs to think about where they want to go, maybe move into management one day. We need to work on our succession planning though, to train up the young ones to be a manager one day. The young ones need managerial training so they can step up, or go for other jobs in the region when they come up. When I'm on leave, all the AHLOs get a chance to step up and do my job (working at higher duties) so they get a taste of dealing with the hierarchy and systems that suck."

(Health Worker manager)

“We need a structured career path – we just keep getting shafted around. We know we could do more and better if we had a clear career path.”

(Health Worker)

“A structure where you work to a certain point in your role. A career path. Many of us go stale as there is no career path.”

(Health Worker)

## 7.5 Transitioning into other workforces

Another aspect of career pathways for Health Workers is the opportunities for transition into other health workforces. This is an important area to examine because the skills used by most Health Workers form the basis for other health workforces such as nursing, medicine, program management and social work. Moreover, articulation into other workforces can provide Health Workers with greater opportunities for career progression, professional recognition and higher salaries.

When asked why they wanted to move into other health workforces, a small proportion of Health Workers said they felt they could make a bigger difference in another health workforce.

In contrast, some of the findings from the focus groups revealed extremely positive views about how Health Workers felt about their current role. Some of them said they wouldn't consider moving roles because they believed that they were able to make a big difference to their community doing what they currently do and they were happy in their current role.

“I don't think people realise that being a Health Worker is an honour. Some of us want to be a Health Worker, not go onto another profession. Some white people think it's just a stepping stone to being a nurse. But it is a good job in itself and needs to be respected as that.”

(Health Worker)

“Don't want to leave even if you think about it sometimes. Want to make a difference. HWs know the person, patients feel confident with the HW. Patients find it easier talking to another Aboriginal person. Being a HW is Aboriginal people working for/with Aboriginal people. Can get along with patients better than non Aboriginal health professionals eg nurses”

(Health Worker)

### 7.5.1 Opportunities for articulation into other workforces

When asked if there were opportunities for Health Workers to move into other workforces, responses from health manager focus groups were very positive, with the majority of focus groups indicating opportunities did exist. Nursing was the most commonly identified workforce followed by Medicine (ie doctors) and Social Worker.

“Yes for sure. Presently 2 of the 13 HWs are studying to be RNs. This organisation supports and encourages education. Workforce development is a strategic key action in the organisational plans.”

(Health Worker manager)

Correspondingly, a large proportion of Health Workers stated in the focus groups that they have thought of moving into other health workforces.

“Possibly nursing due to their scope of practice and recognition, support and remuneration”

(Health Worker)

“I'm going to do nursing. We are pretty much doing the nurse's job we just can't give out meds and immunisations. Next year I am going to do my nursing. As a Health Worker, you can only do a little scope of practice. Nursing you can excel. Nurses can get a job all over the world. Going to do it at university.”

(Health Worker)

### 7.5.2 Barriers to transitioning into other workforces

Some of the barriers participants identified as preventing them from moving into other health workforces were the lack of recognition of their prior learning or skills, and lack of access to the appropriate training and education. The lack of recognition of the prior learning or skills meant they could not qualify for certain training courses or felt they had to repeat some training particularly when transitioning into tertiary education. This was expressed by participants in one Health Worker focus group as follows:

“Sometimes – but to have to go back and start back to the beginning – need to be able to move and have recognition of what we already know.”

(Health Worker manager)

“There has to be articulation set out – pathways for Aboriginal Health Workers to go to a university, say that they want to enrol in a physiotherapy course, and be credited by the university based on their experiences so that they can get into that course. The pathways need to be established for Health Workers to go into pharmacy, podiatry, physiotherapy or whatever they want to do. There needs to be a national framework that recognises that at a certain level Health Worker, you can articulate into each course. It needs to be for every health profession to support all Health Workers to follow their aspirations.”

(Health Worker manager]

“There needs to be recognition of prior learning of Health Workers so that they can map across into other university qualifications. The Health Worker shouldn't have to negotiate individually and advocate for themselves. The process should be put in place for them to move across into universities and articulate into other professions.”

(Health Worker manager)

The CS&HISC aims to contribute to the transitioning process by packaging commonality between ATSIPHC qualifications and other Health and Community Services roles where appropriate.

Other barriers mentioned included the difficulty in obtaining organisational support to attend training and even the trepidation of engaging in tertiary education, given the amount of time and sacrifice required to complete such lengthy courses.

“Four doctors in Alice wanted to pay for me to go through medicine and I said no so they suggested nursing. I said no to that too – I just couldn't handle doing the study. The university thing scares me. You see medical students come through, and the stress that they have, and the amount of work that they've got, the assignments – I just don't know what you would want to put yourself through that for. I like hands on learning. I need to be learning on the job, in practice. You know, you get students in their 4th year coming through and they can't even use the sugar machine. That's ridiculous.”

(Health Worker)

“Yes, but barriers to university degrees – many Health Workers want to continue their career pathway and complete a degree but there are numerous barriers.”

(Health Worker)

## 8. Professional development, supervision and safety

### Key points

The professional development and support of individual Health Workers will contribute to the process of strengthening the broader workforce. Participants in the focus groups emphasised the value of a range of professional development and support opportunities for Health Workers, including:

- opportunities for ongoing training and skills development in the workplace, in addition to formal education qualifications
- access to appropriate mentoring which includes technical mentoring, career mentoring and cultural mentoring
- opportunities to network with other Health Workers and share knowledge about good practice
- access to appropriate social and emotional wellbeing support.

While it seems that a large proportion of Health Workers interviewed have access to ongoing training, many reported limited access to the other items in the list above.

Supervisors play an important role in facilitating access to these opportunities. Supervision is also an important method of ensuring the quality of Health Worker services in maintaining patient safety.

Currently, there is minimal consistency in supervision practices across Australia. In addition, there are varying approaches to ensuring the quality and safety of Health Worker services. Some quality and safety mechanisms in place around Australia include policy and procedure manuals and specific state or territory legislation which restricts or enables Health Worker practice in certain situations. The national registration of Health Practitioners in 2012 will provide an important quality and safety oversight mechanism for Health Workers who are registered as Health Practitioners.

## 8.1 Context

The professional development and support of individual Health Workers will contribute to the process of strengthening the broader workforce. Participants in the focus groups emphasised the value of a range of professional development and support opportunities for Health Workers, some of which include opportunities for ongoing training, having appropriate levels of mentoring and supervision, and opportunities to network with other Health Workers to share knowledge and good practice. These are explored in further detail below.

## 8.2 Professional development and support opportunities

Focus groups with Health Workers, managers and other health professionals identified a range of professional development opportunities available to Health Workers in some workplaces. Participant responses highlighted areas where greater support is desired. This section provides an overview of these discussions, focusing specifically on the following four areas:

- ongoing training and skills development in the workplace
- mentoring
- networking and knowledge sharing
- supporting the social and emotional wellbeing of Health Workers.

### 8.2.1 Ongoing training and skills development in the workplace

Health Worker focus group data shows the vast majority of Health Workers receive some form of ongoing training in the workplace. This refers to learning opportunities that are not part of a formal VET or tertiary educational qualification. When Health Worker and manager focus groups were separately asked about the type of ongoing professional development opportunities available to Health Worker, the two groups provided consistent responses. The three most common types of ongoing training reportedly available to Health Workers are:

- on-the-job training (ie by peers, supervisors, managers and other health professionals)
- internal in-service courses (ie training courses run in-house at health services)
- external short courses (ie short courses delivered by external training providers that are not part of formal educational qualifications).

Some of the positive comments made during interviews in relation to these ongoing training opportunities are provided below:

“We learn a lot from the doctors and they learn a lot from us. We help the new registrars to learn how to deal with the Aboriginal community. Mostly we learn so much more on the job than we can ever learn in the classroom”.

(Health Worker)

“Every Wednesday afternoon is staff training and in-service day. Sometimes we go to conferences and that, or outside visitors come in and do training with us.”

(Health Worker)

“We have ongoing training every week, we have doctors coming in and doing training on dressing, sterilising, etc. They are so supportive. Learning hands on, you pick up quicker so it is great”

(Health Worker)

This feedback demonstrates the value gained from providing opportunities for Health Workers to continually develop their skills outside their formal qualifications. In particular, the value of gaining practical, hands-on experience was emphasised. This was viewed by a number of participants as a crucial step in the education process, as reflected in the comment below:

“Some Health Workers start straight out of uni with things they learnt from a book. It's totally different out in the community – young ones need to get practical experience in the community.”

(Health Worker)

According to those Health Workers who did have access to ongoing learning opportunities, the most common topics of training were in relation to acute and emergency management and social and emotional wellbeing.

However, some Health Workers in the focus groups indicated they had limited access to training opportunities, if any. Often this was attributed to insufficient funding for training purposes. For example:

“I receive no professional development. I just do one or two-day workshops. It all depends on what's in budget and there's not much there. We want government to start supporting us so we can have the opportunity to do more education – funding is a big issue. Guys here are trying to get funding but its hard yakka”.

(Health Worker)

Some health managers highlighted barriers to ongoing training for Health Workers, such as time commitments, family commitments and more urgent clinical priorities. One health manager provided the following comment:

“[there is] Virtually none [training] because they are so remote and rely on the nurses and doctors to train them and they are just so busy coping with life in the community they cannot train them. People are walking through the clinic doors in such sheer volumes that accessing and doing training and mentoring with the other clinic staff just isn't feasible”.

(Health Worker manager)

Health Workers were also asked whether they wanted access to any additional learning and development opportunities to those they currently receive. Not surprisingly, nearly all the Health Worker focus groups answered “Yes”. When probed further about the nature of the desired training, the two major themes that emerged were in relation to external short courses and postgraduate/undergraduate courses. A quarter of the focus groups said they wanted to undertake further training in the area of acute and emergency management, and another quarter said undergraduate or postgraduate courses in medicine or nursing. This demonstrates that many Health Workers desire continued training opportunities that are not currently available.

Focus groups were then asked to give their views on the factors impeding access to ongoing training opportunities. Unsurprisingly, similar to education barriers already discussed in Section 7.4, it was unanimous that the main barriers were limited funding and resources. In addition, Health Workers identified study leave and management support were critical enablers of ongoing training. Health managers highlighted the need for more RTOs to provide the required training courses.

### 8.2.2 Mentoring

Mentoring was raised by Health Workers, managers and other health professionals as another important source of continuing skills development. Discussions on mentoring arrangements highlighted the value of three types of mentoring support for Health Workers:

- technical mentoring (eg relating to the development of clinical or primary health care skills)
- career mentoring (eg relating to the educational and career goals of Health Workers)
- cultural mentoring (eg relating to the development of local cultural knowledge and practices, or culturally sensitive situations).

According to those interviewed, it was not necessary for the same person to provide all three types of mentoring. In fact, sometimes it is essential to have more than one mentor. For example, one Health Worker reported that they received technical mentoring from a non-Aboriginal or Torres Strait Islander nurse but received advice from a local community Elder in relation to challenging cultural situations.

Focus group responses reveal there are a variety of mentoring arrangements in place: some health services have formal mentoring structures; others have informal mentoring relationships; and some Health Workers lack the mentoring support they desire.

Some comments collected during focus groups in relation to each of the three areas of mentoring are provided below.

### Technical mentoring

Technical mentoring was often referred to by all participant groups as a crucial part of developing the skills of Health Workers on the job. Although this type of mentoring was raised mostly in the context of clinical mentors, some Health Workers also spoke of it in relation to the development of prevention and health promotion activities.

The following comments demonstrate the potential value of technical mentoring for Health Workers:

“Last year I had trouble doing my Certificate IV, until a couple of nurses showed me how to do it. When they came in and showed me how to do it, it just clicked. I can't read and write properly, but once they showed me, it just clicked. We get support and mentoring from other staff.”

(Health Worker)

“Mentoring is very important, especially for our young ones. If I look back to when I started I had \_\_\_\_\_ as a mentor. You have two groups of Health Workers – some that are straight out of school and others that have more experience and want to give back into the community. My thing is about workforce – employ the ones that do have experience and get them in and support them to get qualifications. And then with the young ones get them in here and mentor them and don't make them do the shit jobs. Give them the opportunity to grow. It took me a while to know my role – it's the same with young ones. Give them the community support to get there”.

(Health Worker)

“Experience and skills that younger Health Workers don't get to be exposed to – they need to learn from the senior Health Workers. Senior Health Workers ... need recognition in being a mentor and providing training.”

(Health Worker)

### Career mentoring

Some focus group participants believe that career mentors are crucial to the development of the Health Worker workforce. Career mentors provide support and guidance to Health Workers in relation to their educational and career pathways.

A number of Health Workers who had progressed to higher levels of educational qualification or management positions mentioned that a particular individual had mentored them and pushed them to pursue ambitious professional goals. For example:

“ \_\_\_\_\_ encouraged me to do the bachelor course and that’s why I did it. A lot of Health Workers don’t have that and they don’t have the encouragement or the support. You need people in a mentorship role. They have to play that role. My mentor said ‘Why don’t you go to university?’ – I said I have no skills. But because I had a good mentor he got me to go to university. Someone saw value in me and got behind me and supported me. They saw value in me as an individual, not just the colour of my skin. If you have that around you then you will grow and be better. The young ones that come through need that mentoring support.”

(Health Worker)

Others had not yet identified a career mentor, but expressed belief that this kind of support would help them to achieve higher ambitions. For example:

“Where do we go to after being an Advanced Health Worker? The next natural progression is line management. If they were to take on, pick out and mentor who that person would be. It would be nice to be mentored into a line manager position – give us those opportunities.”

(Health Worker)

### Cultural mentoring

The concept of ‘cultural mentoring’ arose in a number of focus groups. Generally, the need for cultural mentoring was identified in circumstances where a Health Worker’s line manager or supervisor was not of Aboriginal or Torres Strait Islander descent. This type of need was particularly highlighted in instances where the Health Worker was relatively young, or not from the same community as the clients. It was also discussed by Health Workers who received a broad mix of clients from different communities. Understandably, these Health Workers were not always confident in their knowledge of the specific cultural needs of clients from different parts of the country.

In these situations, Health Workers reported that cultural mentors could support them to make culturally sensitive decisions, particularly when drawing upon the cultural knowledge and wisdom of more senior Aboriginal and Torres Strait Islander members of the relevant community.

The concept of cultural mentoring was also discussed on the projects’ online forum, supplementing the opinions reported at focus groups. According to one Health Worker on the forum:

“Cultural supervision will play an important role in the maintenance and retention of our workforce ... There needs to be strategies developed to formalise and embed this process into each organisation’s strategic plans which will become part of standard practice ... We also need to ensure that the Cultural Supervisor is familiar with grass roots/coal-face situations and can network and link into further support mechanisms such as Elders from that or within that community.”

(Health Worker)

### 8.2.3 Networking and knowledge sharing

At the Health Worker focus groups, a number of Health Workers expressed their desire for more opportunities to share knowledge with their peers. Some believed that these opportunities used to exist, but were no longer as readily available.

In particular, the value of networking events or conferences was discussed. Both regional and national networking opportunities were mentioned, in recognition of the different benefits that could potentially be gained from each. One of the reasons that some Health Workers valued regional networking opportunities was that they might enable more collaborative health service delivery between Health Workers in a given area, in line with the needs of that specific region. National events were valued by some Health Workers because they gave an opportunity to understand how Health Workers delivered services in different parts of Australia. In this way, Health Workers hoped to learn about good practices and take ideas back to their own health service.

Support for Health Worker networking and knowledge-sharing events is demonstrated in the following comments:

"We used to all get together once a year with Health Workers in the region and that doesn't happen anymore. VACCHO does some forums but you can only send two to three people so it's not enough. We used to have that big forum once a year, one big debriefing. It's really helpful."

(Health Worker)

"We should get together as all the Aboriginal Health Workers in the country. We should be able to go and talk together and bring the news back. We should have our own meetings but that doesn't happen."

(Health Worker)

Another opportunity for knowledge-sharing identified by Health Workers was health service exchange programs. Some Health Workers had been supported to visit other health services and learn about the type of programs different services deliver. Those Health Workers reported that these activities provided a valuable opportunity to develop their skills and expand their knowledge base.

The potential benefits of knowledge-sharing were evident in observations made by interviewers during the site visits. In informal conversations with Health Workers during the Community Mapping activities, some examples of good practice encountered at other sites throughout the project were shared. It was not uncommon for Health Workers to learn of alternative approaches to addressing health needs of communities during these conversations, and express their interest in finding out more about particular models of care.

This seems to indicate an appetite for a more structured approach to information sharing that could empower the Health Worker workforce to build on existing models of care.

### 8.2.4 Supporting the social and emotional wellbeing of Health Workers

A strong theme emerging throughout the Health Worker focus groups was social and emotional support for the workforce. Many Health Workers described experiences of

working in a highly stressful environment where they were juggling the expectations of their colleagues, communities and families simultaneously. It was common for Health Workers to mention feeling as though they were always 'on the job' even outside office hours, particularly if they are from the same community they work in. Both Health Workers and managers commented on high burn-out rates as a result.

For example:

"Sometimes we get midnight phone calls, or visited at home. I have dressings at home. Sometimes you just want to say no, but people can get very annoyed at that."

(Health Worker)

"We get phone calls at home and we are expected to do things for everyone outside of work hours."

(Health Worker)

"They come see me where I work, or they're supposed to, but they often come round on the weekends, or call me. I really try to avoid where they hang out on the weekends or I can't be alone."

(Health Worker)

Others referred to experiencing emotional pressure, particularly when dealing with loss. Some Health Workers mentioned they were often expected to support families and communities through experiences of death and the organisation of funeral arrangements, while simultaneously dealing with their own personal grief. This places Health Workers under a significant emotional burden.

For example:

"There's no social emotional wellbeing services Aboriginal Health Workers can access. We just have to keep going. We care about our people, and it hurts, we get upset when people pass away. One third of our clients are related to us in some way, so you get attached. There isn't debriefing or anything when things happen. We just go out for a smoke and talk. Burn-out rate is really high because it's so demanding."

(Health Worker)

"We are related to so many clients so we are always losing people – we need debriefing services to help us – at the moment we have to talk to each other."

(Health Worker)

Further still, some Health Workers reported being concerned about the safety of their families as a result of fulfilling their role as a Health Worker.

For example:

“We don't have support emotionally and socially to cope with the demands and crises that we see. We lose people all the time who we should be able to keep alive ... If we lose someone we have to worry about payback and this is so hard for us to cope with – will my job jeopardise my family and kids?”

(Health Worker)

“If we are from the community it is both good and bad – good in that they trust us and believe what we say but bad because we are always on duty and can never get away. If someone dies then there may be pay back so we have to be careful to manage emergency stuff so that our families are not put at risk.”

(Health Worker)

These comments highlight that Health Workers are often part of the very communities they serve. This means in some situations where Health Workers are the providers of social and emotional wellbeing services, there is the potential that Health Worker will have social and emotional wellbeing needs of their own that need to be addressed. Yet many do not feel as though they are currently receiving sufficient support to cope with these pressures.

“We need more opportunity to debrief, like formal sit downs every week. You need a safe environment to get stuff off your chest, someone not linked to here. At the moment here if you want to see a counsellor within the service you get asked why, well that's why I want to see one because I don't want to share it with anyone here.”

(Health Worker)

“The Health Worker may be the one constant [in patient care] – it is very demanding. The rest of the workforce may not see the death and dying and blame issues. The grieving and resolving issues. A lot of them [Health Workers] leave due to the pressure of the job.”

(Other health professional)

The risk of not providing sufficient social and emotional support for Health Workers is that the workforce will not be sustainable. Burn-out was mentioned frequently in the various focus groups categories, including Health Workers, managers and other health professionals. Although Health Workers provide health services to Aboriginal and Torres Strait Islander communities, they are also members of those communities themselves. The social and emotional burden of Health Workers therefore contributes to the high rates of mental health conditions experienced by Aboriginal and Torres Strait Islander Australians.

### 8.3 Supervision arrangements

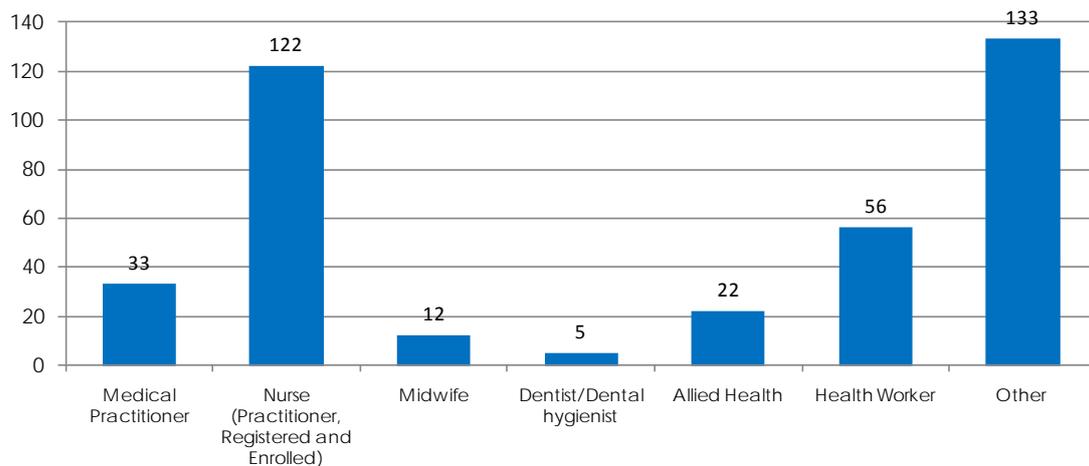
The Australian Commission on Safety and Quality in Health Care aims to achieve safer, more effective and more responsive care for consumers. In August 2010, the Commission released a discussion paper on patient safety in primary health care (Australian Commission on Safety and Quality in Health Care 2010). The discussion raised a number of suggestions for improving safety that included research, clinical governance, and recognition. In response to the paper, it was observed that “Ensuring better supervision of workers in a primary health care organisation is one of the major keys to improving patient safety” (Barrett, 2010).

As supervision is a large part of good clinical governance, this section examines supervision of Aboriginal and Torres Strait Islander Health Workers.

#### Supervision – Who from?

One of the key questions in the Health Worker survey related to appropriateness of the supervision; that is, who do Health Workers frequently receive supervision from? The responses were mixed, as illustrated in Figure 17.

Figure 17: Types of workforces providing supervision to Health Workers as reported by survey respondents



\*Note: survey respondents were able to select more than one supervisor which means the number of responses is greater than the number of respondents.

In summary, it would appear that:

- a large proportion of respondents currently receives supervision from nurses and ‘other’ workforces which were not specified, although it could refer to line managers who may or may not be a health professional
- a smaller proportion receives supervision from other Health Workers and medical practitioners.

Results from the Community Mapping interviews were similar with just under half the Health Worker focus groups reporting they receive supervision from their direct line manager followed by other clinical health professionals of which nurses were the majority.

The Health Worker Community Mapping focus groups reported that being supervised by a non-Health Worker could lead to tension, as there was a lack of understanding of the role, as reflected in the comment below:

"There has been a tendency for AHWs to be placed in teams that are supervised by people who aren't ATSIHWs. So their experience and performance is ranked by a different system that is not applicable to HWs. The level of scrutiny I had was ridiculous – they have a different disciplinary background. You don't expect dieticians to be managed by nurses. That is the challenge. There is this sense that "you should be out in the community" but then they check up on you and are worried about what you are doing and they don't understand. You have to actually build relationships with the community and maintain them. Some people just don't understand the work that HWs do – it's easy to assume".

(Health Worker)

My line manager doesn't understand my role so it is hard to get the support that I need.

(Health Worker)

In comparison to the Health Workers, managers stated that direct supervision is done first by other clinical health professionals then by direct line managers.

It was raised a number of times during the focus groups that supervision of junior Health Workers is often most effective when done by senior Health Workers as they have a better understanding of the role and challenges.

"Our Health Workers are supervised by the clinic manager who is a Health Worker, and also by Senior Health Workers . At our clinic we try and upskill people so that when the clinic manager is away one of the Senior Health Workers acts in the role and then a less experienced Health Worker then acts in the Senior role."

(Health Worker manager)

"As a Senior Health Worker, I give supervision to the other Health Workers that are more junior, all the time."

(Health Worker)

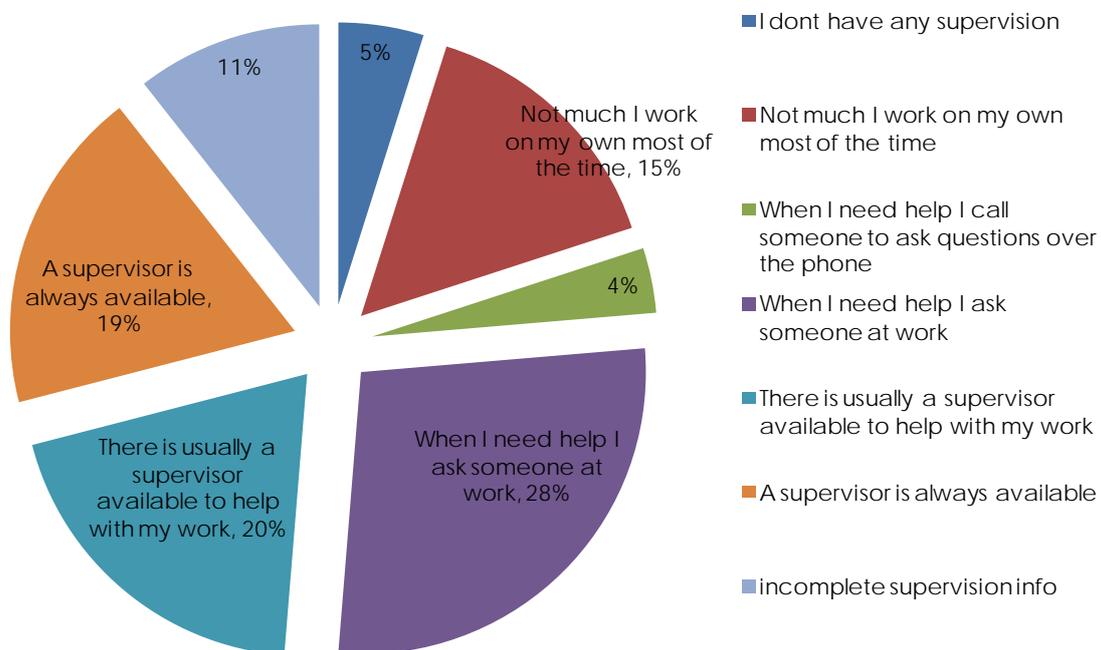
"The Health Workers are supervised by the Clinic Manager who is a senior Health Worker. She has worked here for many years."

(Health Worker)

### Availability of supervision

Health Workers were asked in the survey to comment on the availability of supervision in their work place. Specifically, they were asked: “What type of supervision occurs in your regular work?” Six categories were included in the survey to reflect varying types of supervision. These categories were designed to provide some indication of whether supervision is automatically available, or if the Health Worker must ask for it; and also whether the supervision is provided in person or over the phone. The results at a national level as reported by Health Workers are illustrated in Figure 18.

Figure 18: Availability of supervision as reported by Health Worker survey respondents – Nationally



In summary, it appears that:

- 71% of the 351 Health Workers surveyed have direct or indirect (by phone or colleague support) access to supervision
- a supervisor is “always” or “usually” available for 39% of respondents
- approximately one-third have access to supervision on request (28%)
- 15% receive “no regular supervision” or “work on their own most of the time”.

These findings are consistent with the findings from the Community Mapping focus groups, where 72% of the Health Worker focus groups indicated that they receive some form of supervision as part of their daily work.

“As a Senior Health Worker, I give supervision to the other Health Workers that are more junior, all the time. We also have a Chronic Disease Supervisor, Clinic Team Leader and Child Health Team Leader. If any issues arise in those teams then those supervisors manage that. I'm out more in the community than in the clinic, because I have more experience dealing with the community in their health and in the promotion stuff.”

(Health Worker)

The availability of supervision profiled by jurisdiction, area of remoteness and employer organisation was completed and the results can be found in Appendix G.

In summary, it was noted that:

- Victoria and Queensland had the highest proportion of respondents with either direct or indirect access to supervision
- there were no discernable differences in the levels of access to supervision of Health Workers across areas of remoteness or employer organisation.

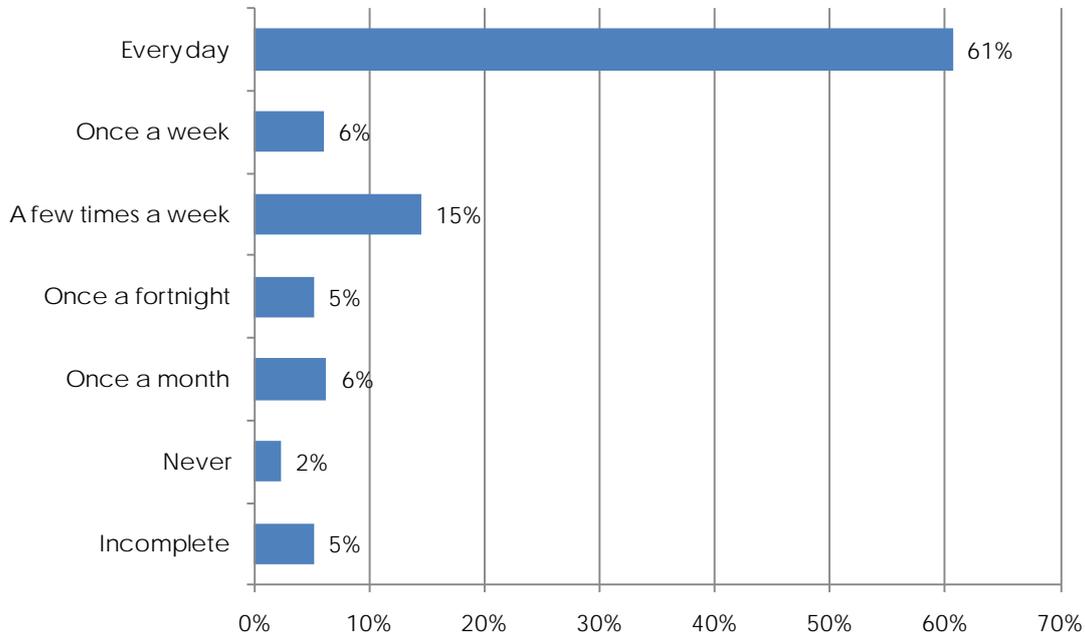
#### Type and frequency of supervision

Health Workers receive supervision in different forms. The most effective form reported is face-to-face supervision, where the Health Worker works alongside their supervisor in the same location, thereby having constant access to them. This is not always possible given some Health Workers work in remote locations and at times on their own. In such cases supervision is made available by phone, email or through regular visits.

The type of supervision received was examined, particularly in relation to its frequency. Given direct face-to-face supervision is expected to have a higher impact on the safety and quality of patient care than supervision provided over the phone or via email, the frequency of face-to-face supervision was analysed in more detail.

Figure 19 provides the results of the frequency of face-to-face supervision on a national level.

Figure 19: Reported frequency of face-to-face supervision by Health Worker survey respondents – Nationally



As can be seen above:

- almost two-thirds of the 351 Health Workers surveyed reported that they receive face-to-face supervision every day (61%)
- only 2% indicated they never receive face-to-face supervision.

#### Issues raised regarding supervision

While the frequency of supervision was not specifically addressed in the Community Mapping focus groups, participants were asked to raise any issues relating to their current supervision arrangements. Responses were mixed, with some focus groups reporting they do not receive sufficient supervision while others reporting they receive too much, to the extent they feel they are not trusted to perform their role.

“We are micromanaged. They always want to know things like how long you are on the phone for, what was it about, what did you do at the home visit, what meetings are you going to. It's ridiculous. It is offensive. Up until a month ago I couldn't even look at my client's chart. We weren't allowed to access the files.”

(Health Worker)

"I don't have good supervision. Non-existent. What is happening is that sometimes team leaders take on a parental role with an AHW and over-supervise, micro-manage – that is not respecting someone's professionalism and their individualism or independence. It says that we are untrustworthy."

(Health Worker)

Interestingly, a quarter of focus group respondents stated they were sufficiently confident in their skills and their role that they needed only minimal supervision. In such cases, Health Workers often commented they were very comfortable in their current roles, they knew what they were doing on a daily basis and not in need of constant supervision.

"We work unsupervised and we know what needs to be done and we just do it. In the case of an emergency we ask the nurse or the doctor."

(Health Worker)

"No close supervision, not really needed, we are all capable of deciding what needs to be done. It works well, just too busy."

(Health Worker)

An important theme for Health Workers who work in isolation in remote locations or clinics highlighted they do not have frequent access to supervision and as a result may feel isolated, as illustrated in the comment below:

"I fill in my schedule and fax it to my team leader every week to show the work I am doing. My team leader doesn't say much to me and check on me because she realises how much I do. I feel isolated – I don't have any other Health Worker or anyone in Indigenous Health. If anything happens I'm in isolation. I need more peer-support. I am isolated. I need cultural supervision – we don't have that. I also need support for critical incidences involving cultural issues."

(Health Worker)

Supervision is an important aspect of providing support to Health Workers as well as of maintaining quality and safety of practice. The availability of supervision, along with its type and frequency, are important contributors to Health Workers' confidence to perform their duties in a safe environment while being able to seek help when required.

CS&HISC are currently embarking on a competency development project to review the management, leadership and supervision requirements of the health workforce, including Health Workers. This is likely.

## 8.4 Other quality and safety mechanisms

### 8.4.1 Policy and procedure manuals

In Queensland, authorised Aboriginal and Torres Strait Islander Health Workers are trained in, and work according to, the Primary Clinical Care Manual (PCCM). This 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 practise.

Since 2005 the PCCM has been used by nurses in 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 practise 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 (eg pneumothorax)
- guidance on common conditions that might otherwise be intimidating for staff (such as psychotic patient)
- 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 to be qualified to administer immunisations. This is a five-day face-to-face course providing professional evidence-based education to manage and administer vaccines in compliance with 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).

### 8.4.2 The National Registration and Accreditation Scheme

In 2008, the Council of Australian Governments (COAG) established the National Registration and Accreditation Scheme for 10 health professions. The Australian Health Practitioner Regulation Authority is the single Agency that supports the Boards and the National Scheme. Australian Health Ministers decided Aboriginal and Torres Strait Islander Health Practitioners will be registered under the National Registration and Accreditation Scheme for Health Workers from July 2012. Apart from the Northern Territory and some instances of Isolated Practice in Queensland, no other jurisdiction specifically regulates its Health Worker workforce. The decision as to entry level requirements will be made by the (yet to be established) National Aboriginal and/or Torres Strait Islander Health Practitioner Board. Information from this project will assist in informing the work of the board.

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

- no 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 any new standards will be consistent with them in principle.

### 8.4.3 Legislation

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). This is referred to as Isolated Practice Authorisation.

Health Workers who receive Isolated Practice Authorisation are permitted to:

- obtain and possess a restricted drug
- 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 other health professionals. According to this regulation, an Isolated Practice Area (IPA) is defined as a place that is:

- Cow Bay, Marpuna and Weipa
- remote from pharmaceutical services
- serviced by a plane operated by the Royal Flying Doctor Service (Queensland Government, 2010).

The available literature does not indicate how many Health Workers have Isolated Practice Authorisation or use it on a regular basis. Nor is there any evidence available that distinguishes how Isolated Practice Authorisation influences the Health Worker role.

## 8.5 Performance monitoring and impact measurement

There are no consistent national approaches to performance monitoring or measuring the outcomes and impacts of the value that Health Workers bring to their community.

This is an important area for the ongoing development of the workforce, particularly as it approaches professional recognition. A systematic mechanism for performance measurement would:

- enable Health Workers to feel a sense of achievement and fulfilment in their roles
- enable the information to be used for continuous improvement

- help other health professionals to understand the unique role that Health Workers play in the community and see how Health Workers are contributing to improving the health outcomes of their community.

At present, as reported in a number of focus groups, given the lack of a consistent performance monitoring system, Health Workers often do not know how they are performing or feel they have to continually justify what they do to their colleagues, as demonstrated in the quotes below:

“Stats don't look good when I've been out driving all day in the hot sun and others [other health professionals] look as though they've been doing all the work.”

(Health Worker)

“Without having any sort of defined role and goal setting – how do you ever know if you're doing a good job and making a difference? I've been trying to do that but it isn't going down that well. I have great difficulty managing them from a supervision point of view. I don't dispute the value of what they are doing in any way. But I think that if you are given a bit of slack then people make the most of it. I've been asking people to do some career planning, performance appraisal development plans. No one has done it. So I had to tell them you had to do it. They are adults.”

(Health Worker manager)

“There doesn't seem to be a good system of key performance indicators of what they are achieving for the money that is being invested. For example, \_\_\_\_\_ have a really good sense of their outcomes for clients, they check the outcomes for child visits, etc. --> [this creates] better outcomes by being more goals oriented.”

(Health Worker manager)

A relevant approach to evaluation that might be worth considering has been described by Judd et al in the context of community-based health promotion programs (2001). This paper describes an approach that presents evaluation of health promotion activities “as being mutually beneficial to both funders/government and practitioners” (Judd et al., 2001).

The authors emphasise the importance of ensuring that community practitioners do not feel that evaluations are imposed upon them by a body that does not understand the uniqueness of their community. Therefore, the paper supports a participatory approach to evaluation that is sufficiently flexible to be tailored to diverse community settings:

*“...evaluation is necessarily a collaborative group activity, fundamentally democratic, participatory, and must examine issues of concern to the community in an open forum. Evaluations of community-based health promotion programmes limited to aggregates of changes in health behaviour or attitudes made at an individual level can underestimate the gains that an intervention might make.”*

(Judd et al., 2001)

Judd et al. describe the development of evaluation programs as a multi-stage process, that involves:

1. setting objectives for the program by:

- a. identifying the objects of interest to be measured
- b. articulating standards of acceptability for each object of interest
2. executing the strategies
3. collecting the data
4. assessing the relative success or failure of a given intervention.

The paper also describes different levels of evaluation, referring to the need to:

*“integrate ‘process’ evaluation (ie intervention activities, staff performance, etc.) with ‘impact’ evaluation (ie proximal, intermediate changes in behaviour, lifestyle and the environment) and with ‘outcome’ evaluation (i.e. distal, longer-term changes in policy, health status, etc.).”*

(Judd et al., 2001)

These are a few considerations that may be relevant to the process of measuring the impact of the Health Worker workforce.

## 9. Underlying themes emerging from the analysis

### Key points

#### Enabling workers in the workplace

Health Workers work across Australia in different team environments at different workplaces in which a range of interlinking issues and overlapping themes associated with team dynamics are present. These relate to the presence or lack of:

- empowerment, trust, respect and recognition within teams
- cultural security in the workplace
- leadership and management in the workplace.

Although these themes are difficult to measure, the fact that they were raised so frequently by Health Workers, managers and other health professionals alike suggests they have a tangible impact on the Health Worker workforce and the capacity of Health Workers to reach their full potential.

#### Recruitment and retention

Health Worker recruitment and retention strategies are essential to workforce sustainability, yet this is a major issue for a large proportion of health services. For example, there are reportedly large numbers of vacancies. Some health services are finding it challenging to recruit appropriately trained Health Workers with the right level of literacy and numeracy skills, while others face problems with retention attributed to 'burn-out' or exhaustion. A perceived lack of recognition and appropriate remuneration are also contributing issues.

Yet other health services face no such recruitment or retention challenges; indeed, some services report overwhelming interest from potential applicants. In these circumstances, promoting the organisation as a good place to work and building its reputation in the community were flagged as effective recruitment strategies. Also, increasing Health Worker job satisfaction through ensuring that they are consistently well supported and respected in their role was reported as being important for retaining Health Workers.

In short – it seems that recruitment and retention issues may be reduced if Health Workers are enabled and empowered.

#### Systemic issues

Health Workers, managers and other key informants voiced major concerns about some systemic issues, including:

- the emergence of new workforces from the implementation of the COAG Closing the Gap initiatives; these new workforces have reportedly undermined the Health Worker workforce by contributing to confusion about the Health Worker workforce's role, and competing with them in the recruitment market
- a range of issues associated with training including access, funding and comparability across jurisdictions which is symptomatic of a fragmented system that is hard for Health Workers to navigate and progress through
- the potential for Health Workers to be disadvantaged through their employment as it may result in loss of entitlement to other benefits such as community housing

- the ongoing low pay levels when compared to other workforces (eg nurses) and also the difference in pay between different sectors and geographic locations.

There is a need to consider Health Workers within the broader health workforce, for example:

- the role of the Health Worker workforce in addressing workforce gaps in other health workforces
- the implications of workforce shortages in other health workforces on the Health Worker role for example, the impact of fly-in, fly-out nursing and medical staff in remote areas.

## 9.1 Context

Throughout the focus groups conducted with Health Workers, managers and other health professionals, a number of themes emerged which have intrinsic value in themselves, but also reflect some of the reasons for the issues raised in the preceding chapters.

Consideration of these themes is relevant in the context of many of the discussions presented in this report. For example, an enabling workplace environment can affect an individual Health Worker's scope of practice, learning and development trajectory, career pathway, and level of supervision and support received.

These issues have been categorised into three areas:

- empowering Health Workers in the workplace
- recruitment and retention
- systemic issues.

## 9.2 Enabling Health Workers in the workplace

Health Workers work in different team environments at different workplaces across Australia. In the focus groups it became clear some Health Workers feel empowered to perform to their full capacity while others reported feelings of disempowerment, racial discrimination and exclusion.

Most comments were in the context of discussions about team dynamics including relationships with other health professionals, direct supervisors and management staff. Others were mentioned by Health Workers and managers in response to questions about what they would like to change about the Health Worker workforce. Analysis of these responses has emphasised the importance for many Health Workers of trust and recognition within the team, cultural safety and strong leadership in the workplace.

The following section discusses the themes identified in relation to workplace team dynamics. More specifically, it reports on the overlapping themes of:

- empowerment, trust, respect and recognition within teams
- cultural security in the workplace
- leadership and management in the workplace.

Although these themes are difficult to measure, the fact that they were raised so frequently, and by Health Workers, managers and other health professionals alike,

suggests they have a tangible impact on the Health Worker workforce and the capacity of Health Workers to reach their full potential.

### 9.2.1 Empowerment, trust, respect and recognition within teams

#### Empowerment

The definitions of 'empowerment' are varied and many, even when confined to the context of Aboriginal and Torres Strait Islander health. Eckermann et al explore the variety of definitions in *Binan Goonj: Bridging cultures in Aboriginal health* (Eckermann et al., 2010). They summarise the range of definitions on 'empowerment' by observing that most writers:

*"... believe that empowerment occurs when people take control of their lives, when they are in a position to influence decision making, when they have the ability and the opportunity to set themselves goals, when they have a vision about what they want to do and how they can achieve it."*

(Eckermann et al., 2010)

Eckermann et al also refer to definitions that highlight the difference between individual, group and structural empowerment, as outlined in the following excerpt:

*"Indicators of personal empowerment include improved perceptions of self-worth, empathy and perceived ability to help others, the ability to analyse problems, a belief in one's ability to exert control over life circumstances and a sense of coherence about one's place in the world. Group empowerment manifests in strong social networks and community participation in organisational decision making, perceptions of support, community connectedness and the ability to reach consensus on goal-oriented strategies. Structural empowerment refers to actual improvements in environmental or health conditions, evidenced by changes in systems, public policy and the community's ability to acquire resources to create healthier environments."*

(McEwan et al., 2009)

This highlights the importance of considering empowerment of Health Workers at the individual level (eg in their place of employment) as well as at the group level, as a collective workforce which contributes to the broader health system.

The theme of empowerment was raised by Health Workers, managers and other health professionals in both an explicit and an implicit way. Empowerment was explicitly mentioned by some participants in terms of the need for Health Workers to have greater involvement in decision-making, including designing and leading health programs or working more independently. For example:

Interviewer: "If you could change one thing about your job, what would it be?"  
"More say on how to run programs – we know what's needed for our communities."  
(Health Worker)

"We also need to empower them – support them to get to a point where they can do things for themselves"  
(Health Worker manager)

Some Health Workers and managers noted that many Health Workers have a clear understanding of the health needs of their community and how to respond to them. An empowered Health Worker might work in an environment where they are enabled to act on these insights, while a disempowered Health Worker might feel frustrated by their inability to influence change and participate in relevant decision-making processes.

The comment below shows how one Health Worker felt disempowered after being excluded from a particular decision-making process:

"A few years back two of us were told we had to go into Aboriginal Health Service from the Community Health Service. We were told we had to, we had no choice. I felt like I was back in my grandmother's shoes and it was very hard to do. White nurses come in and take over – they were more qualified. It's disempowering and demeaning. They think we're incompetent here – they say: 'Come and work with us as team but don't take over'."

(Health Worker)

Although this is just one example, analysis of the qualitative data suggests a number of Health Workers have limited involvement in decision-making. For example, to obtain some insights into team dynamics, Health Workers were asked who decides what tasks they will perform. Of those who responded to this question, only one-fifth reported that they were responsible for making their own decisions about the tasks they undertake. Most of the others stated that other people were responsible for deciding what the Health Worker could or could not do whether through a team or management decision-making process.

When asked the same question, manager focus groups reiterated the views of the Health Workers. Only one quarter of the manager focus groups reported that the preferences of a Health Worker determined the activities they would perform. The other three quarters stated that either managers or other health professionals decided what tasks Health Workers would perform.

Obviously, in any workplace environment there are limitations to the degree to which certain staff members can influence decision making, particularly in a hierarchical organisational structure. Therefore, this information should be interpreted with caution as there is no established indicator of what an ideal level of Health Worker participation might be in decision making processes. However, it does present some insights into current decision making practices.

On the other hand, focus groups highlighted examples of positive inter-professional relationships where Health Workers felt empowered:

"The nurses don't think they're more important than us – with them it's all about the team. We get along really well. It comes down to personality. You have to be able to work as a team, and not think that you're better because you've got a degree. The doctors that we've had the last few years have been like that. We have one doctor, one medical student, and two that come in for a half day each. The nurses are really good at giving us opportunities to step up and develop our skills."

(Health Worker)

## Trust

Trust was raised in response to questions about team expectations and also in response to questions relating to supervision. Almost two-fifths of the issues raised by Health Workers in relation to supervision centred around a perceived lack of trust from their supervisors, or experiences of perceived micro-management. Many Health Workers mentioned trust when asked, “if you could change one thing about your job, what would it be?”

The concept of ‘trust’ is difficult to identify, measure or prove.<sup>33</sup> Given its intangible nature, this section seeks only to report the comments made by Health Workers in relation to trust during the focus groups.

For example:

“Can they please listen to us and trust us. Trust your workers. I need to be treated as an adult, not a 16-year-old or an infant or a mental patient.”

(Health Worker)

“When we do go out [to do outreach] together, there is no trust in us – it doesn’t make me feel good inside. They are trying to control us ... I am disempowered as an Aboriginal man.”

(Health Worker 1)

“He needs to be out there, empowered, getting out in the community and building relationships. We need to go out there in the communities at least once a month and get to know people and understand their needs.”

(Health Worker 2)

Others provided anecdotes which imply an absence of trust in their relationships with colleagues. Although these are open to interpretation, it is the opinion of the interviewers that issues of trust are implicit in the following Health Worker comments:

“If I had a magic wand to fix my job with, I wouldn’t be justifying every single thing I do all the time, every single day. I wouldn’t have questions like: ‘Why did you take the car? Where did you go? Why were you standing talking to that person? Where are you going?’ and all that ...”

(Health Worker)

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<sup>33</sup> Trust is both a noun and verb – as a noun, it is defined as “a feeling of confidence in someone that shows you believe they are honest, fair and reliable”; the verb is defined as “to be confident that someone is honest, fair and reliable” MACMILLAN DICTIONARY. 2010. Trust [Online]. Available: [http://www.macmillandictionary.com/thesaurus/british/trust\\_23](http://www.macmillandictionary.com/thesaurus/british/trust_23) [Accessed].

“They [other health professionals] keep an eye on us, they notice when you're not here, they see if you're there or not and then they go and tell others if you're not. They don't think we notice but we do. They don't realise that we are doing work even if we are not at our desk. If you're at your desk as a Health Worker you are disengaging yourself from the community.”

(Health Worker)

“Why do Health Workers need someone working over their shoulder after they have been deemed competent by recognition of course and placements?”

(Health Worker)

From these comments alone it is not always clear whether Health Workers' colleagues are aware of the impact of their behaviour.<sup>34</sup> Communication between Health Workers and their colleagues is therefore important. These comments highlight the interrelationship between the themes of trust, empowerment, respect and recognition.

### Respect and recognition

The concepts of respect and recognition are closely connected. 'Respect' is defined as “a feeling of deep admiration for someone or something elicited by their abilities, qualities, or achievements” (Oxford Dictionary, 2010). To respect someone therefore requires recognition of their achievements.

'Respect' is also used in the context of 'cultural respect'. 'Cultural respect' is defined as the “recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples” (Australian Health Ministers' Advisory Council, 2004). Recognition is therefore central to the definition of cultural respect.

With regard to the Health Worker workforce, both the above definitions of respect are relevant. Respect was raised in two different contexts during the focus groups:

- Health Workers reported that they want to be respected as a workforce and recognised for the work they do
- Health Workers reported issues of cultural respect (see Section 9.2.2 for further detail).

The theme of respect in the professional context usually arose in the focus groups with references to other health professionals. The findings suggest many Health Workers believe other health professionals, particularly nurses, do not respect their role as a Health Worker, in part because they do not understand it.

For example:

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<sup>34</sup> For example, from the perspective of one health professional, they might be checking on the work of a Health Worker within the belief that they are maintaining accountability or service standards, but the way this is done might make the Health Worker feel as though they are not trusted. In such circumstances, interprofessional conflicts might result from misunderstanding rather than deliberate intent.

“The rest of the team don't like working with us. The nurses don't respect us or value us. They just call us when they need us to do something like round up the patients or something. We don't really get recognised. The nurses just think we drive around and do nothing all day. They've just learnt to deal with the fact that we're there.”

(Health Worker)

“The main problem here is the nurses don't understand our role or how we know the community. They think they know better. They don't see us as professionals but more as we are part of the community we can never be professionals. They use us to run around and do little jobs. They don't understand our ability and potential.”

(Health Worker)

This is also shown through the responses of some Health Workers to the question: “What would it take to change the situation so you could have a bigger role?” For example:

“Respect from all other health professionals – after 34 years we still have to explain what we do as Health Workers.”

(Health Worker)

“They need to have an understanding of what our role is, and the culture of our community. If we weren't there, half of these Indigenous people would be sick. Our team don't understand us. With my mum, she suffered for ages. They thought she had urinary tract infection. They waited until the last minute to fly her out when her kidney was about to fail. They found out she had kidney stones. If there had been a Health Worker there, they could have helped her.”

(Health Worker)

“The lack of understanding about what the Health Worker's role was supposed to be resolved in 2007. The Community Services & Health Industry Skills Council developed a package of Health Worker competencies. They were also supposed to provide a package of materials and PowerPoints and things to educate the wider community. If we had that, you wouldn't have doctors and non-Indigenous staff questioning the skills of Health Workers. What we need to do is educate new professionals about what Health Workers do and what they are capable of. With the AMS, if you employ a doctor you should have Health Worker awareness training as part of the orientation.”

(Health Worker)

Discussions of respect and recognition were often framed in terms of equality with other health workforces. When asked what they would like to change about their job, some Health Workers responded as follows:

"I would like to be seen equal and with expertise in my own area. All Indigenous employees to be recognised as equals in all areas."

(Health Worker)

"More recognition about how important Health Workers are. You have your nursing profession come under health professions, Health Workers should also be recognised as a profession."

(Health Worker)

Some Health Workers commented on the relationship between qualifications and respect, observing that if they attained higher qualifications they might gain more respect from other health professionals. Some appear to be of the view that their existing qualifications are not always respected or recognised. For example:

"At the moment they don't take our pieces of paper too seriously. It might be good if we do get registered just so that they value us. Like \_\_\_ said, We're not the cleaners anymore! We're left out on this little limb like cleaners."

(Health Worker)

Some Health Workers appear to measure their level of respect and recognition by the benefits they receive (or do not receive). This became particularly apparent in situations where Health Workers noticed they were not receiving the same type of benefits as other health professionals in comparable roles. This was reported numerous times. For example:

"If a nurse came to the clinic they'd get the wage, car, house, training, because conditions are not the same in remote areas. Health Workers get none of that."

(Health Worker)

"Nurses are given five uniforms – Aboriginal Health Workers have to pay for their own."

(Health Worker)

"Nurses and Health Workers often do the same – but nurses get paid double."

(Health Worker)

"Aboriginal Health Workers are the lowest paid Health Workers in the whole of Australia, even though we've been trained for years and have so many certificates. We are the lowest paid in the Community Controlled sector and in mainstream. They need to look at what qualifications we have, what level of pay we deserve. We don't get paid overtime, even though we do night clinics until 9pm at night. We should get recognition for the extra time we do.

We are passionate people, and we want to be here to help the community. But we also have families and mortgages."

(Health Worker)

These comments highlight issues of equity in relation to recognition and respect for Health Workers. It appears some of these issues stem from the fact that the Health Worker workforce is not clearly defined and their qualifications are not always respected by other health professionals who have achieved tertiary qualifications.

These challenges appeared to be exacerbated in health services where there was a high level of rotation of other health professionals. For example, in many remote locations, nurses are employed on a short-term basis and may rotate frequently (eg three weeks to six months). Some Health Workers pointed out this required them to continually orientate new staff to their role, working hard to demonstrate their own value and re-establish credibility. Some Health Workers reported being disillusioned and frustrated by the process of having to prove their value again and again to transient health professionals.

The impact on team dynamics of fly-in, fly-out health professionals is evident in the following comments:

"Even if they [nurses] come for just three weeks they get good money. And they got no experience, we get all the trainees. We like guinea pigs. We the same as Enrolled Nurses but we get less pay. White people just come in and out, in and out. We not happy with these nurses, when we got an emergency they turn their phone off. The community members come to us. We have suicide they still don't answer the phone. Only when they hear the rock on the roof might they come. Even in the night when someone or baby is really sick they make us walk over to the clinic. We want a permanent one here not just changing all the time. Sometimes they don't even say hello to us, they stay in the clinic and go home and stay home and don't know us. They just come just because they want big pay."

(Health Worker)

"I want just the same whitefella to stay permanent. We don't like seeing all these different nurses coming through all the time. Some just stay in the clinic then they go home. They don't introduce themselves, they only know community by the ones they see in clinic."

(Health Worker)

“How can we trust the nurses when they come and go all the time? They don’t even consult us. Registered Nurses don’t even know our name sometimes, but they tell us off saying you can’t take this or you can’t do that. Some of the Registered Nurses can’t get through to the locals, and they wonder why people get to talking back.”

(Health Worker)

“People come and go so often that they tell us things will change but never do. It would be nice if management would be understanding rather than just jumping up and down and yelling I’m the boss, you listen to me. We want to be equal.”

(Health Worker)

As the following section will explore, some Health Workers also believe issues of respect and recognition in the workplace are at least partially related to cultural awareness.

### 9.2.2 Cultural security in the workplace

The importance of cultural awareness for the effective delivery of health services to Aboriginal and Torres Strait Islander people has been discussed throughout this report and in the accompanying Environmental Scan. These discussions have largely focused on the cultural safety of Aboriginal and Torres Strait Islander clients, but the cultural safety of Aboriginal and Torres Strait Islander Health Workers in their workplace is equally important. Analysis of the qualitative data emphasised the relationship between cultural respect and the cultivation of positive team dynamics.

Terms like ‘cultural respect’, ‘cultural safety’ and ‘cultural security’ are often used interchangeably but have slight variations in meaning. Each term is defined in Section 1.3.4.

Information collected via surveys identified many Health Workers work in team environments that are partially or mostly staffed by health professionals who are not of Aboriginal or Torres Strait Islander descent. This was also evident at the interviews with other health professionals during the site visits – almost all those interviews were conducted with people who were not of Aboriginal or Torres Strait Islander descent. This was not through deliberate selection but because those people were the only other health professionals available and willing to participate in interviews on the day of the site visit.

Some Health Workers function in culturally secure workplaces where principles of cultural respect are well entrenched. However, other Health Workers reported experiences of racial discrimination and said they do not feel culturally safe in their workplaces. For example:

“Sometimes it is blatant racism – like ‘you can’t be doing this because you’re black’.”

(Health Worker)

“Racism is still an obstacle in the workplace especially with the nurses ... There is no support for us up here. We need a strong voice – someone who can be diplomatic. No one gets on with our managers and they don’t know how to deal with [our] issues.”

(Health Worker)

“We Aboriginal Health Workers are on one side of the building and it hadn’t even been fixed since the flood [12 months ago]. The roof was falling in, the building was all flooded. If the nurses had been there they would have complained and gotten it fixed and refused to work there. Instead they just let us work there.”

(Health Worker)

In these examples, it is clear the team dynamics between Health Workers and non-Aboriginal and Torres Strait Islander colleagues are poor. Usually this is indicated by reports of mutual distrust or feelings of disrespect, or reported issues with inter-professional communication.

However, many focus group participants discussed strategies for overcoming these types of situations, speaking of cultural security issues in a constructive way. For example, a number of participants emphasised the value of cultural awareness training in creating positive workplace environments. This is evident in the examples below:

“Non-Aboriginal or Torres Strait Islander Health Workers need cultural awareness training and understanding – this is critical.”

(Other health professional)

“Cultural awareness amongst non-Aboriginal managers. They need to understand our family and kinship system which is really strong. Things not seen as a ‘big deal’ by them are to an Aboriginal person. They should all do cultural awareness training regularly.”

(Health Worker)

One common factor of successful cultural awareness programs was the investment of a genuine amount of time and effort in the training. For example, one day of training was perceived by several participants to be insufficient to fully understand the cultural context and needs of the community. These views are reflected in the two examples below:

“We need to bring back education and cultural awareness [in our teams]. Ideally it would be for two days and take them out to the sites and the land ... it should at least be online mandatory training. The frontline staff need it – particularly those in administration who see many Indigenous patients. Those in drug and alcohol should get both drug and cultural awareness training.

(Health Worker)

“I am concerned regarding the cutting back of cultural awareness training for non-Aboriginal staff. There used to be a four-part cultural awareness training program. This was the most effective way to get true cultural awareness. While it keeps getting cut back to one day in orientation then I do not see the ability of white Australians to understand their needs and how to be culturally appropriate.”

(Health Worker manager)

In addition, a number of Health Workers stressed the need for training programs to go beyond generic information and be tailored to the local culture, in recognition of the cultural diversity of Aboriginal and Torres Strait Islander people. The involvement of local Elders in the development and delivery of cultural awareness programs was identified as an important way of achieving this and demonstrating respect to community Elders.

“The attitudes towards Aboriginal and Torres Strait Islanders is bad. The Elders notice every single thing. They take it all in. We went to a cultural awareness day – as soon as you walked in the white people went and sat on the other side to us Aboriginal and Torres Strait Islander people. You know the people, some of them you even went to school with. They’re just racist. It was about cultural awareness and when they were asked what they learnt, they said “the birthing tree”. That’s not even relevant to here. We don’t have birthing trees. The training did not involve Elders from the community – the trainer was from the city.”

(Health Worker)

The above views are perceptions of effective approaches to cultural awareness training reported by participants; they are not evidence-based studies on effective cultural awareness training practices. However, these perceptions do align with some of the literature on the topic.<sup>35</sup>

Although most of the comments above refer to culturally unsafe working environments, many good practice examples of culturally respectful working environments were also identified during site visits. These good practice examples appeared more often in Aboriginal Community Controlled Health services than in mainstream health services. However, there were mainstream examples, showing that it is possible to successfully create a culturally safe workplace for Aboriginal and Torres Strait Islander staff regardless of which sector the health service belongs to. This is exemplified in the case study below.

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<sup>35</sup> See the Environmental Scan

## CASE STUDY 8: Cultural safety in a mainstream acute-care setting

### Description of the service

**Name of Service:** St Vincent's Hospital

**Location of Service:** Melbourne, Victoria

**Type of Service:** Tertiary health service (public hospital run by not-for-profit provider)

### Key features of the service

St Vincent's Hospital is located in the heart of Melbourne and provides acute medical and surgical services, emergency and critical care, aged care, diagnostics, rehabilitation, Allied Health, mental health, palliative care and residential care. The hospital has over 6,000 staff, an operating budget of \$491 million and 848 beds.

This area of Melbourne has a rich Aboriginal heritage and a higher concentration of Aboriginal residents than other parts of the city. St Vincent's employs an Aboriginal Hospital Liaison Officer (AHLO) and an Aboriginal Liaison and Training Officer (ALTO).<sup>36</sup> One is a trained Health Worker whose primary area of focus is patient and family support.

St Vincent's also has five state-wide Aboriginal beds in the mental health inpatient unit and in response to requests from the Aboriginal community has begun a six-month trial of an Aboriginal Mental Health Liaison Officer position. The trial involves providing cultural support to Aboriginal mental health inpatients and will finish in December 2011.<sup>37</sup> An evaluation framework has been developed to assess the outcomes of the trial in collaboration with an Aboriginal researcher.

### What is working well

St Vincent's hospital is committed to providing culturally safe health care services to Aboriginal clients.

The Aboriginal liaison staff are central to this process. Both the managers and the Aboriginal liaison staff interviewed stated that management support empowers them to share their cultural knowledge with other health workforces to improve the cultural safety of the health service. The ALTO regularly delivers a cultural awareness training program to other health workforces. This is tailored to the local culture and provides an opportunity for the ALTO to educate other staff members, develop inter-professional relationships across hospital units and raise awareness about the value of the Aboriginal liaison roles. The program involves a 'Cultural Walking Tour' of local areas to explain the cultural, historical and political significance of heritage sites. According to reports, the program has been very effective at raising cultural awareness in other health professionals which has resulted in an increased number of requests for advice or referrals to the AHLO.

However, as observed by one of the managers interviewed, "with just two Aboriginal

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<sup>36</sup> Note that these are the actual position titles used by St Vincent's Hospital. These liaison officers are within the scope of this project given that a broad definition of "Aboriginal and Torres Strait Islander Health Workers" has been used. They may or may not fit within the future national definition of the workforce, which is yet to be determined.

<sup>37</sup> The project plan for this trial was developed in consultation with the Victorian Aboriginal Health Service Family Counselling, Onemda VicHealth Koori Health Unit (University of Melbourne), Victorian Aboriginal Community Controlled Health Organisation and the Department of Health (Mental Health)

liaison staff in a hospital of 6000 staff, the whole organisation has to be committed [to cultural safety]. We have to have systems for them to work comfortably”.

The Aboriginal liaison staff are therefore supported by a broader hospital policy that emphasises the importance of continually striving to improve services for the Aboriginal community. The *Aboriginal and Torres Strait Island Patient Quality Improvement Toolkit for Hospital Staff* contributes to the implementation of this policy. The toolkit was developed as part of the Improving the Culture of Hospitals project being undertaken by the Lowitja Institute, the Aboriginal Health Council of South Australia, La Trobe University and Onemda VicHealth Koori Health Unit (The Cooperative Research Centre of Aboriginal Health et al., 2010). The toolkit is designed to provide a systematic approach to improving Aboriginal health service delivery in a hospital environment.

St Vincent’s is one example of the way in which Aboriginal liaison staff contribute to the cultural safety of an acute care health service. The success of their efforts is demonstrated by reports that some of St Vincent’s Aboriginal and Torres Strait Islander clients travelled to St Vincent’s from other jurisdictions because they believed St Vincent’s would provide a higher level of cultural safety.

#### Challenges

Capacity to meet demand is one of the main challenges reported by the Aboriginal liaison staff and managers. These demands relate to direct client services, in addition to demands from other health professionals for support, advice and cultural awareness training. As the cultural awareness of staff at St Vincent’s increases, so too does demand on the Aboriginal liaison staff as other health professionals recognise the value that these Aboriginal liaison staff provide for Aboriginal and Torres Strait Islander clients.

### 9.2.3 Leadership and management

A number of focus group responses from Health Workers and managers sheds some light on the role that leadership and management has in building enabling workplaces for Health Workers. Also, while leadership is distinct from management in the sense that it is more transformative than process driven, both have great value in enabling an effective workforce. Interestingly, the distinction between the two concepts was not drawn out by focus group participants which perhaps indicates that both are equally important from their perspective.

Below is one Health Worker’s reported experience of working in an environment with strong management structures and processes, compared to a later situation in the same workplace when these processes had reportedly deteriorated.

“We used to have meetings with management or Indigenous Health Workers or the communities on a monthly basis – it might have been with Hospital Liaison Officers or the community or the government. It was all up the hierarchy, different levels. We need to bring them back. It used to give us an update, a chance to air our grievances, have our voice heard and hear about the needs of our community. Indigenous workers need to be involved more in the Health Service. Also, if we had continual community meetings once a month or once every six weeks, that would be the top priority for me – that is the only time I can engage with the community, get to know who is who, and feedback to the Health Service.”

(Health Worker)

This excerpt shows the value some Health Workers place upon having a structured opportunity for two-way communication with management staff at different levels of the organisational hierarchy. Participation in management processes, whether through direct involvement or feedback, gives Health Workers the opportunity to be empowered in the workplace. As identified by the Health Worker above, management processes can enable Health Workers to influence health services by reporting on community needs and also give Health Workers a chance to voice their own needs or grievances.

Health Workers who do not feel as though they work in an environment where they can properly communicate with management used negative language. For example, when asked, “if there was one thing you could change about your job, what would it be?” one Health Worker responded as follows:

“Greater awareness and understanding from our managers and the mainstream community. To have more control and say in the cultural awareness orientation at the hospital – I hate it. A manager who is easier to work with.”

(Health Worker)

Below is a quote that gives an insight into a contrasting scenario: a Health Worker was originally working in an environment they believed did not have appropriate management, but a change in management helped turn the workplace around for the better. It is now reportedly a health service where “people want to come to work”.

“We’re happy in our jobs now, people want to come to work here. Having a non-Indigenous manager didn’t work – we need someone who will fight for us. But now we have an Aboriginal manager it’s now good. Maybe other managers need to be more proactive and vocal. Now we have a reconciliation event every year, Aboriginal and Torres Strait Islander artists can showcase their work and their art can be bought. The atmosphere is now welcome and safe.”

(Health Worker)

Therefore, leadership and management clearly have a tangible impact upon the environments that Health Workers work in. These factors can contribute to the creation of an enabling workplace where Health Workers are empowered and culturally secure.

But what are the features of strong leadership and management in the context of the Health Worker workforce? Do leaders have to be of Aboriginal or Torres Strait Islander descent, as suggested by the comment above?

Many Health Workers reported that they prefer this to be the case – an Aboriginal or Torres Strait Islander leader can help create a culturally safe environment. However, others seem to believe the cultural identity of a leader is not relevant in empowering Health Workers in the workplace. This became clear when considering two observations.

First, some Health Workers reported negative management experiences despite having Aboriginal and Torres Strait Islander people in management roles. Second, others reported positive experiences where non-Aboriginal or Torres Strait Islander people were in leadership roles. Cultural identity was therefore not the only consideration for strong management in those cases.

However, in instances where managers were not of Aboriginal or Torres Strait Islander descent, many Health Workers spoke of the need to access other leaders or mentors for cultural knowledge and support. The value of 'cultural supervisor' or 'cultural mentor' roles was discussed at a number of site visits and also on the projects online forum (Section 8.2.2 also comments on cultural mentoring). These types of roles could support Health Workers to further develop their cultural knowledge and navigate cultural circumstances that are outside their comfort zone, particularly if they have a manager who does not identify with the local community.

Finally, some participants in focus groups pointed out that sometimes Health Workers are installed in management roles without being given appropriate opportunities to develop the necessary skills.

For example:

"I was a senior Health Worker and the CEO moved me to the Practice Manager role. I learnt how to be a manager on the job but it would have been good to have the proper training in management so I could know I was doing it right. Also, in the past the Registered Nurse was the Practice Manager but now the CEO doesn't actually let me manage. I said to the CEO, let me run the practice and you get on with the administration. The CEO has no clinical background – they can run an office but not an AMS. This is why CEOs employ managers so they should just let us do our job! The CEO just took over everything and doesn't listen to us. They give no power to us."

(Health Worker)

"I think young Aboriginal managers need some support and they are too shy to ask for help – they need to be nurtured."

(Health Worker)

To empower Health Workers in leadership roles it is not sufficient to promote them to management positions and assume they will be empowered. Like any new manager, Health Workers in leadership roles need to be supported to develop the skills, tools and knowledge to succeed. This is a continuing development issue for any manager in any workforce. One Health Worker manager captured this principle in the comment below:

“Part of my philosophy at an AMS is you need to be doing community development – by developing the Health Workers to step up.”

(Health Worker manager)

In summary, leaders and management processes do influence the Health Worker workplace environment. They can foster enabling environments where Health Workers feel culturally secure, respected and supported. But equally, where strong leadership and management is absent, it can be very damaging. As a consequence, consideration needs to be given to how leadership and management skills are developed in health services where Health Workers work.

### 9.3 Recruitment and retention barriers and enablers

Together with the Closing the Gap target on employment, 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 (Standing Committee on Aboriginal and Torres Strait Islander Health, 2002, Australian Health Ministers' Advisory Council, 2008).

Currently, there is limited transparency about the Health Worker recruitment market since little reliable information exists regarding the size and geographic distribution of the workforce. As a consequence, this project has obtained perceptions from the ‘front line’ of Health Workers and health managers on the issues of recruitment and retention. The results are presented below.

#### 9.3.1 Recruitment challenges

There was overwhelming consensus from the health manager focus groups that they experienced significant challenges in recruiting Health Workers.

“Presently we have six vacancies available in our region and we really struggle to find, recruit and employ Health Workers.”

(Health Worker manager)

A major challenge was the lack of appropriately trained or skilled staff. This was echoed in the results of the health manager survey, where 69% of respondents indicated the lack of applicants with appropriate qualifications is a significant challenge they currently face.

“One of the issues in mental health is that we can’t get people to apply for the jobs and other times there are no appropriate people.”

(Health Worker manager)

“There is not a pool of skilled HWs within the community that the Health Centre can draw upon”

(Health Worker manager)

“Simply it is availability of staff. There is not enough of a pool of staff who are trained and willing to work. There is not enough trained staff.”

(Health Worker manager)

“Education levels are the biggest barrier to community recruitment as very few have the right level to gain Certificate IV without a lot of help and education from us just to come up to the level required by the RTO. The RTO has a ‘bums on seats’ mentality because they are paid on enrolment and graduation. Without a lot of support the classroom training is not suitable for our trainees and many drop out which causes them a lot of personal pain and loss of confidence – Shame. The male students do not complete the classes because the teaching is for both genders and they cannot learn and discuss men’s business in a joint environment. They need specific classrooms to cover this stuff.”

(Health Worker manager)

Some of the issues concerning appropriate levels of qualification related to low levels of literacy and numeracy.

“When people are coming out of year 12 unable to read and write well enough to write a letter, there are serious issues.”

(Health Worker manager)

“Numeracy and literacy is the major issue to recruitment and education”

(Health Worker manager)

“Accessing appropriate training at their literacy/numeracy level is also proving to be a stumbling block.”

(Health Worker manager survey)

“What they don’t realise is that Indigenous people are still disadvantaged in education. Especially at an academic level, because the school system had failed us when we are going to school. And yes, at the end of the day it is the parents that are responsible – but it’s also about comprehension.”

(Health Worker)

The low rates of pay were often raised as a concern for health managers in recruiting (as well as retaining) Health Workers.

“The pay – we can't pay them what they deserve. We have most of the Health Worker positions vacant – we cannot fill the roles. We can appoint people but it takes them so long to get through Certificate III and Certificate IV.”

(Health Worker manager)

“No incentives to become employed when they see the current staff receive nothing. Housing and rates of pay indicative of their role and responsibilities are not equal to other health professionals.”

(Health Worker manager survey)

Another recruitment challenge identified in the health manager survey was the lack of funding for Health Worker positions, while health managers from rural/remote areas also stated that accommodation and housing issues often serve as a barrier. For example, as one health manager noted:

“If accommodation was included in part of the package when Health Workers are advertised then appropriately qualified Health Workers will apply for the positions. In some instances, applicants who hold the correct qualifications are turned away because accommodation is not offered as part of the package”.

(Health Worker manager)

On a positive note however, a small number of health manager focus groups indicated that overall, they did not have too much difficulty in recruiting Health Workers. This is addressed in further detail in the following sections.

### 9.3.2 Retention challenges

Health Workers were asked whether they wanted to stay in their current roles and even though the response rate to this question was low, the majority of focus groups said they did want to stay in their current role. For those who said they did not the reasons given included a feeling of being burnt-out, low morale in the workplace and remuneration considerations. The lack of career progression opportunities was also an issue.

“One major problem is that I have a family but do not make enough money to support my family. If we do overtime we do not get paid for it”

(Health Worker)

Health managers stated that remuneration/salary considerations were one of the main reasons Health Workers tended to either leave the workforce or change jobs.

"Their role is identical to what we do ... It makes me feel like a bit of an idiot really because I open up my pay packet and I have twice as much there. If we didn't turn up, nothing would change."

(Other health professional)

"Low salary is a concern. There are no incentives like remote allowance or housing or accommodation and transport."

(Health Worker manager)

"We want to stay here but we are looking to going mainstream so that we can earn enough to support our families. We are only on about \$30,000."

(Health Worker)

"Disparity of conditions and recognition of the role. For instance nurses come into community on a short-term contract and are provided with a free house, a large salary and support to practise. HWs are expected to find their own accommodation even if they are moving communities because they have access to family homes. Often the living conditions are cramped and very poor with sewage constantly and continuously bubbling up out of the toilet of one of our worker's homes. They have to pay rent, which is about to go up, and cannot rest if they are up all night because there are kids running around and it is crowded."

(Health Worker manager)

Health managers agreed burn-out was one of the reasons for Health Worker departure from the workforce along with a lack of respect and support for Health Workers.

"Burn-out rate is so incredibly high – clinical supervision in a hierarchy within Aboriginal networks is not set up either."

(Health Worker manager)

"Pressure on Health Workers is very high. For them it is a 24/7 job. They never get to switch off as they have community expectations to always be on call."

(Health Worker manager)

"A lot are retiring as they are burnt out and tired."

(Health Worker)

“Burn-out rate is really high because it’s so demanding. We get paid 8-4 but we go home really late.”

(Health Worker manager)

### 9.3.3 High attrition rates

High attrition rates in the Health Worker workforce were frequently referred to throughout the Health Worker manager focus groups and the key informant interviews. This reportedly meant that many Health Worker positions remain vacant for long periods.

Some of the factors contributing to attrition are stress, salary, lack of job security, and opportunities to move into other health workforces that have fewer qualification requirements but higher pay.

For example, when asked about the main reasons Health Workers leave the workforce, some managers provided the following comments:

“People are leaving to go to higher-level positions in other streams like the AO5 positions. There is higher money, less stress, less qualifications required.”

(Health Worker manager)

“Pay parity – they can get better paid jobs as community workers or in other areas. Also the lack of an appropriate career structure which recognises skills within the different levels and remunerates appropriately for these levels.”

(Health Worker manager)

“One issue is around contracts. In all services in the region length of contracts is based on funding. Hence a six month funding stream equals a six month contract. There is no job security for Health Workers.”

(Health Worker manager)

### 9.3.4 Effective recruitment strategies

Responses were mixed when health managers were asked what they saw were good strategies to attract Health Workers. Some suggested presenting Health Workers as good community role models along with being seen to provide appropriate training and support for Health Workers was effective, while some health managers indicated that there was no good strategy.

Overall, having a good reputation in the community appears to play an important role in attracting staff. For example, it was reported that Health Workers tend to rely on their community networks and sources to know which organisations are good places to work and which ones are not. The following quotes provide further insight into this dynamic relationship between the health service and the community.

“Not too much difficulty recruiting HWs. Some people are training in the community that are waiting for a position. It's a tight-knit community, we've got a damn good boss at the top who is very community-oriented. If you didn't have that, we wouldn't have the ease of recruitment. It is the support – we support HWs to be educated, there is a family-like environment and a very supportive workplace.”

(Health Worker manager)

“No challenges of recruitment – everyone wants to work here and always rings us up”

(Health Worker manager)

“We have no problems with recruitment. Everyone wants to work here. We are turning people back. Both Health Workers and doctors. We have five doctors and two Indigenous. We sent some doctors across to another area when they needed them. We have achieved all of this in three years. It is possible to turn a health service around in a short period of time. If you have the right philosophy and vision, and you bring on the right people who are committed to that vision, you can do it. And you need to recognise if you have the wrong staff and make some difficult decisions.”

(Health Worker manager)

Just over half the health managers' focus groups indicated that recruitment for Health Workers came most often from the local community. A smaller proportion said they recruited from the general public.

“[Recruitment is] mainly done locally due to community. Each person is known to the community. Being accepted by the community is critical due to the scope of practice of the role. Even if people are from the community if they are not accepted they might not be the right person.”

(Health Worker manager)

“Most AHW are employed from the community they live in.”

(Health Worker manager)

Another opportunity for recruitment is raising awareness about the role and potential career pathways at an earlier age, for example at school. This acknowledges that the Health Worker workforce is an ageing population while there is a huge potential for growth from the younger members of the community.

“We need to look at promoting the Health Worker career pathway to children at high school and then introduce a local VET program to ensure that high school students are equipped to meet the requirements of the training. We need to start earlier and demonstrate the benefits to the community and the individual. If we wait until they leave school in year 10 or 12 we get them with education levels that are not high enough and the skill gap is almost too hard to close and puts the students at risk of failing even though it is the system that is failing them. We have an education system that’s failing our kids out there.”

(Health Worker manager)

“I want to see more young ones coming through. Us old ones will not be around forever.”

(Health Worker)

“I’d like to see them get out and do the work. A lot of the young fellas don’t want to do this work because of Shame. To encourage them you have to get them into it first – they have to go to school and get more educated. I have a 15 year old that wants to be a doctor but she told me that the day that she was skipping school. They need to go to school to get educated. And then you need job opportunities – there aren’t enough around here. And social services mean that they don’t need jobs.”

(Health Worker)

### 9.3.5 Effective retention strategies

Some of the positive reasons given by Health Workers for wanting to stay in their current role included high job satisfaction and having strong ties to their community and wanting to make a difference. Some of the examples provided through the focus groups include:

“I don’t think people realise that being a Health Worker is an honour. Some of us want to be a Health Worker, not go onto another profession. Some white people think it’s just a stepping stone to being a nurse. But it is a good job in itself and needs to be respected as that. It is not easy, it is a pretty full-on job, it is a high pressure job. We don’t sit around drinking coffee all day – it’s a big, big job, and it’s well worth it. You’re not going to get a pat on the back – in 13 years I don’t think anyone has said thank you. I tell that to young people. But we just do our job – it’s what we do.”

(Health Worker)

“We have been working here for 20 years, we love it. We love treating our mob. This is our home. The CEO, the Deputy CEO, the clinic coordinator and multiple programs coordinators worked at the only Sydney AMS 20 years ago and then we set up this service and have been here since. Working in health makes a difference to my communities: I want to be part of that.”

(Health Worker)

“Want to stay as it is a good job and doing good for the community.”

(Health Worker)

“No – Love the job – love the responsibility and still have back up – AHW first person to see the community. Have a really good manager who is supportive – listens to proposals and what needs to be done for the community. Love what able to do for the community – love the people and do it for them – conditions need to be better though – should get the same housing as nurses.”

(Health Worker)

Other important features contributing to high levels of job satisfaction of Health Workers are having a supportive management structure along with adequate and appropriate levels of respect from their colleagues. This was echoed by health managers who indicated providing Health Workers with respect, recognition and support in their role is important to improving their job satisfaction levels, as is having effective Aboriginal and Torres Strait Islander leadership or management where possible.

“Nice environment – safe practices, culturally appropriate workplace and recognition and respect for traditional cultural activities within community that can take us away from work at times.”

(Health Worker manager)

“Community leadership and recognition and respect for the role.”

(Health Worker manager)

“Having a Health Worker-led service. Also during the two year training process we pay a full salary.”

(Health Worker manager)

“Supporting staff, provided a good workplace, encouraging development of staff”

(Health Worker manager)

Health managers reported that increasing opportunities for further education and training along with providing Health Workers with flexible working conditions to accommodate family or community obligations were important.

“Having good training and education supports through our development team.”  
(Health Worker manager)

## 9.4 The systemic context

Throughout the consultations with key informants, Health Workers, health managers and other health professionals, a range of common systemic issues were raised. These issues highlight the need for a more coordinated approach to workforce development from all levels of government and across relevant government departments at each level.

### 9.4.1 Closing the Gap: implications for the Health Worker workforce

As pointed out in Chapter 1, the COAG ‘Closing the Gap’ strategy being implemented through the National Partnership Agreements is designed to address health inequality between Aboriginal and Torres Strait Islander people and other Australians.

Although the COAG Closing the Gap strategy and the development of the Health Worker workforce appear to share this same objective, reports have highlighted an unintended tension between these two initiatives. This largely stems from the fact that the Closing the Gap strategy has resulted in the creation of new workforces established and funded by COAG to address specific health needs. For example: Outreach Workers, Healthy Lifestyle Workers, Tobacco Workers, Environmental Workers and Physical Activity Workers.

The emergence of these new workforces is perceived by some project participants to undermine the development of the Health Worker workforce in three ways.

First: **confusion about the Health Worker role.** These new workforces contribute to the confusion about the Health Worker role, scope of practice, qualification requirements and value. There is a significant overlap in some of the roles and responsibilities. For example, the Healthy Lifestyle Workers and Outreach Workers funded by COAG perform similar activities to Health Workers. However, those workers are not required to identify as being of Aboriginal or Torres Strait Islander descent and many of the new positions have lower qualification requirements than Health Worker positions. Some participants therefore believe the new workforces have a lower capacity to affect health outcomes than the Health Worker workforce.

Second; **competition for applicants.** The new workforces compete from the same pool for the Health Worker workforce candidates which undermines recruitment strategies for the Health Worker workforce. Many participants in the Health Worker and manager focus groups claimed the new workforces receive much higher salaries than Health Workers despite having lower educational requirements and lower levels of responsibility. Consequently, the new workforces offer incentives that entice some Health Workers, or people considering becoming a Health Worker, to pursue COAG Closing the Gap positions instead. This is likely to have ongoing implications for the sustainability of the Health Worker workforce. The comments below demonstrate these views:

"Some are thinking they will apply for COAG positions because they've been here so long and pay is higher."

(Health Worker)

"Pay difference is a major issue. Within our own service two different program streams like Stream A and Stream B get paid different wages as they come under different awards. For example Stream A gets \$47,000 and Stream B gets paid \$35,000. The people with more qualifications and experience are actually getting paid less."

(Health Worker)

"Aboriginal Administrative Officers are paid more than a Health Worker 003 or 004 stream and you don't need any qualification whatsoever. Aboriginal Hospital Liaison Officers are paid at the Administrative Officer level, but Administrative Officers don't need any qualifications. Obviously something isn't gelling right if they're starting to create more positions."

(Health Worker)

Third: **resources and funding**. The Closing the Gap positions use COAG funds that might have otherwise been invested in the development or expansion of the Health Worker workforce. Some Health Workers, managers, other health professionals and key informants referred to the fact that limited resources and funding were preventing Health Workers from expanding their role or delivering more programs. Given the Health Worker workforce and relevant infrastructure was already in place, there was some disappointment that the COAG funds had been used to create new overlapping workforces instead of strengthening the existing Health Worker workforce.

These sentiments are summarised in the comment made by a key informant:

"It is weird that this new workforce, imposed upon the sector without a clear evidence base, were employed at an 'entry level' to help improve access for Aboriginal people to culturally appropriate health care ... Isn't that a key function of Aboriginal Health Workers as well? Many Outreach workers are paid just as much as a Health Worker with years of experience and training behind them. I don't understand why Outreach Workers are allocated over \$85,000 funding to support them in their role. Surely a Health Worker could perform this function just as well ... I don't know, it just doesn't seem to make sense."

(Key informant)

The new workforces will face the same challenges as those currently facing the Health Worker workforce; for example, how education providers meet the educational needs of this workforce and how the funding for education is provided. Some of the new workforce will be unlikely to perform the same cultural safety role as Health Workers given that many of the new positions, such as Healthy Lifestyle Workers and Tobacco Workers, do not actually require the applicant to be of Aboriginal or Torres Strait Islander

descent. Therefore, rather than addressing the existing challenges surrounding the Health Worker workforce, COAG may be faced with more fragmented challenges spread across a number of overlapping workforces.

These challenges must be acknowledged and addressed to optimise the impact of both the Health Worker workforce and the Closing the Gap workforces.

#### 9.4.2 Access and funding for training

Some health managers reported there was simply a shortage of RTOs to deliver the required training. However, course over-subscription was not frequently raised as an issue from training providers and other key stakeholders in key informant interviews. Currently the data is not available to verify whether this is the case or not.

"Access and choice of RTOs is a barrier. The RTO in the region is not preparing the Health Worker for real work."

(Health Worker manager)

"I pay for my training myself because [RTO 1] was full, and so was [RTO 2]. I'm at [RTO 3] with people from [health service] but we couldn't get into the course till the next year. We want to go to courses but the positions aren't there. And we need more information about funding – there is heaps out there but we just don't know about it."

(Health Worker)

Challenges of current funding models for training were frequently mentioned by key informants from training organisations, jurisdictional health and peak bodies. Where funding was reported as being available for some programs (such as the DEWEER Workplace Education Program) in other cases it was hard to obtain funding to provide:

- appropriately funded bridging courses
- a range of blended Health Worker courses to meet the needs of students still acquiring numeracy and literacy skills
- regional training assessors and mentors.

Also, innovation and local delivery were reported to be limited by the requirement to deliver in the most cost-effective location.

#### 9.4.3 Training pathways and models

A number of health managers reported challenges in the current training models and pathways. Disparity in training courses and clinical requirements between jurisdictions were reported as a concern by most jurisdictional and ACCHO representatives. Comparability in course pathways and cross-jurisdictional accreditation of courses was also raised with regard to future training models. These issues are likely to be relevant to the new national RTO regulator that is being established.

“RTOs signing off students who have not done the work is a real problem here. There needs to be better support while studying, including travel, ABSTUDY, organisational needs such as forms. The amount of training is because of the de-skilling that has gone on – training models and programs need to be revisited.”

(Health Worker manager)

“The training organisations need to improve and then a team of people need to be overseeing the clinical training and assist with clinical assessment in the workplace.”

(Health Worker manager)

#### 9.4.4 Welfare incentives and disincentives

Some Health Workers reported they were paid too little to live without some form of government welfare or housing support. However, for some, employment as a Health Worker makes them ineligible for certain welfare options such as community housing and Centrelink payments. In other cases it was noted Health Workers refused to receive fringe benefits from their employer because doing so would push them over the threshold of eligibility for welfare.

Unfortunately for some Health Workers in this situation, the potential income or housing arrangement provided by government welfare services offers a better economic situation than employment as a Health Worker. Therefore, without more equitable wages, some Health Workers are presented with incentives that encourage welfare dependency.

This is demonstrated in the comments below.

“I’m getting kicked out of my HomesWest house because my pay is \$50 too much. I’ll have to give up work so I can keep my house.”

(Health Worker)

“If they don’t earn significantly more than Centrelink gives them, then the incentive is not there to work as a Health Worker.”

(Health Worker manager)

“These Health Workers work full time, take a low income, they’re still dependent on government support – how can they help people to get out of a disadvantaged position if they are disadvantaged themselves? They are lining up for Centrelink even though they work full time.”

(Health Worker manager)

#### 9.4.5 Industrial awards and pay parity

Pay parity has consistently been identified as an issue, during key informant interviews, focus groups (across all participants) and surveys. Pay disparities are evident even

through the data collected by the ABS, particularly in relation to area of remoteness and across jurisdictions.

“Lots qualify as Health Workers and then go work at the mines and leave the health industry because pay is very poor and there are no prospects.”

(Health Worker manager)

“Parity of pay issues for staff working in Human and Social Services and the industrial sector – they get \$44,000-\$55,000 in the Human and Social Services sector; but a trades assistant at an industrial site gets \$120,000. This is a problem because we are expecting that they have to have a tertiary qualification and then don't get paid much.”

(Health Worker manager)

“There's no incentive to be a manager here, you get nothing – it's just stressful here. We earn 20c per hour less than when we worked for Red Rooster as unqualified staff. People get more money at Coles working on Saturday afternoon. We're that far behind. Kids doing night packing get more than us. A lot of people are leaving and going to mining – more benefits, travel everything. It's cheaper to get an AHW than to get a nurse in.”

(Health Worker)

“I really believe that the Aboriginal Community Controlled Health Service award of 2006 is not sufficient – it pays them mid \$30,000s. That's what we pay our administration staff. The award does injustice.”

(Health Worker manager)

Perceptions of pay disparity in the government/ACCHO sector are demonstrated in the following comments:

“We need salary scales to be the same in all sectors, so that if you work for one group you get the same as other Health Workers with the same education and experience.”

(Health Worker)

“The State Government award system is differently structured to the Community Controlled sector. There are significant parity issues between State Government wages and wages as an Aboriginal Community Controlled Sector Health Worker. The comment from a bureaucrat on pay parity is that, ‘The only reason government uses community controlled is that it’s cheaper’ – this is a wrong view. It is really because the Community Controlled Sector provides important access opportunities. Parity issues are large. For us to retain the workforce it’s hard – if Government Health jobs are coming up, do you stay in Community Controlled sector or jump the fence? You get larger wages, better super fund if employed by government.”

(Health Worker manager)

There were also reports of pay disparity across similar workforces:

“It would be good to have equal rights as nurses, like they get houses and what not. At one stage we were showing ENs what to do, but they get paid more than us.”

(Health Worker)

“Enrolled Nurses can't do as much as Health Workers but get paid more. That's not fair. Health Workers deserve the same as Enrolled Nurses because they do just as much.”

(Health Worker)

## 10. Opportunities for action: where to from here?

“I fear we will lose the Health Worker role entirely in our region because so much needs to change to make it a viable career pathway for our young people. Without Health Workers, the care of our communities will get much worse and the gap will widen.”

(Health Worker manager)

### 10.1 Context

Information collected throughout this project contributes a new body of evidence to inform ongoing development opportunities for the Health Worker workforce. The key findings presented throughout this report are both overlapping and interlinked.

This section presents the current picture that can be derived from the data collection and then explores what is required to transform the Health Worker workforce. This transformation is likely to involve five steps:

1. **Define the workforce** using nationally consistent titles and develop a national understanding of the Health Worker scope of practice
2. **Clarify and strengthen education and career pathways** to ensure that Health Workers have access to opportunities for career progression and recognition
3. **Build a systematic approach to workforce planning** to facilitate workforce development at the systemic level; for example, by creating mechanisms to coordinate planned responses to workforce supply and demand issues
4. **Create enabling workplace environments** to ensure that policies from the top are effective on the ground
5. **Collect and share an evidence base** to recognise the value of Health Workers, promote good practice, and inform future workforce planning.

These steps are intended to guide the continued development of the Health Worker workforce. The opportunities for action which are highlighted in this chapter are not intended to serve as prescriptive or definitive recommendations.

Instead, they provide a basis for ongoing consideration. In particular, they are likely to be discussed as part of a series of workshops being held across Australia between May and July 2011. Therefore, although this report may not provide the answers, it does ask questions that must be addressed as the Health Worker workforce continues to mature.

### 10.2 The current picture

Australia is faced with the challenge of overcoming health inequality between Aboriginal and Torres Strait Islander Australians and the broader Australian population. As discussed in Section 4.2, some of the main causes of this poor health status are cardiovascular disease, mental disorders, chronic respiratory disease, diabetes and injury. The high burden of disease experienced by the Aboriginal and Torres Strait Islander population, and the social determinants of health contributing to this disease burden, are well recognised.

At the same time, a number of barriers undermine access to health care services for some Aboriginal and Torres Strait Islander Australians. Transport, cost and geographic

proximity impede health care access for some (Section 4.3). Yet the most significant barrier identified during national consultations related to cultural security (Section 4.3.3). According to reports from Health Workers, managers and other health professionals, some Aboriginal and Torres Strait Islander Australians are likely to avoid health services if they do not provide culturally safe environments. This observation was identical across all three focus group categories.

The Health Worker workforce is perceived to play an important role in addressing these health and service needs. Health Worker roles currently being performed are described in Chapter 5. In particular, information collected demonstrates Health Workers have been recognised for their unique role in fostering culturally safe health services and reducing barriers to health care accessibility (Section 5.3). The comprehensive primary health care services they deliver target the specific health needs of Aboriginal and Torres Strait Islander Australians. Embedded in this approach is the holistic concept of health valued by Aboriginal and Torres Strait Islander cultures. Importantly, the prevention and health promotion role that many Health Workers perform (described in Section 5.4) creates an opportunity to identify, treat or prevent illness – before an individual arrives at the hospital emergency department, where it is often too late.

However, evidence suggests that the Health Worker workforce is not empowered to reach its full potential. For example:

- the workforce is not clearly defined – substantial variation in Health Worker roles across the country contribute to confusion about the scope of practice, undermining inter-professional relationships (Section 3.2; Chapter 4; Section 9.2)
- significant barriers to education and career advancement exist, hindering some Health Workers from functioning to their full capacity (Chapter 7)
- there is limited evidence to demonstrate the actual impact of the Health Worker workforce on health outcomes, and thereby value their contribution (Section 8.5)
- some Health Workers report working in culturally unsafe environments, or in teams that are undermined by issues of trust, respect, and leadership (Section 9.2).

Although the value of the Health Worker workforce is widely reported, evidence suggests it is potentially not being optimised in the current environment.

### 10.3 The opportunity to transform the workforce

Given this situation, there is an opportunity to enhance the role the Health Worker workforce plays in closing the gap in health inequality in Australia. A common theme emerging is that to enhance the contribution made by Health Workers, recognition and empowerment of the workforce is essential.

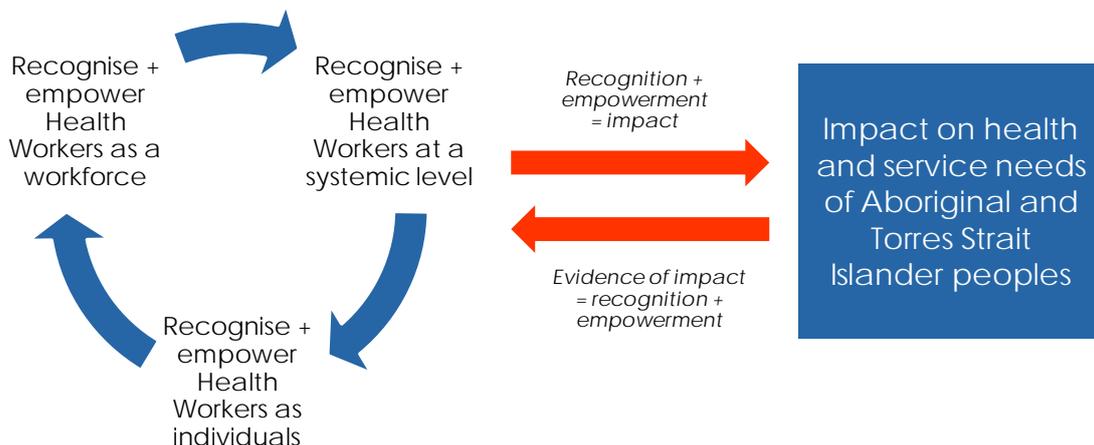
Health Workers need to be recognised and empowered at the individual level, the group level, and the systemic level. A potential future scenario in which Health Workers are valued and empowered at all levels, could look like this:

- at the **individual** level, Health Workers who are valued and empowered are supported to perform to their full capacity. They are empowered to use their initiative and respond to the community needs they see every day. They are empowered to influence decision-making in health services, foster culturally safe environments and seize leadership opportunities

- at the **group** level, a Health Worker workforce that is valued and empowered is able to function as a distinct professional entity – clearly distinguished from other health professionals. Members of this workforce are empowered to support one another and share information, good practice and lessons learnt. They are empowered to advocate as a coherent group for culturally secure workplaces and fair reward and recognition. The Health Worker workforce is empowered to continue to evolve and reach its full potential
- at the **systemic** level, recognition of the Health Worker workforce is reflected in the strategic incorporation of the workforce into health system planning. Relevant funding arrangements involving the education, health and employment sectors are coordinated to facilitate the development of a sustainable workforce supply. The deployment of the Health Worker workforce is evidence-based, planned and strategically targeted to optimise its impact. Collaboratively, the government and Aboriginal Community Controlled health sectors fully utilise the Health Worker workforce to improve health outcomes for Aboriginal and Torres Strait Islander Australians

Given the links between these levels of the system, any progress made at one level is likely to be mutually reinforcing (see Figure 20). For example, measurement of the impact of the Health Worker workforce at the group level might generate greater recognition at the systemic level; greater recognition at the systemic level might earn individual Health Workers more trust, respect and empowerment in the workplace; respected individual Health Workers might receive greater support to develop local networks and share innovative Health Worker workforce models with other Health Workers. Each level of the system is therefore crucial to the process of optimising the contribution made by the Health Worker workforce.

Figure 20: Recognising and empowering the Health Worker workforce – a virtuous cycle



### 10.3.1 What are the next steps?

When presented with a vision for the future, the steps required to get there are not always obvious. However, in this instance there is a substantial body of work to build on as highlighted in both the Environmental Scan and in this report.

For example, the Northern Territory has had a functioning Health Worker registration system since 1984; the CS&HISC developed the national Health Worker qualification framework in 2008; the National Aboriginal and Torres Strait Islander Health Workers' Association was established in 2008; and the groundwork is currently being laid for the

national registration of Health Practitioners in 2012. This project builds upon these efforts, contributing an additional body of evidence to shape future developments.

As mentioned above, five key steps are required to transform the workforce into a profession in which Health Workers are recognised and empowered at every level. These steps are:

1. Define the workforce
2. Clarify and strengthen education and career pathways
3. Build a systematic approach to workforce planning
4. Create enabling workplace and community environments
5. Collect and share an evidence base.

The following sections explore each of these steps in more detail.

## 10.4 Define the workforce

### 10.4.1 The definition of an Aboriginal and Torres Strait Islander Health Worker

- As demonstrated in Section 3.2, national consensus regarding the Health Worker definition has not yet been reached. Defining the workforce is a critical stage in the development of the profession for three key reasons: to give Health Workers and other health professionals a clear understanding of the workforce and the contribution of their role to Aboriginal and Torres Strait Islander health and well being
- to publicly recognise and promote the Health Worker role, to enable greater understanding within inter-disciplinary teams
- to lay the foundation to address the various challenges associated with the development of the workforce (such as recruitment and retention, career pathways, scope, inter-professional relationships, underlying themes).

One of the key outputs of this project was to develop a working definition of the Health Worker workforce for national consideration. After collecting and analysing the various definitions existing in Australia, the following working definition has been developed:

#### Working definition

An Aboriginal and Torres Strait Islander Health Worker is a person who:

1. identifies as being of Aboriginal and/or Torres Strait Islander descent
2. holds an Aboriginal and Torres Strait Islander Primary Health Care qualification
3. adopts a culturally safe and holistic approach to health care.

Section 3.2 explains the rationale underpinning the development of this working definition which is deliberately broad to include the many titles currently being used by Health Workers. For example, Mental Health Workers, Sexual Health Workers and Healthy Lifestyle Workers can all be considered as Health Workers if they meet the three criteria above. The national workshops will provide an opportunity to test this definition with a wide range of stakeholders to assess whether it is appropriate. It will be refined, iteratively, in an effort to reach national consensus.

### Opportunity for action #1

Test, refine and agree on a nationally consistent definition of an Aboriginal and Torres Strait Islander Health Worker.

Importantly, the definition should be considered in parallel with discussions about the national Health Worker scope of practice.

#### 10.4.2 The Health Worker scope of practice

Section 5.2 demonstrates substantial variation in the Health Worker scope of practice across Australia. As the workforce matures, it will be necessary to refine the national Health Worker scope of practice in order to:

- clearly delineate the workforce from other health professions
- inform the development of education and training pathways to ensure Health Workers are equipped with the skills and competencies they require
- inform the development of national practice standards.

The information collected during this project provides the first evidence-based national picture of the scope of practice. This information, presented in Section 5.2, highlights core aspects of the Health Worker scope of practice which are generally consistent across Australia.

These include:

- culturally safe health care roles (eg advocating for Aboriginal and Torres Strait Islander clients to explain their cultural needs to other health professionals – see Section 5.3)
- prevention and health promotion roles (eg running programs that raise awareness of health issues and/or target the social determinants of health – see Section 5.4).

In addition, there are key elements that contribute to the definition of the Health Worker scope of practice but vary across the workforce. These are:

- the level of complexity of clinical roles performed (eg ranging from basic health checks to clinical interventions that involve breaking the skin and/or the risk of loss of life or limb – see Section 5.5)
- areas of specific primary health care or clinical focus (eg a focus on chronic disease management, mental health, sexual health, etc – see Section 5.6).

Looking forward, this existing scope of practice must be reconsidered to determine whether it is the *optimum* scope of practice: in other words, does this scope of practice enhance the Health Worker contribution to the health and service needs of their communities?

### Opportunity for action #2

Review the Health Worker scope of practice to ensure the role of the Health Worker workforce is appropriately aligned to the health needs of Aboriginal and Torres Strait Islander peoples.

However, this question cannot be answered without an appropriate evidence base.

Currently, the perceptions of Health Workers, managers and other health professionals provide one source of information to contribute to this discussion. The national competency framework can also inform the scope of practice. However, a more systematic approach to measuring the impact of the Health Worker workforce would help to understand whether the scope of practice is appropriate. This is explored further in Section 10.8.

Further, although the scope of practice should be nationally consistent, it must also be flexible and inclusive. The concept of workforce segmentation, discussed below, may provide one opportunity to achieve this.

### 10.4.3 Workforce segments

Many health workforces are segmented in some way, for example:

- varying career pathways and opportunities for specialised interests within the workforce
- varying levels of education and experience
- varying levels of practice regulation.

Nursing and Social Work are examples of health professions that introduced workforce segmentation as the profession matured. Likewise, as the Health Worker workforce is professionalised, there will be a need to explore options for workforce segmentation.

The national registration of Aboriginal and Torres Strait Islander Health Practitioners in July 2012 will form part of this process. 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 Act as enacted in participating jurisdictions). Therefore, registration will only apply to Health Workers who perform services that carry a risk to public safety.

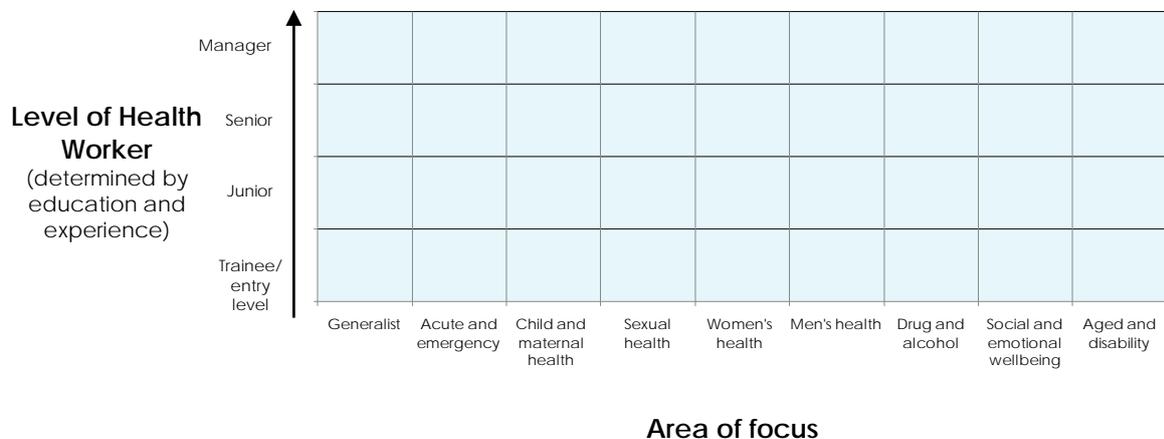
It may be necessary to explore options for other Health Worker workforce segments to reflect the variation in Health Workers' levels of experience and specific areas of focus as a whole. Also at the individual level, these structures may help Health Workers gain clarity about their position within the broader workforce, identify career pathways and establish educational goals.

#### Opportunity for action #3

Explore options for identifying distinct categories within the Health Worker workforce (eg unqualified Health Workers, registered Aboriginal and Torres Strait Islander Health Practitioners).

Using evidence collected throughout this project, the following picture of the Health Worker workforce has emerged as a basis for these considerations (Figure 21). It may be necessary to introduce a third axis to this conceptual diagram to reflect the level of public risk involved in each Health Worker's role. This third axis is likely to take shape as progress is made towards the national registration of Aboriginal and Torres Strait Islander Health Practitioners. Figure 21 will therefore be considered further during the national workshops.

Figure 21: Conceptualising workforce segments – an option for discussion



## 10.5 Clarify and strengthen educational and career pathways

As mentioned in Section 3.2, some of the defining attributes of a workforce are a group of individuals who are publicly recognised to possess special knowledge and skills; an organised body of learning; and professional standards (Australian Competition & Consumer Commission, 2011).

To truly establish the Health Worker workforce, it is important to have these building blocks in place. They contribute to the process of creating clear professional career pathways that are aligned to, and supported by, appropriate educational pathways.

A strong foundation for workforce development requires the following:

- Health Worker educational requirements
- Health Worker career structures
- Health Worker practice standards.

These building blocks are discussed below.

### 10.5.1 Health Worker educational requirements

The educational requirements for a profession must be sufficient to equip each individual with the knowledge and skills to support their role. Both the curriculum and the skill level are relevant considerations.

The CS&HISC qualifications framework outlined in Section 7.2.1 guides the educational requirements for the existing Health Worker workforce (Community Services & Health Industry Skills Council, 2008). However, as the role of the Health Worker workforce continues to evolve, these educational requirements need to be reviewed to ensure their relevance and appropriateness. This review process is undertaken as part of the CS&HISC continuous improvement plan.

#### Opportunity for action #4

Review and determine the appropriate qualification requirements of the Health Worker career structure (in tandem with the ongoing development of career pathways for Health Workers).

Some key informants commented that the existing qualifications structure includes dual qualification streams (Community Care and Clinical Practice) at the Certificate IV level and above. Although the historical reasons underpinning this decision are broadly accepted, questions have been raised about whether this approach is appropriate in future.

As discussed in Section 7.3, some focus group participants and key informants believe Health Workers should be equipped with clinical knowledge at the Certificate IV level, regardless of whether their usual role involves high levels of clinical risk to clients. These views were connected to expectations that a Health Worker performing a prevention and health promotion role would be more effective if they had a greater base level of clinical knowledge.

Other comments related to the fact that the existing curricula do not necessarily provide Health Workers with sufficient training in prevention and health promotion roles. Some feel as though they do not have relevant skills such as public speaking, marketing, communications and program management. However, if required, the national qualification packaging rules allow for the 'import' of such units into the competencies for the qualification.

Post-qualification assessment was noted as a potential skill requirement by some stakeholders. Some suggested a new 'graduate placement' or apprenticeship period during which the Health Worker honed and consolidated clinical skills within the practice environment. This might be similar to graduate placement programs used by other health professions, such as nursing, which requires a certain amount of practical experience and demonstration of clinical competencies before a nurse is able to be registered.

In addition, depending upon decisions regarding workforce segmentation, different qualification requirements may be necessary for different roles. It is imperative that the educational pathways support available career pathways to enable Health Workers to advance their careers within the Health Worker workforce. Consideration will need to be given to how experience-based learning is measured and recognised to minimise the risk of losing valuable members of the workforce if educational requirements change in future.

#### 10.5.2 Health Worker career pathways

The CS&HISC qualifications framework has established a structure for the Health Worker workforce. However, as shown by comments included in Section 7.4, the reality for many Health Workers is that career pathways are not so well defined. This can be partly attributed to jurisdictional variation in career structures and is affected by the limited availability of opportunities for career progression in many workplaces. Strengthening these career pathways for Health Workers is likely to:

- motivate Health Workers to undertake further education and qualifications for the purposes of continuous improvement and career advancement

- provide opportunities for Health Workers to move into management and more senior roles within their organisations
- attract new recruits to the workforce
- enable a fair and equitable remuneration structure to be established that takes into consideration the level of qualification, years of experience, expertise and level of responsibilities.

As part of the process of establishing clear career pathways for Health Workers, it will be necessary to develop:

- the range of relevant Health Worker 'grades' within the workforce which will best meet the needs of the Aboriginal and Torres Strait Islander community (as mentioned in Section 7.3).
- complementary and nationally consistent levels of qualification and experience which will be relevant to each grade; currently, there is some concern that the ATSIPHC qualifications are not comparable across the states and territories as a consequence of the fragmented nature of the VET sector in Australia
- an expected or 'blueprint' career pathway for each grade including transitioning into management or other professions, both at the national and health service level
- a set of national practice standards to provide an overarching practice framework for the workforce at all grades.

Numeracy and literacy issues are still a barrier to progression for some Health Workers. Unless the reform of the Health Worker workforce is considered as a whole, changes to qualification requirements risk excluding valuable and experienced members of the existing Health Worker workforce. Therefore, appropriate consideration should be given to supporting Health Workers during a transition period to ensure they stay in the workforce.

#### **Opportunity for action #5**

Strengthen Health Worker career pathways by linking them to education, experience and individual choices – both within the Health Worker workforce and when transitioning into other health professions.

### **10.5.3 Health Worker practice standards**

Practice standards support safe, ethical practice within health professions, contributing to the quality and safety of patient care. To date, the only jurisdiction with Health Worker practice standards is the Northern Territory (Northern Territory Department of Health and Families, 2010).

Phase 2 of this project will provide a foundation for the development of practice standards for Health Workers and for Health Practitioners to inform preparations for national registration in 2012. The draft standards for Health Practitioners will require further development and endorsement by the Health Practitioners Registration Board.

#### **Opportunity for action #6**

Develop national practice standards for the Health Worker profession.

## 10.6 Build a systematic approach to workforce planning

The first two steps outlined above involve defining the Health Worker workforce; and then putting in place the building blocks which are fundamental to an established profession.

The third step involves reinforcing the structural environment. This refers to the systemic context within which health services, education providers and Health Workers operate, discussed in Section 9.4.

### 10.6.1 Responding to demand: how do Health Workers fit within the health system?

Health Workers form one part of the broader health system response to the needs of Aboriginal and Torres Strait Islander Australians. The way Health Workers currently contribute to this system varies across Australia. This is at least partially attributable to the historical evolution of the Health Worker role, which was often organic and in direct response to local health service gaps. For this reason, Health Workers in different contexts serve various functions in the health system.

As the workforce continues to develop, there is an opportunity to adopt a more proactive and strategic approach to workforce deployment. Although there may always be variation in the way that Health Workers fit within the health system, some models are likely to be more effective than others.

To truly optimise the contribution made by the Health Worker workforce, a number of questions might be relevant for consideration. For example:

- How does the Health Worker workforce best contribute to health needs at different levels of the health system? (eg in both comprehensive primary health care and acute care environments)
- Which workforce models best support service delivery in different health service settings and geographic locations? (eg Health Worker-first approaches, outreach models, prevention and health promotion program delivery, etc)
- How can Health Workers best respond to the geographic distribution of health need? (eg is there an optimum ratio of Health Workers to the population, and does this vary based on level of remoteness?)
- How is the Health Worker workforce best positioned alongside other workforces? (eg other health professionals, like nurses, and the emerging Closing the Gap health workforces, such as Healthy Living Workers, Tobacco Workers, etc)

These are just a few examples of questions that may help foster more strategic approaches to workforce deployment. Currently, there is no coordinated source of evidence available to inform discussions. However, across the workforce and broader health sector, there is a wealth of knowledge, expertise and experience that can be drawn upon to guide the process in the future.

#### Opportunity for action #7

Consider mechanisms to enable a coordinated and strategic approach to workforce planning in response to health and service needs.

### 10.6.2 Ensuring supply: how can a sustainable pool of Health Workers be maintained?

Without appropriate planning and coordination, there is a risk that the supply of Health Workers may not be sufficient to meet demand in future. Some issues were raised during

the Community Mapping focus groups and key informant interviews that signal the importance of supply planning. For example, it was reported that:

- barriers exist which hinder some potential Health Workers from entering the workforce; for example, the geographic location of training courses, literacy and numeracy challenges, cost of education, lack of available course positions, challenges navigating available support programs (eg scholarships), lack of family support, etc (see Section 7.4)
- many health services face recruitment challenges; for example, there are large numbers of long-term Health Worker position vacancies, particularly in the government health sector (see Section 9.3)
- many health services face retention challenges, particularly due to high rates of Health Worker burn-out (see Section 9.3)
- there are specific challenges in the supply of male Health Workers, who form only 30% of the workforce despite the fact that males represent 50% of the Aboriginal and Torres Strait Islander population (see Section 3.3)
- many Health Workers do not believe they are appropriately recognised and remunerated (see Section 9.3)
- some Health Workers are working towards articulation into other health workforces, like nursing, because of perceptions that there are limited career opportunities as a Health Worker (see Section 7.5).

Unaddressed, these issues will undermine the sustainability of the Health Worker workforce. To ensure an adequate supply of Health Workers to meet demand for their services, key points along the workforce 'pipeline' should be targeted, including:

1. the point of entry into the workforce
2. the retention of the existing Health Worker workforce
3. the articulation of Health Workers into other health workforces.

These areas cannot be strengthened without a coordinated, cross-sector approach to supply planning.

For example:

- To strengthen the point of entry into the workforce, educational opportunities need to be both accessible and appropriately tailored to the cultural needs of Health Workers; this requires collaboration between the education and health sectors.
- Available sources of support for Health Workers to overcome entry barriers (such as scholarships) are currently fragmented and difficult to navigate – in part because they are provided by a number of different government departments at both federal and jurisdictional levels; streamlining this support environment requires coordination.
- A major factor reported to contribute to Health Worker retention is appropriate remuneration; pay parity cannot be addressed without cross-sector approaches.
- If the right career pathways are provided within the Health Worker workforce, there may be less inclination to articulate into other health workforces; however, the option should be available and more easily navigable for those who do wish to pursue alternate career paths (the National Aboriginal and Torres Strait

Islander Health Council's *Blueprint for Action* provides relevant insights into these issues (National Aboriginal and Torres Strait Islander Health Council, 2008).

Without reinforcing this structural environment, health services that require Health Workers may continue to experience recruitment and retention challenges.

#### Opportunity for action #8

Consider a coordinated and planned approach to ensuring a sustainable supply of Health Workers.

### 10.7 Create enabling workplace and community environments

The success of policies designed to recognise and empower Health Workers is dependent on the implementation process. The benefits of constructing an enabling systemic environment will potentially be undermined if these actions are not reinforced by enabling workplace and community environments.

Health Workers work in different team environments at different workplaces across Australia. Section 9.2 provided some insights into a range of interlinking issues that have been reported with regard to team dynamics. These relate to presence or lack of:

- empowerment, trust, respect and recognition within teams
- cultural security in the workplace
- leadership and management in the workplace.

These issues have a tangible impact upon the Health Worker workforce and the capacity of Health Workers to reach their full potential.

Therefore, practical strategies are required to support health services in cultivating enabling workplace environments.

#### Opportunity for action #9

Support workplaces to become culturally secure environments for Aboriginal and Torres Strait Islander staff, where Health Workers are empowered within supportive teams.

The importance of community recognition, respect and support for Health Workers has been highlighted throughout this report. For example, health services appear to experience fewer recruitment and retention challenges when they are located in communities that promote the Health Worker role and support Health Workers to reach their full potential. Further, a supportive community environment can assist Health Workers to overcome some barriers to education and career advancement, such as family commitments and burn-out.

#### Opportunity for action #10

Support communities to become enabling environments that recognise, value and support Health Workers.

## 10.8 Collect and share an evidence base

The question underpinning any workforce development initiative is: How do we know when we're getting it right? Without the appropriate data, it is not possible to evaluate progress or demonstrate good practice. Equally, a weak evidence base makes it difficult to identify gaps in service delivery and monitor the quality of patient care.

Therefore, key to workforce development is to collect and share relevant information.

### 10.8.1 Information collection

As established in Section 8.5, a national mechanism does not currently exist to collect data relevant to the development of the Health Worker workforce. Information collection would be useful for a number of reasons, including:

- to measure the impact of the Health Worker workforce on health outcomes – both at the individual and workforce level
- to monitor and improve the performance of individual Health Workers as part of their professional development
- to identify and demonstrate good practice, such as innovative workforce models which support service delivery
- to contribute to evidence-based workforce planning.

#### Opportunity for action #11

Consider mechanisms for measuring the impact of the Health Worker workforce at both the broader workforce and individual level.

However, information collection must be balanced by reasonable expectations of reporting requirements. Already, Health Workers are reporting burn-out – it is important to avoid adding to this burden with onerous administrative and reporting requirements which do not have a clear purpose or feedback mechanism.

### 10.8.2 Information sharing

Once the information is collected, it should be used and shared appropriately. Data that informs workforce planning at the systemic level may also help health services and Health Workers learn from one another.

Site visits highlighted a number of innovative Health Worker workforce deployment models that effectively support service delivery (outlined in Chapter 6). Within the broader participant group, awareness of these examples varied. Many Health Workers mentioned a desire to have access to more information about what worked well at other health services (Section 8.2.3).

Providing an ongoing opportunity to network, exchange skills, and share information would help the workforce develop its social capital. Some suggested avenues include networking events or forums, health service exchange programs, and mentoring programs (Section 8.2.3).

### Opportunity for action #12

Develop information sharing opportunities to encourage good practice and innovation (at all levels: peer-to-peer, service-to-service, jurisdiction-to-jurisdiction, sector-to-sector).

Each of these opportunities for action is related and interlinked. They have the potential to have an impact at the systemic, workforce and individual levels. A summary of these opportunities and potential impacts is provided in Table 13. These identified opportunities for action will be advanced further in Phase 2 of this project.

Table 13: Opportunities for transforming the Health Worker workforce: potential impact at the systemic, workforce and individual levels

Five key steps	Opportunities for action	Potential Impact			
		at the systemic level	at the workforce level	at the individual level	
1. Define the workforce	1	Test, refine and agree on a nationally consistent definition of an Aboriginal and Torres Strait Islander Health Worker.	Facilitates workforce design and planning in response to health needs; facilitates national alignment of education, health and employment policies to support Health Worker workforce	Distinguishes and recognises the Health Worker workforce as a cohesive group that is clearly delineated from other health professions	Provides individual Health Workers with a clear understanding of their role and identity as part of the Health Worker workforce
	2	Review the Health Worker scope of practice to ensure the role of the Health Worker workforce is appropriately aligned to the health needs of Aboriginal and Torres Strait Islander people.	Enables the Health Worker scope of practice to better target gaps in the national response to the health and service needs of the target community	Distinguishes and recognises the Health Worker workforce as a cohesive group that is clearly delineated from other health professions	Provides individual Health Workers with awareness of their full scope of practice, within which they are able to choose career pathways and establish personal goals
	3	Explore options for identifying distinct categories within the Health Worker workforce (eg Health Workers with no formal qualifications, registered Aboriginal and Torres Strait Islander Health Practitioners).	Contributes to workforce planning: coordination of education and career pathways; and management of quality and safety risks	Enables workforce segments to develop more clearly defined areas of specialisation and expertise; strengthens career structure; fosters support networks within/across different levels of the workforce	Gives clarity concerning career pathways, providing opportunities for education and career progression within an aligned structure
	4	Review and determine the appropriate qualification requirements of the Health Worker career structure (in	Creates alignment between health, education and employment systems to optimise the workforce and maintain supply of appropriately qualified Health Workers; addresses public	Ensures that the Health Worker workforce is sufficiently equipped with the knowledge, skills and competencies required to	Provides clear educational pathways that are aligned to scope of practice and career structure
2. Clarify and strengthen education and career pathways	4	Review and determine the appropriate qualification requirements of the Health Worker career structure (in			

Five key steps	Opportunities for action	Potential impact		
		at the systemic level	at the workforce level	at the individual level
3. Build a systematic approach to workforce development	tandem with the ongoing development of career pathways for Health Workers).	safety risks by setting appropriate educational standards	support their role	Provides clear career pathways and opportunities, which are aligned to scope of practice and qualification requirements
		Helps to attract new recruits into the workforce by providing clear career pathways and appropriate entry points into the profession; helps retain Health Workers by providing opportunities for career progression	Facilitates development of fair and equitable remuneration structure; provides a tangible opportunity to promote Health Worker leadership and management roles in reflection of seniority and experience	
	Strengthen Health Worker career pathways by linking them to education, experience and individual choices – both within the Health Worker workforce and when transitioning into other health professions	Addresses public safety risks by minimising potential for harm to patients	Guides the scope of practice by establishing clear boundaries; helps protect the workforce from public safety risks	Guides personal development; protects Health Workers from situations outside their skill level through practice standards
	Develop national practice standards for the Health Worker profession.	Promotes workforce deployment models that are demonstrated to be effective in relevant contexts – thereby optimising impact of Health Worker workforce on health outcomes	Cultivates a better understanding of the role of the workforce and its position within the broader health system; may help to negotiate funding to address service gaps on the ground	Aims to ensure each Health Worker is empowered to perform to their full capacity
	Develop mechanisms that will enable a coordinated and strategic approach to workforce planning in response to demands for health services	Ensures ongoing supply of Health Workers that is sufficient to address the needs of Aboriginal and Torres Strait Islander people	Maintains a sustainable, skilled workforce with fewer recruitment and retention challenges	Facilitates smooth entry and exit points into the workforce for individuals; encourages appropriate recognition and
	Develop a coordinated and planned approach to ensuring a sustainable supply of Health			

Five key steps	Opportunities for action	Potential impact		
		at the systemic level	at the workforce level	at the individual level
4. Create enabling workplace and community environments	Workers			remuneration
	9 Support workplaces to become enabling environments that are culturally secure, where Health Workers are empowered within supportive teams	Provides greater confidence in the implementation of policies that involve Health Workers as part of the response to Aboriginal and Torres Strait Islander health needs	Empowers the workforce to reach its full potential and work productively alongside other health professionals	Empowers individuals in the workplace – so that they might always feel culturally secure, supported, trusted and respected
	10 Support communities to become enabling environments that recognise, value and support Health Workers	Contributes to supply and demand challenges by promoting the workforce in local communities where demands are high	Helps the workforce to grow from local areas – retaining local knowledge and support networks	Provides individual Health Workers with the community recognition, respect and support they deserve
5. Collect and share an evidence base	11 Develop a mechanism for measuring the impact of the Health Worker workforce at both the broader workforce and the individual level	Provides an evidence-based view of the impact the Health Worker workforce has on Aboriginal and Torres Strait Islander health outcomes – this will inform ongoing workforce developments	Promotes respect as a unique and valued workforce distinct from other health professions; demonstrates the impact of the workforce; providing an evidence base for advocacy and support purposes	Values and recognises the individual's contribution; informs personal and professional development; promotes team relationships based on respect and trust
	12 Develop information sharing opportunities to encourage good practice and innovation (at all levels: peer-to-peer, service-to-service, jurisdiction-to-jurisdiction, sector-to-sector)	Encourages optimal use of the Health Worker workforce by promoting innovative, evidence-based practice - across all jurisdictions, sectors and services	Helps to create a culture of continuous improvement, knowledge sharing, collaboration and support; thereby strengthening the workforce as a unified group of empowered individuals	Helps to provide individuals with the tools, insights and support they need to introduce new ideas, initiate change, and contribute to the best of their ability

## Conclusion

The Health Worker workforce forms an integral part of the COAG Closing the Gap strategy to address health inequality in Australia.

This project highlights an opportunity to improve Aboriginal and Torres Strait Islander health outcomes by recognising and empowering the Aboriginal and Torres Strait Islander Health Worker workforce. However, such change will only occur if there is a joint and real commitment by all key stakeholders to do this. Stakeholders include Health Workers themselves, relevant government departments at all levels, the Aboriginal and Torres Strait Islander Community Controlled Health Sector, relevant education and training organisations, regulatory bodies and associations.

Without this nationally consistent approach, there is a risk that the potential impact on health outcomes may be undermined by the unforeseen consequences of siloed or piecemeal initiatives. For example, although sharing the same objective, the new workforces emerging from the COAG Closing the Gap strategy are perceived to undermine the development of the Health Worker workforce.

The challenge of developing a sustainable Aboriginal and Torres Strait Islander Health Worker workforce may appear daunting. However, if it is successful, the benefits will be realised not only for Health Workers and their respective communities but also for the wider Australian population. This is because the way Health Workers do business involving a comprehensive approach to primary care – will be embedded within the whole health system to help manage the growth in chronic disease in a more cost-effective way.

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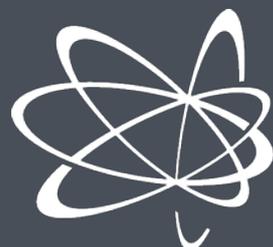
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**HealthWorkforce**  
AUSTRALIA



**Interim Report – Appendix B**

Additional information on the project methodology

28 June 2011

Health Workforce Australia

## Contents page

Appendix B	Additional information on the project methodology	1
<b>1.</b>	<b>Context</b>	<b>1</b>
<b>2.</b>	<b>Key informant interviews</b>	<b>1</b>
<b>3.</b>	<b>Survey participants</b>	<b>3</b>
3.1	Health Worker survey participants	3
3.2	Health Worker manager survey participants	11
<b>4.</b>	<b>Focus group participants</b>	<b>14</b>
4.1	Community Mapping focus groups: Health Worker participant profile	14
4.2	Community Mapping focus groups: Health Worker manager participant profile	17
4.3	Other health professionals focus groups: total number of focus groups and participants	20

## Appendix B Additional information on the project methodology

### 1. Context

This appendix contains additional detail on each of the key participant groups:

- key informants
- survey participants (Health Workers and managers)
- Community Mapping focus group participants (Health Workers, managers and other health professionals)

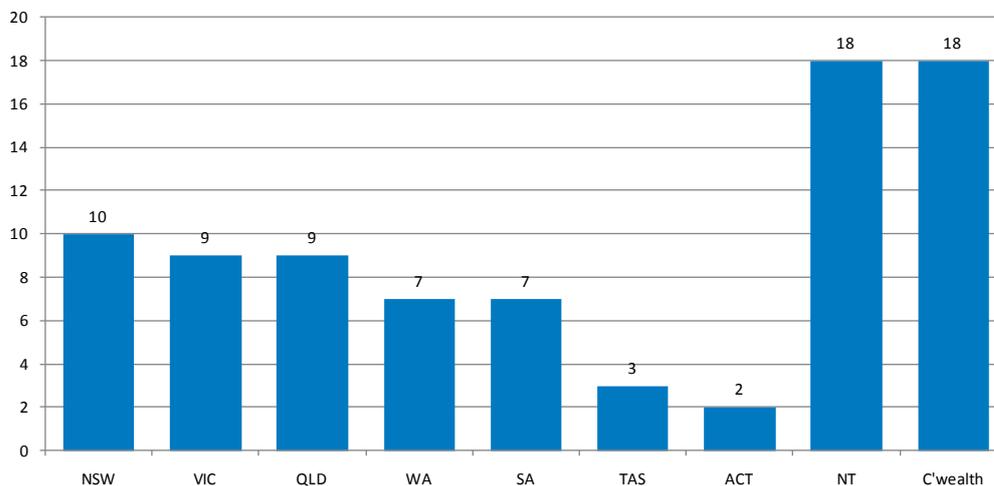
Some of the data was statistically analysed and in those cases, the sample was weighted to compensate for biases by age, gender, place of employment, jurisdiction and area of remoteness. The 'weights' were calculated via a method called 'sample balancing' (also known as 'raking') based on the data from the 2006 ABS Census and the 2009 ATSIHWG.

### 2. Key informant interviews

#### 2.1.1 Distribution of key informant interviews by jurisdiction

There were 138 key informant interactions during this first phase of the project. These interactions involved 83 individual key informants, with some individuals consulted more than once. A breakdown of the key informants by jurisdiction is provided in Figure 1.

Figure 1: Number of key informant interviews: distribution by jurisdiction (n=83)



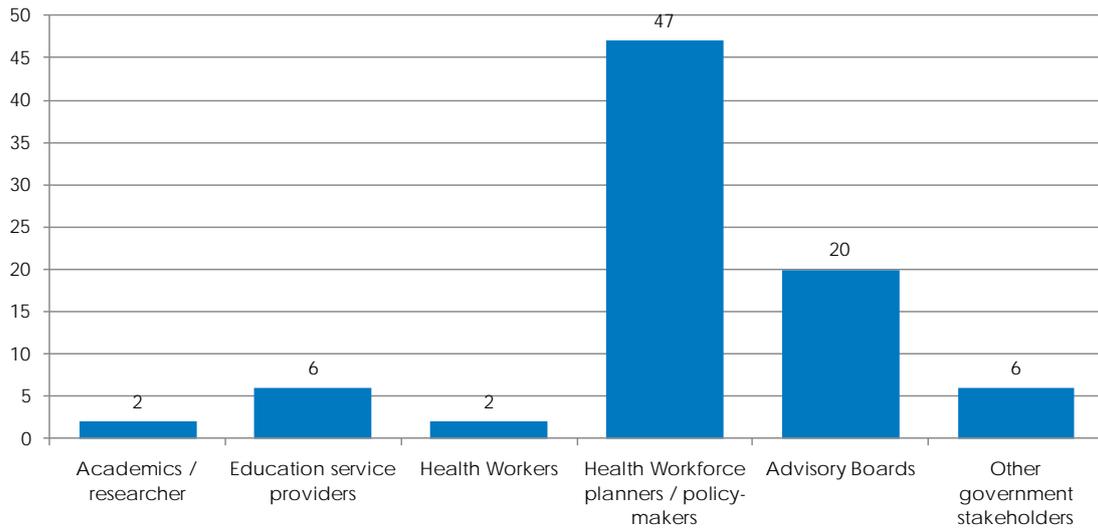
In addition to the jurisdictional representation, 18 key informant interviews were with representatives of Commonwealth Government departments or agencies, who provided a national perspective to the discussion.

#### 2.1.2 Distribution of key informant interviews by industry group

The project team developed industry group categories in order to ensure that different stakeholder groups were consulted. Figure 2 shows the key informants by the industry group they represent. The majority of key informants consulted were either health

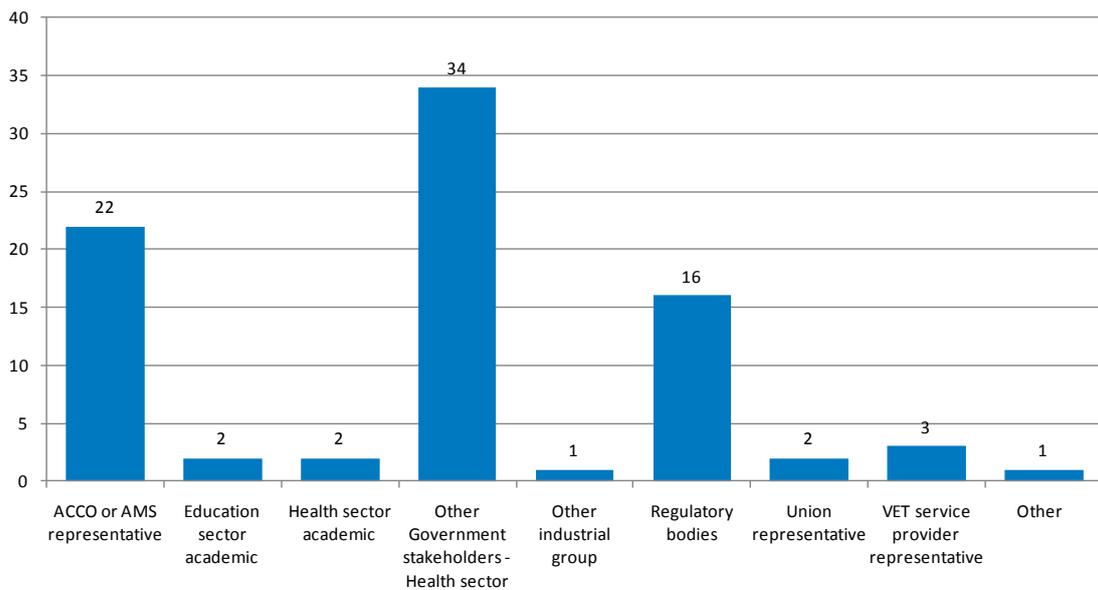
workforce planners or policy makers, with a number from the various jurisdictional Departments of Health. The group constituting 'Advisory Boards' includes those consulted as part of membership in advisory boards, such as the Aboriginal Community Controlled Health Sector Reference Group and the Expert Reference Group (convened by this project).

Figure 2: Distribution of key informants engaged by industry group (n=83)



The key informants were also categorised by sub-industry groups, as shown in Figure 3. There was good representation from the Aboriginal Community Controlled health sector, government sector and relevant regulatory bodies.

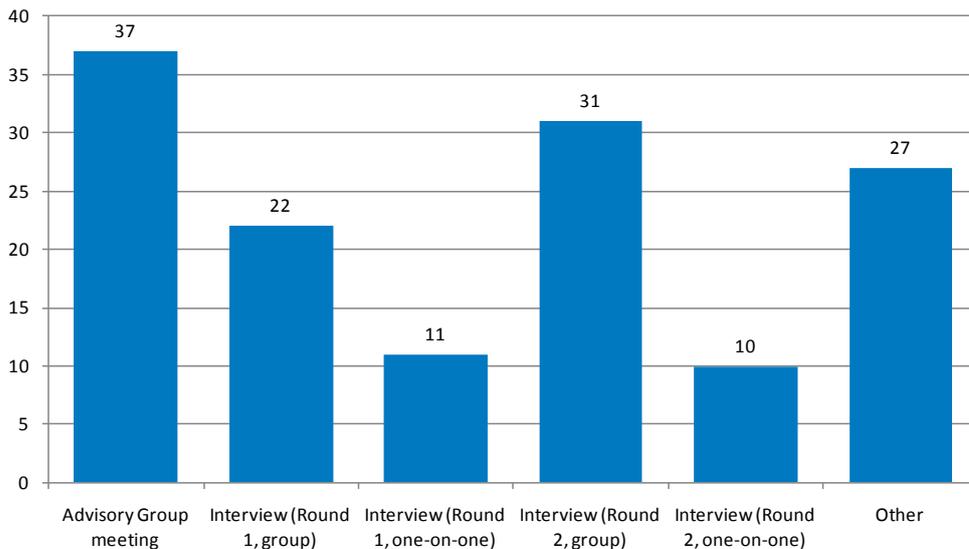
Figure 3: Distribution of key informants engaged by sub-industry group (n=83)



### 2.1.3 Method of engagement with key informants

There were two rounds of key informant interviews, each using one-on-one or group interviews depending on which approach was most appropriate. This is illustrated in Figure 4. A number of key informants were engaged more than once, either as a follow-up interview or through their participation in the advisory group meetings (eg Expert Reference Group, Jurisdictional Planning Group).

Figure 4: Key informants methods of engagement (n=83)



## 3. Survey participants

### 3.1 Health Worker survey participants

A profile of Health Worker survey participants is provided in this section and is analysed as follows:

- total sample group
- distribution by jurisdiction
- distribution by area of remoteness
- distribution by place of employment
- distribution by age and gender
- distribution by length of time as a Health Worker.

#### 3.1.1 Health Worker survey total sample group

There were 392 responses to the Health Worker survey. These responses were 'cleaned' to ensure that all participants fitted within the parameters of the working definition of the Health Worker workforce. Following the cleaning process, 40 surveys were excluded from the analysis, bringing the total included for analysis to 351.

To assess the representativeness of this group, the 2006 ABS Census data (which recorded a total of 1007 Health Workers) was used as the main benchmark, as it is the only source which includes information on Health Worker demographics and

geographic location. However, this data may under-report Health Worker numbers. In 2009, the Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG) estimated that the total number of Health Workers in Australia was 1612.

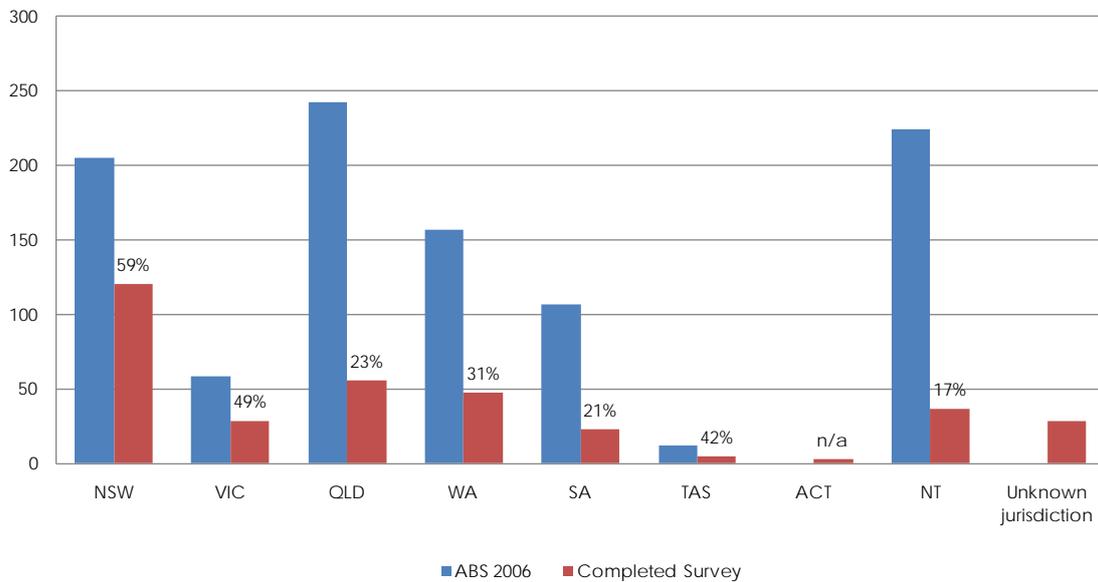
Using the 2006 ABS data, the 351 Health Worker survey participants equate to a whole-of-population response rate of 35%. When compared to the ATSIHWWG data, the response rate is 22%.

In both instances, this is a higher response rate than has been achieved by previous surveys targeting Health Workers.

### 3.1.2 Distribution of Health Worker survey participants by jurisdiction

To determine the representativeness of the survey group by geographic distribution, the participants were profiled by jurisdiction. The results are presented below.

Figure 5: Distribution of Health Worker survey participants by jurisdiction (n=351)



<sup>1</sup> % = Survey response rate as a proportion of an actual workforce (according to ABS, 2006 data)  
n/a = There was no data reported for the ACT in the 2006 ABS Census data and therefore the representativeness of the response rate from the ACT could not be analysed.

Table 1: Distribution of Health Worker survey participants by jurisdiction

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Unknown jurisdiction	Total
ABS 2006 data	205	59	243	157	107	12	N/A <sup>1</sup>	224	0	1007
Number of survey respondents	121	29	56	48	23	5	3	37	29	351

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Unknown jurisdiction	Total
Number of respondents as a proportion of total estimated workforce	59%	49%	23%	31%	21%	42%	N/A	17%	N/a	35%

A comparison of the jurisdictional distribution of survey respondents as a proportion of the estimated workforce (ABS 2006 Census data) is shown in Figure 5 and Table 1. This data shows that:

- when compared to the ABS 2006 Census data, Health Workers from NSW are over-represented in the Health Worker survey – 59% of Health Workers in NSW completed the survey ( $p < 0.0001$ )
- when compared to the ABS 2006 Census data, Health Workers from the Northern Territory and Queensland are under-represented in the Health Worker survey – only 17% of Health Workers in the NT and 23% of those in QLD completed the survey ( $p < 0.0001$ ).

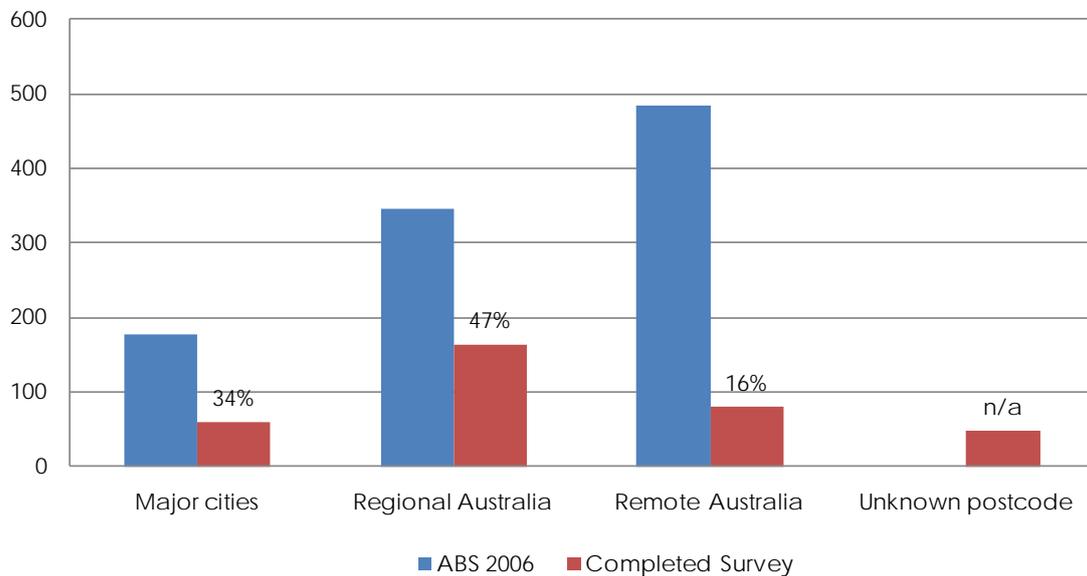
### 3.1.3 Distribution of Health Worker Survey respondents by area of remoteness

The area of remoteness was determined using the Australian Standard Geographic Classification (ASGC) system, which has five categories:

- major cities
- inner regional Australia
- outer regional Australia
- remote Australia
- very remote Australia.

For data analysis purposes, 'inner regional' and 'outer regional', were grouped together and are referred to as 'regional'; and 'remote' and 'very remote', were grouped and are referred to as 'remote'.

Figure 6: Distribution of participants by area of remoteness (n=351)



% = Survey response rate as a proportion of actual workforce (according to ABS, 2006 data)

Table 2: Distribution of participants by remoteness

Jurisdiction	Major cities	Regional Australia	Remote Australia	Unknown postcode	Total
ABS 2006 data	177	346	484	0	1007
Number of survey respondents	60	164	79	48	351
Number of respondents as a proportion of total workforce segment	34%	47%	16%	N/A	35%

As revealed in Figure 6 and Table 2:

- when compared to the ABS 2006 Census data, regional areas are over-represented in the Health Worker survey – 47% of Health Workers from regional areas undertook the survey ( $p < 0.0001$ )
- when compared to the ABS 2006 Census data, remote areas are under-represented in the Health Worker survey – only 16% of Health Workers in remote areas completed the survey ( $p < 0.0001$ ). Within this category, Health Workers in very remote areas are particularly under-represented, with only 3% of the estimated workforce completing the survey ( $p < 0.0001$ ).

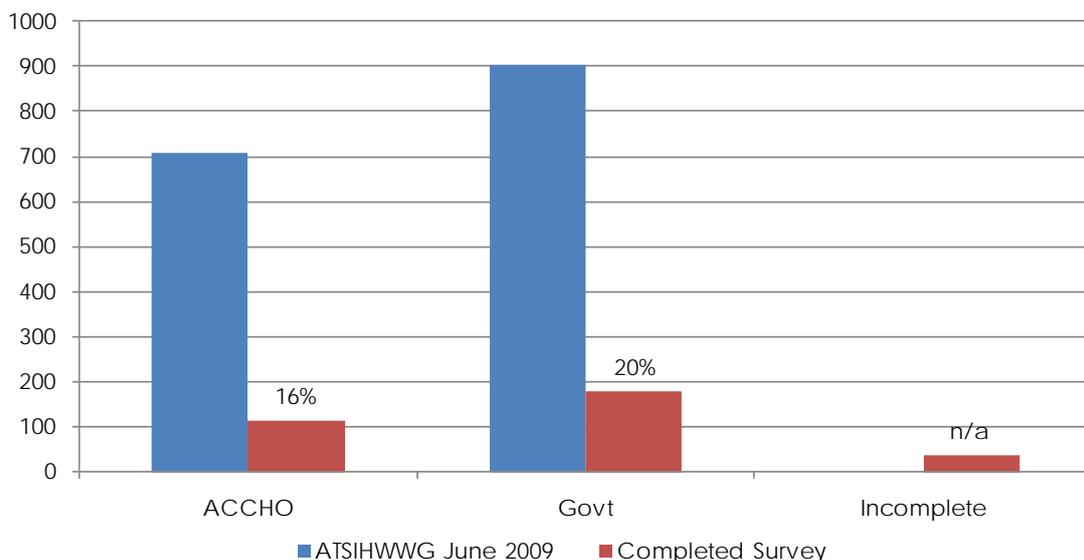
### 3.1.4 Distribution of Health Worker survey participants by place of employment

The Health Worker survey aimed to collect the perspectives of Health Workers employed by the government health sector, the Aboriginal Community Controlled sector and other health services (eg divisions of general practice, private hospitals, etc). The ABS Census does not collect this data, so the only information to determine representativeness by place of employment was from the Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG). In June 2009, ATSIHWWG collected Health Worker workforce estimates from government employers and Community Controlled sector employers.

This information revealed that the survey respondents have a similar representation by place of employment as that in the ATSIHWWG data. A comparison of the survey responses against the ATSIHWWG data is presented in Figure 7.

Statistical analysis was conducted to compare the proportion of survey respondents employed by government employers and Community Controlled sector employers against the ATSIHWWG estimates. The analysis found that the survey respondents are representative on the basis of employing organisation  $p = 0.1213$ , where  $p > 0.05$  suggests there is no statistical difference between the two populations.

Figure 7: Distribution of Health Worker Survey participants by place of employment (n=351)

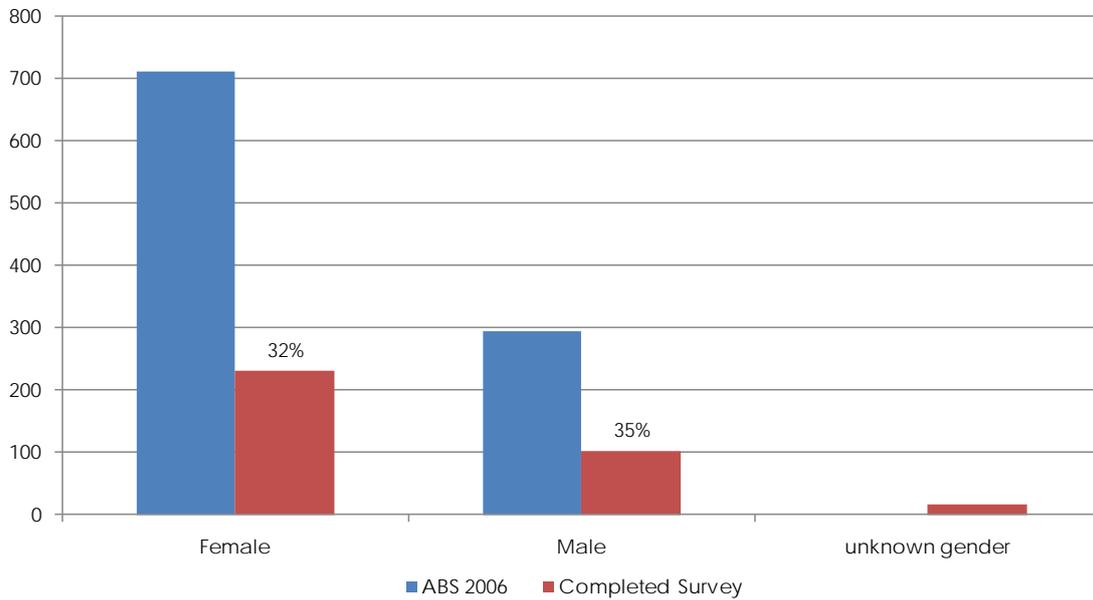


% = Survey response rate as a proportion of actual workforce (according to ATSIHWWG, 2009 data)

### 3.1.5 Distribution of Health Worker survey participants by gender and age

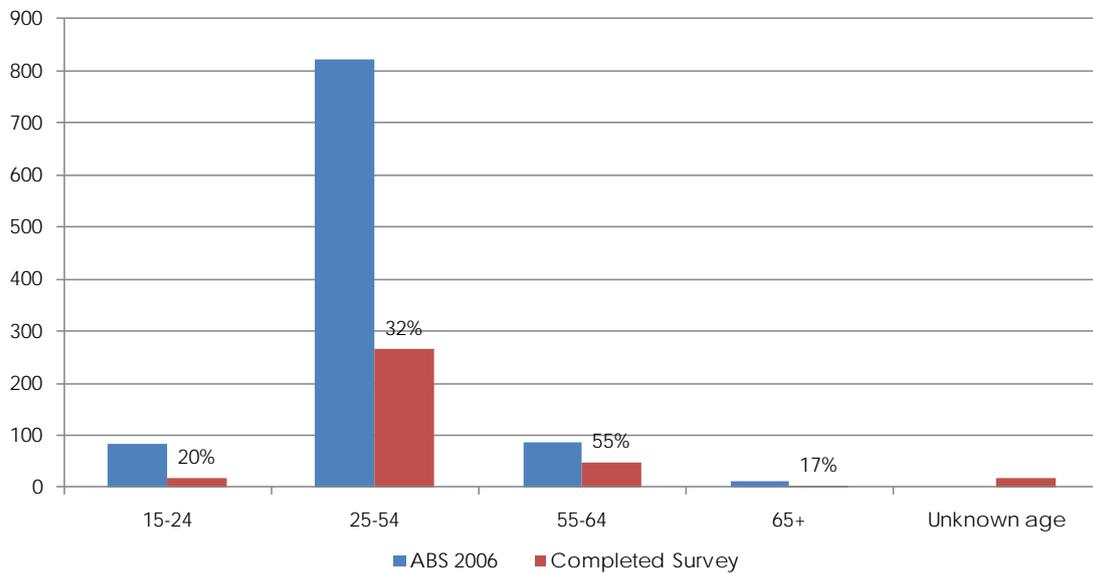
Analysis of the age and gender breakdown of survey participants is presented Figure 8 and in Figure 9. The Health Worker population is predominately female (70.6%) (ABS 2006 Census data). The respondent group is representative of the Health Worker population on the basis of gender. On the basis of age, the respondent group was not representative, with an over-representation in the 55 – 64 age groups ( $P = 0.0056$ ).

Figure 8: Distribution of Health Worker survey participants by gender (n=351)



% = Survey response rate as a proportion of actual workforce (according to ABS, 2006 data)

Figure 9: Distribution of Health Worker survey participants by age



% = Survey response rate as a proportion of actual workforce (according to ABS, 2006 data)

### 3.1.6 Distribution of Health Worker survey participants by length of time as a Health Worker

Information about the experience of respondents as Health Workers was also collected and compared by jurisdiction, area of remoteness and place of employment. This information is presented below in Figure 10, Figure 11 and Figure 12, respectively.

Figure 10: Distribution of Health Worker survey participants by length of time as Health Worker and jurisdiction (n=351)

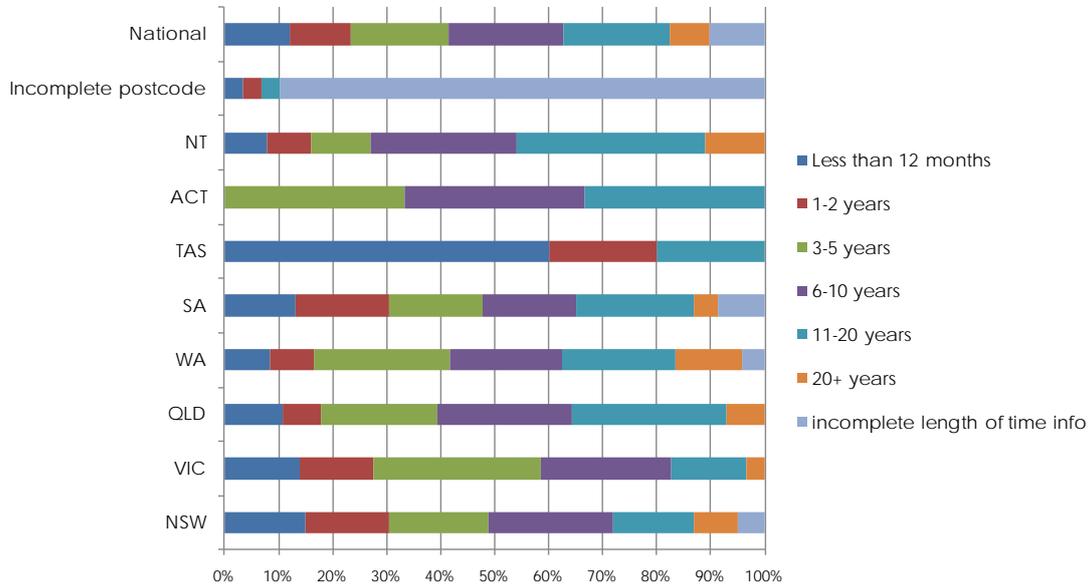


Figure 10 shows that:

- just over a quarter of survey respondents had had 11 or more years of service as Health Worker nationally
- compared with other jurisdictions, the NT and WA had the highest proportion of survey respondents with 11 or more years of service as a Health Worker, while TAS and NSW had the lowest.

Figure 11: Distribution of Health Worker survey participants by length of time as a Health Worker and by remoteness (n=351)

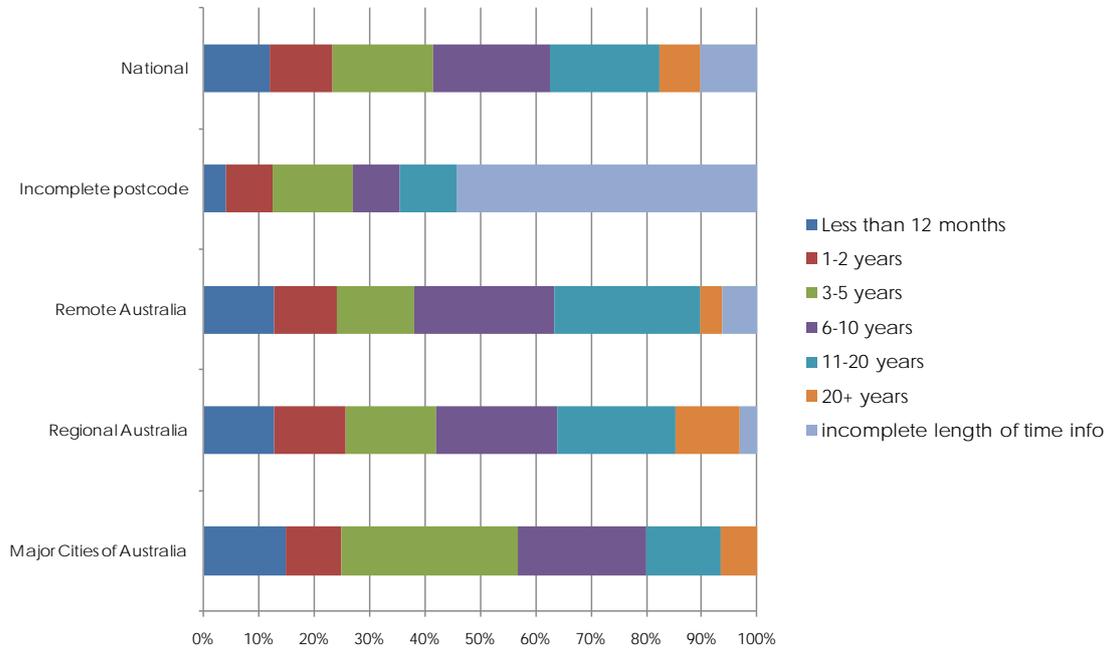
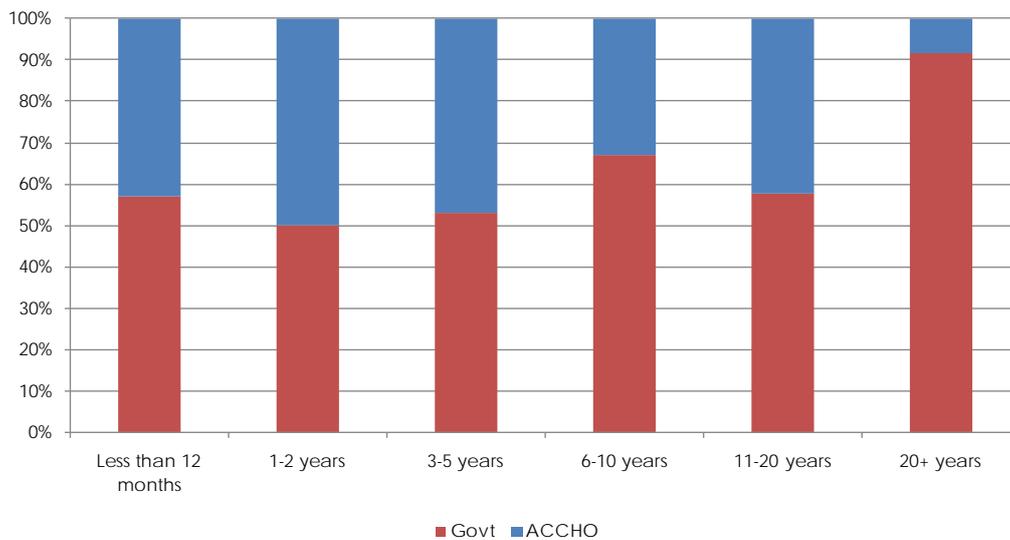


Figure 11 shows that:

- survey respondents from remote areas appeared to have the most years of service as a Health Worker, with 56% having six years experience or more; this was followed closely by survey respondents from regional areas, with 55% having the same length of experience.

Figure 12: Health Workers employed in the ACCHO and government sector by length of time as a Health Worker (n=351)



Source: HWA Aboriginal & Torres Strait Health Worker Survey 2010

Figure 12 shows:

- there is an equal distribution of Health Workers in both sectors with up to 5 years of experience, after which a difference is evident
- Health Workers with the most years of experience (20+ years) appear to be predominantly employed in the government sector rather than in ACCHOs.

## 3.2 Health Worker manager survey participants

A profile of Health Worker manager survey participants is provided in this section and is analysed as follows:

- total sample group
- distribution by jurisdiction
- distribution by area of remoteness
- distribution by place of employment
- distribution by age and gender.

### 3.2.1 Health Manager survey total sample group

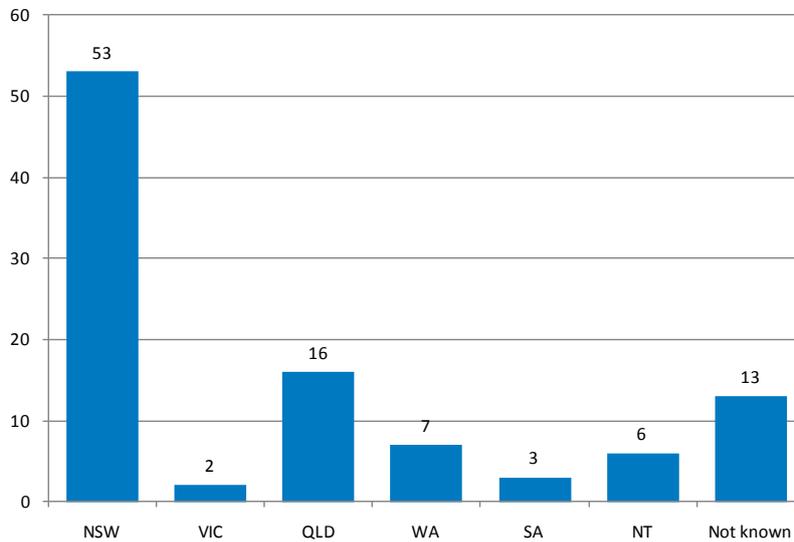
Similar to the Health Worker survey, for those surveys that were completed online, data was extracted directly from the survey database; however, for those that were completed manually, an extensive data entry exercise was required to input all the responses electronically. The data was then 'cleaned' to exclude responses that were mostly incomplete. At the close of the survey, the total responses were 103. After the cleaning process, three surveys were excluded from the analysis due to incompleteness, leaving the final number at 100.

Extensive data analysis was then undertaken on these 100 responses and the results are presented below. Unlike the Health Worker survey responses, no statistical analyses were conducted on the Health Manager survey participants.

### 3.2.2 Distribution of Health Manager survey participants by jurisdiction

The Health Worker manager survey respondents were profiled by jurisdiction. Figure 13 shows the results.

Figure 13: Distribution of Health Manager Survey respondents by jurisdiction (n=100)

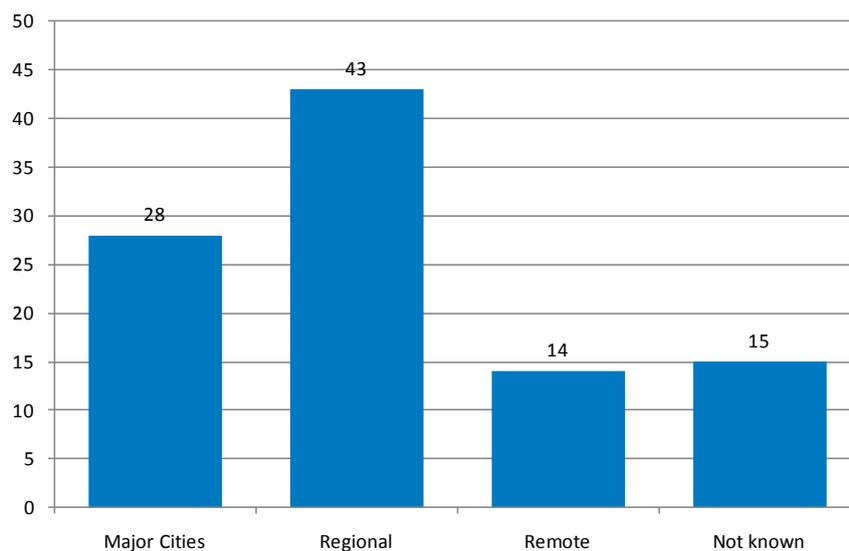


The greatest proportion of Health Worker managers who responded to the survey were from NSW (53%), followed by Queensland (16%). Thirteen respondents did not indicate which jurisdiction they were from.

### 3.2.3 Distribution of Health Worker manager survey respondents by area of remoteness

The Health Worker manager survey respondents were also profiled by area of remoteness, as shown in Figure 14.

Figure 14: Distribution of Health Manager Survey respondents by remoteness classification (n=100)

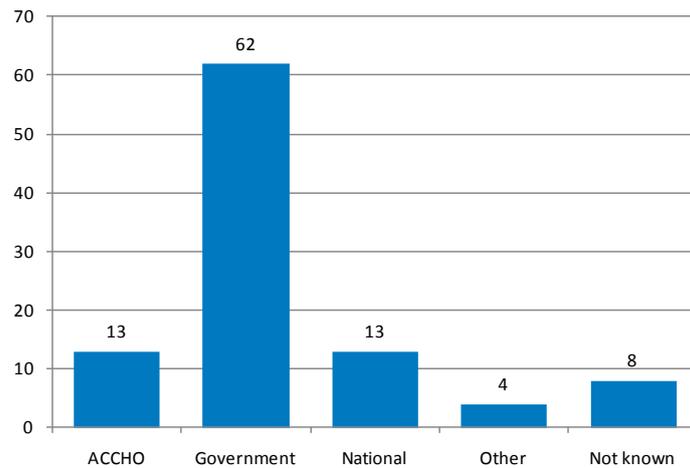


The highest proportion of survey respondents identified as living in regional areas (43%), followed by major cities (28%) and remote areas (14%). 15% of survey respondents did not identify where they were from.

### 3.2.4 Distribution of Health Worker manager survey participants by place of employment

The distribution of Health Worker manager survey participants by place of employment is shown in Figure 15.

Figure 15: Distribution of Health Manager survey participants by place of employment (n=100)

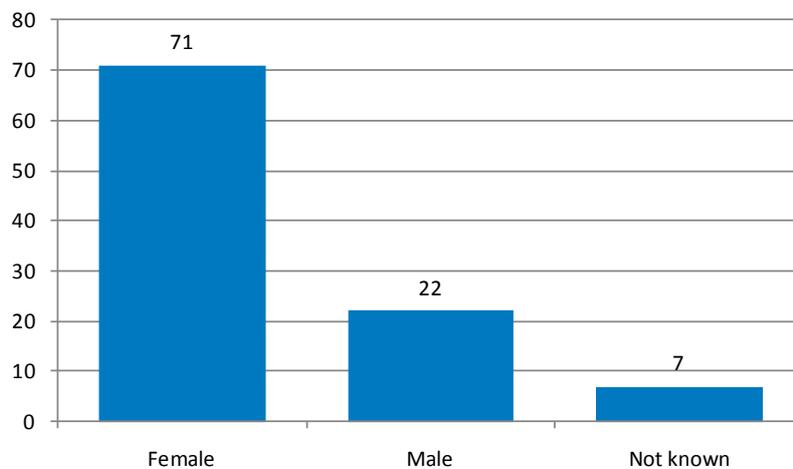


62% of Health Worker manager survey respondents were employed in the government sector, followed by 13% who were employed in the Community Controlled sector. 8% did not provide any information on their place of employment.

### 3.2.5 Distribution of Health Worker manager survey participants by gender and age

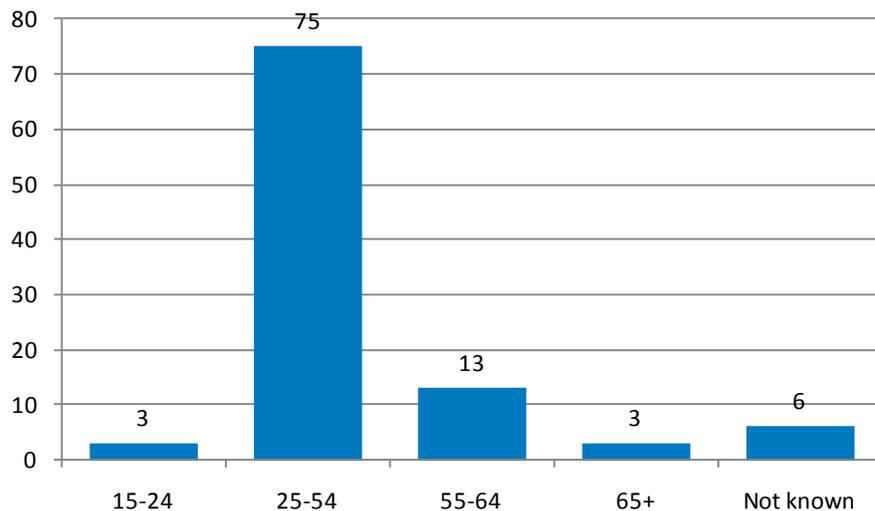
The age and gender breakdown of Health Worker manager survey participants is presented in Figure 16 and Figure 17.

Figure 16: Distribution of Health Manager survey respondents by gender (n=100)



The majority of the Health Worker manager survey respondents were female.

Figure 17: Distribution of Health Manager Survey respondents by age group (n=100)



Three-quarters of the Health Worker manager survey respondents said they were in the 25 to 54 age bracket.

## 4. Focus group participants

The Health Worker and manager focus groups are profiled below as follows:

- total number of focus groups and participants
- distribution of focus groups by jurisdiction
- distribution of focus groups by area of remoteness
- distribution of focus groups by place of employment
- distribution of focus group participants by self-reported identity (eg as being of Aboriginal and Torres Strait Islander descent).

### 4.1 Community Mapping focus groups: Health Worker participant profile

#### 4.1.1 Health Worker focus groups: total number of focus groups and participants

Sixty eight Health Worker focus groups were conducted across 64 sites; 264 Health Workers participated in the process. The number of Health Workers who participated in each focus group varied – for example, in some instances there were 12 participants and in others only one or two. The number of focus groups by size of participants is presented in Table 3.

Table 3: Number of participants and focus groups conducted with Health Workers

Size of focus group (number of participants)	Number of focus groups at each size
1	13

2	9
3	10
4	10
5	11
6	10
7	1
9	2
12	2
<b>TOTAL</b>	<b>68</b>

#### 4.1.2 Distribution of Health Worker focus groups by jurisdiction

The distribution of Health Worker focus groups by jurisdiction is represented in Figure 18.

Figure 18: Distribution of Health Worker focus groups by jurisdiction (n=68)

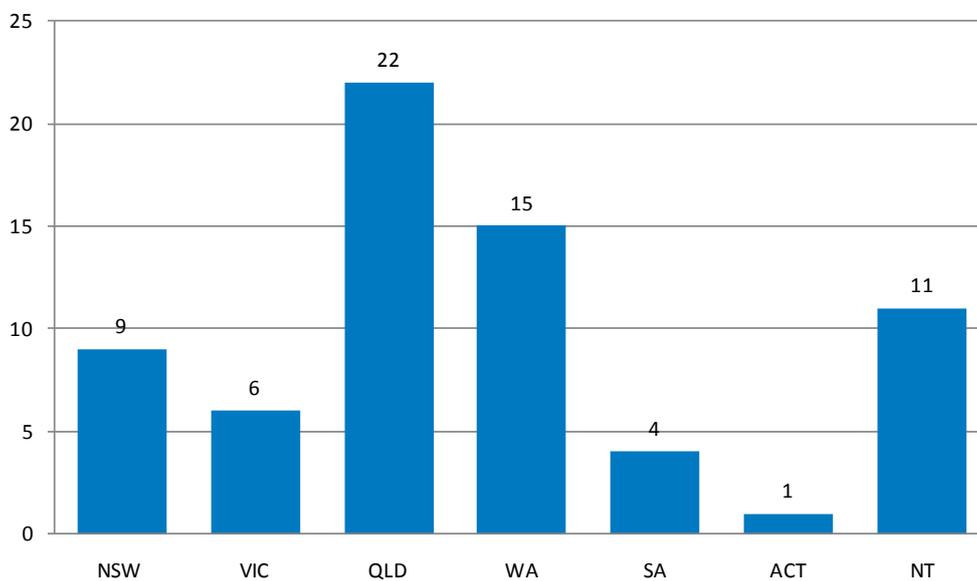
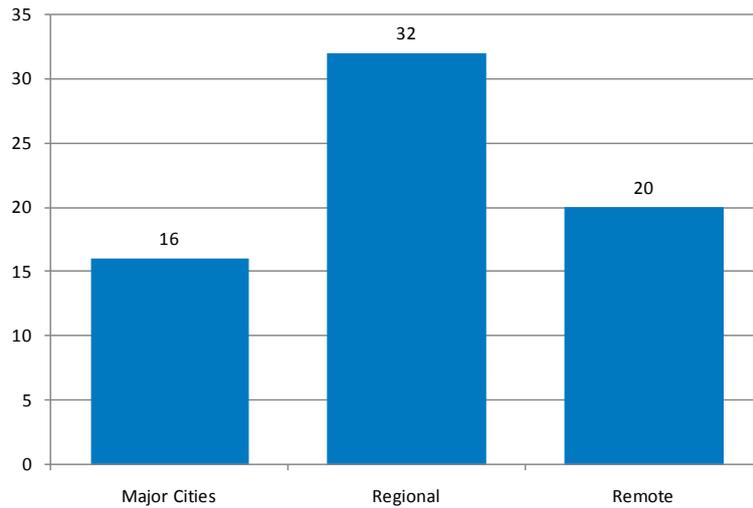


Figure 18 shows that, of the 68 Health Worker focus groups conducted, the greatest proportion were in Queensland (32%), followed by Western Australia (22%) and the Northern Territory (16%). There was only one conducted in the ACT and none in Tasmania.

#### 4.1.3 Distribution by of Health Worker focus groups by area of remoteness

The area of remoteness was determined using the Australian Standard Geographic Classification (ASGC) system, as for the Health Worker survey. Figure 19 shows the results.

Figure 19: Distribution of Health Worker focus groups by area of remoteness (n=68)

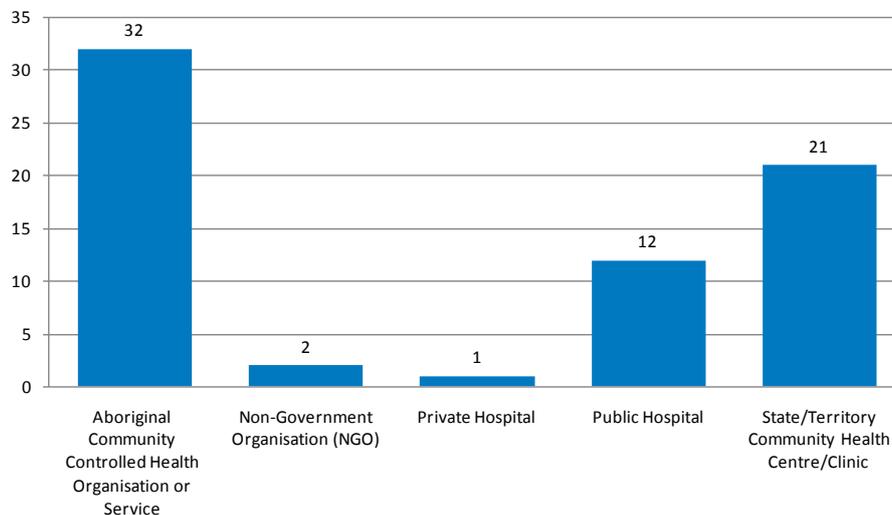


Just under half (47%) of all Health Worker focus groups were conducted in regional areas of Australia, 29% in remote areas and 24% in major cities.

#### 4.1.4 Distribution of Health Worker focus groups by place of employment

The Community Mapping activity targeted Health Workers from a range of employment areas, including the government health sector, ACCHOs and the other health sectors. Figure 20 provides a breakdown of the Health Worker focus groups conducted by employer organisation.

Figure 20: Distribution of Health Worker focus groups by place of employment (n=68)

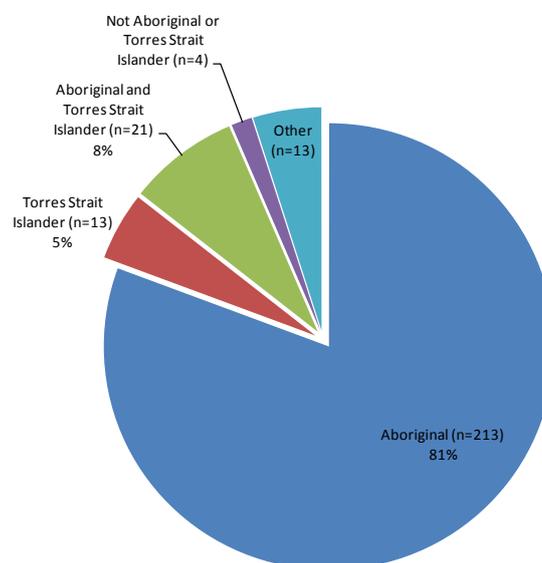


The largest proportion of Health Worker focus groups were conducted with Health Workers from ACCHOs (47%), followed by those employed within state/territory community health centres and/or clinics (31%).

#### 4.1.5 Distribution of Health Worker focus group participants by self-reported identity

Unlike the Health Worker survey, the Community Mapping activity included participants who did not identify themselves as either Aboriginal or Torres Strait Islander, although they were in the minority (Figure 21). There were also a small number of Health Worker participants that identified as South Sea Islanders and they have been included in the analysis under the 'Other' category.

Figure 21: Distribution of Health Worker participants in focus groups by self reported identity (n=264)



Of the total 264 Health Workers who participated in the focus groups:

- 81% identified themselves as Aboriginal
- 5% identified themselves as Torres Strait Islanders
- 8% identified themselves as Aboriginal and Torres Strait Islander
- 8% identified themselves as 'Other' (some South Sea Islanders were included in this group).

## 4.2 Community Mapping focus groups: Health Worker manager participant profile

### 4.2.1 Health Worker manager focus groups: total number of focus groups and participants

47 Health Worker manager focus groups were conducted across 64 sites, with 100 participants. These health managers were generally either direct line managers of Health Workers within the service or were managers of the service itself.

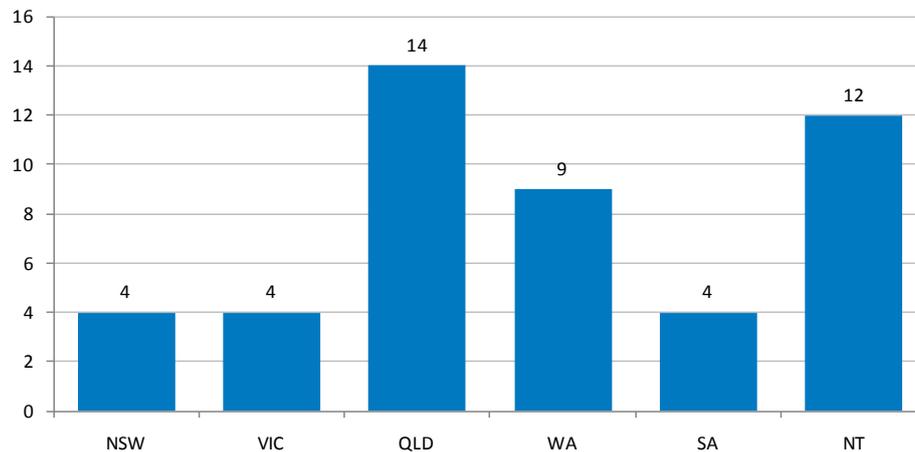
The number of health managers who participated varied from group to group, as shown in Table 4.

Table 4: Number of participants and focus groups conducted with health managers

Number of participants	Number of focus groups
1	24
2	8
3	7
4	4
5	3
8	1
<b>TOTAL</b>	<b>47</b>

#### 4.2.2 Distribution of Health Worker manager focus groups by jurisdiction

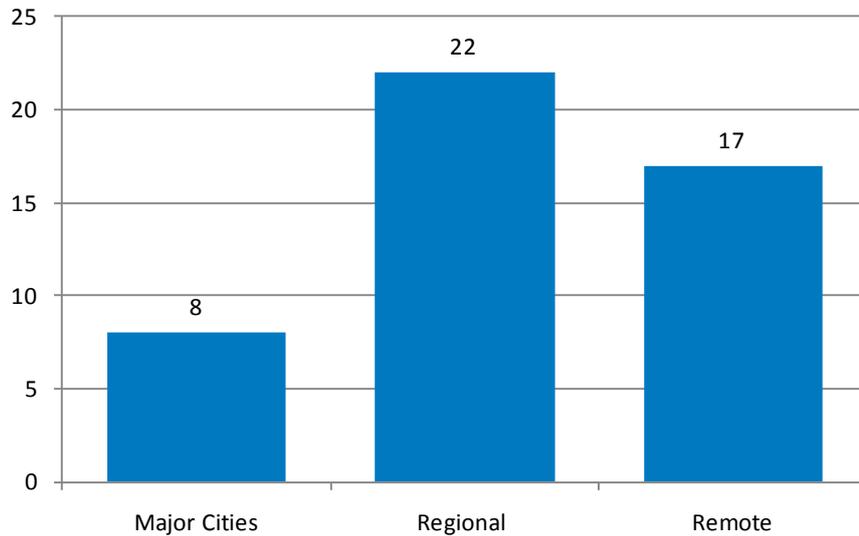
Figure 22: Distribution of Health Worker manager focus groups by jurisdiction (n=47)



30% of the Health Worker manager focus groups were conducted in QLD, followed by the NT (26%). Four were conducted in each of NSW, SA and VIC.

#### 4.2.3 Distribution of Health Worker manager focus groups by remoteness classification

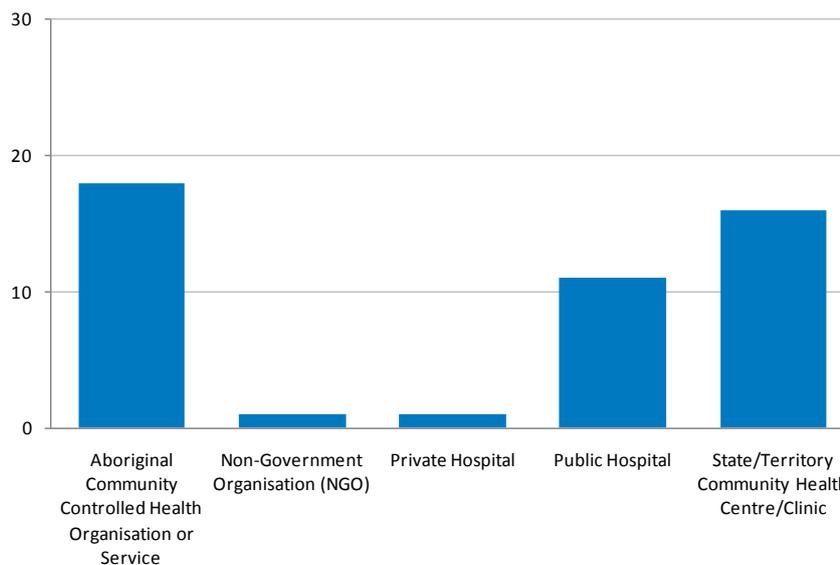
Figure 23: Distribution of Health Worker manager focus groups by area of remoteness (n=47)



Just under half the Health Worker manager focus groups were conducted with those from regional areas; and 36% were from remote areas.

#### 4.2.4 Distribution of Health Worker manager focus groups by place of employment

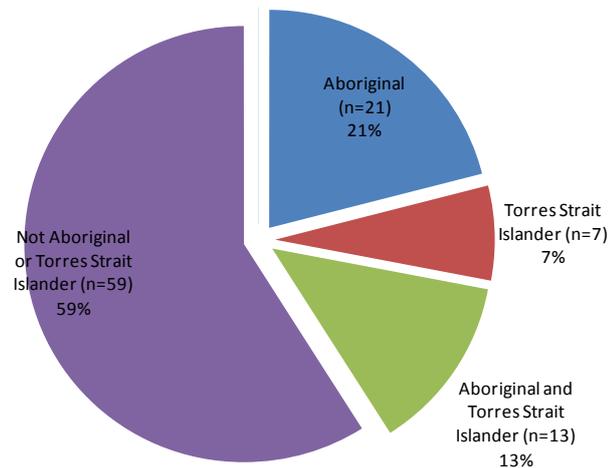
Figure 24: Distribution of Health Manager focus groups by place of employment (n=47)



38% of the interviews were conducted with Health Managers employed by ACCHOs, and 34% were with those employed by state/territory community health centres/clinics. A smaller proportion (23%) were employed by public hospitals.

#### 4.2.5 Distribution of Health Worker manager focus group participants by self-reported identity

Figure 25: Distribution of Health Worker manager focus group participants by self-reported identity (n=100)



Of the 100 Health Managers who participated in the focus groups, 59% identified themselves as neither Aboriginal nor Torres Strait Islander. 21% of the participants stated that they were Aboriginal and 13% that they were both Aboriginal and Torres Strait Islander (Figure 25). Community Mapping focus groups: other health professionals participant profile

#### 4.3 Other health professionals focus groups: total number of focus groups and participants

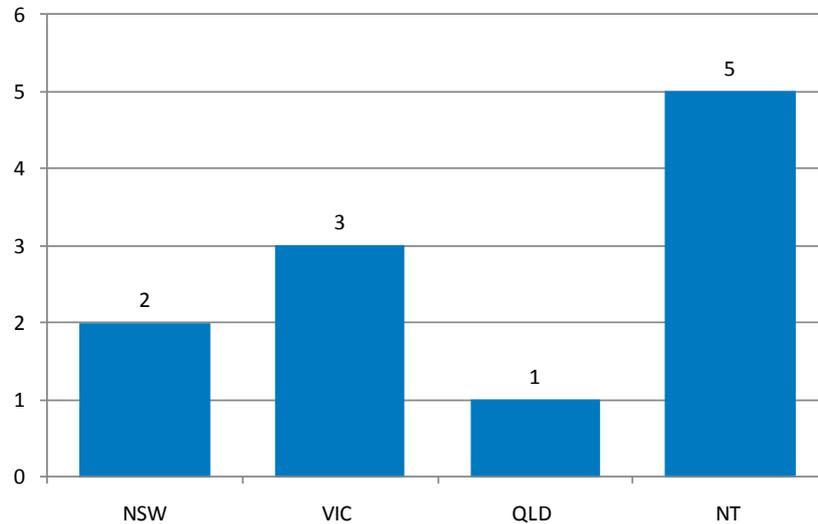
11 focus groups with other health professionals were conducted across eight locations, with a total of 25 participants. Table 5 provides a breakdown of the number of focus groups conducted with their corresponding participation size.

Table 5: Number of participants and number of focus groups conducted with other health professionals

Number of participants	Number of focus groups
1	6
2	3
3	1
10	1
<b>TOTAL</b>	<b>11</b>

#### 4.3.1 Distribution of other health professionals focus groups by jurisdiction

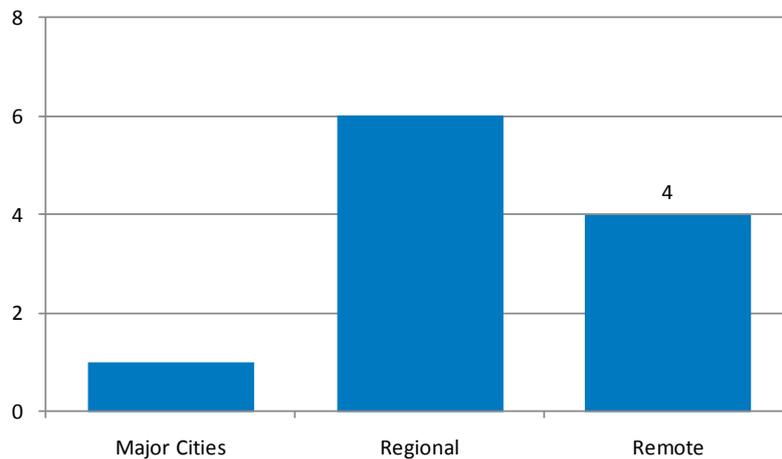
Figure 26: Distribution of other health professionals' focus groups by jurisdiction (n=11)



Just under half (45%) the other health professionals focus groups were conducted in the Northern Territory, with 27% in Victoria.

#### 4.3.2 Distribution of other health professionals focus groups by area of remoteness

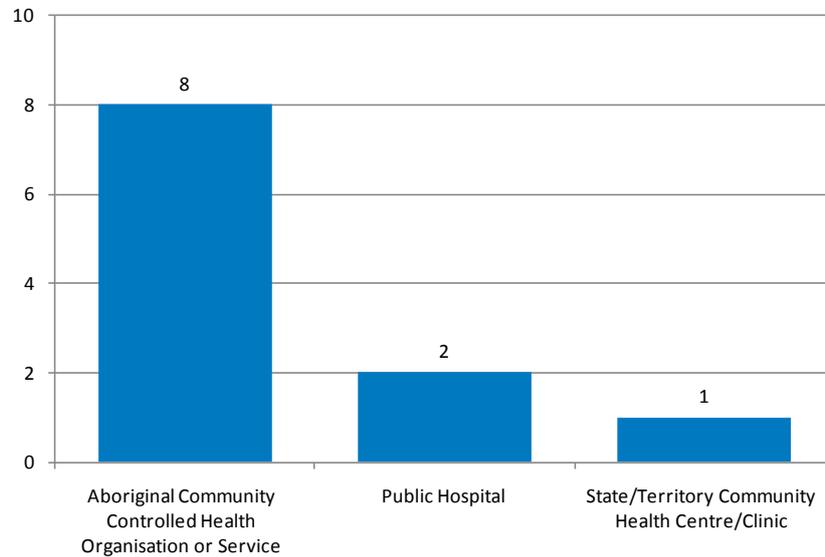
Figure 27: Distribution of Other Health Professionals focus groups by area of remoteness (n=11)



Of the 11 focus groups conducted, six were conducted with other health professionals in regional areas and four were in remote areas.

#### 4.3.3 Distribution of other health professionals focus groups by place of employment

Figure 28: Distribution of other health professionals focus groups by place of employment (n=11)

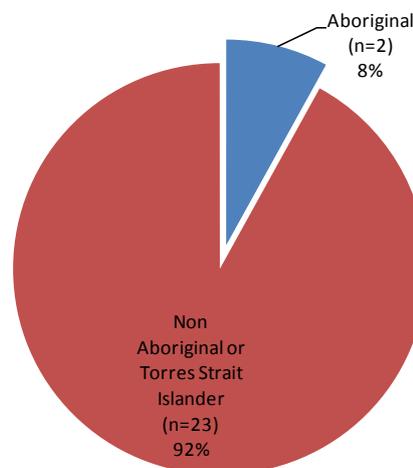


8 of the 11 focus groups were with other health professionals employed by ACCHOs, two were with those employed by public hospitals and one with state/territory community health centre employees.

#### 4.3.4 Distribution of other health professionals focus group participants by self-reported identity

The majority of the other health professionals focus group participants reported themselves to be neither Aboriginal nor Torres Strait Islander. Only two participants identified themselves as Aboriginal (Figure 29).

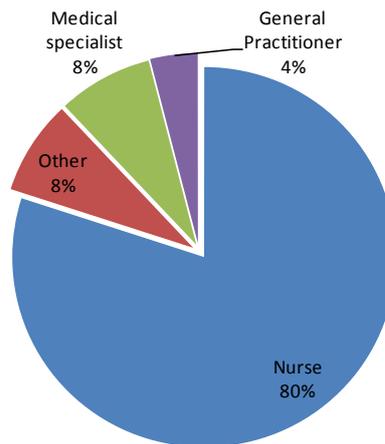
Figure 29: Distribution of other health professionals focus group participants by self reported identity (n=25)

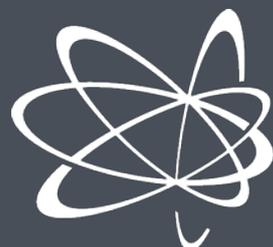


#### 4.3.5 Distribution of other health professionals focus group participants by profession

80% (n=20) of the other health professionals focus group participants were nurses, two were medical specialists and one was a general practitioner (Figure 30).

Figure 30: Distribution of Other Health Professional focus group participants by profession (n=25)





**HealthWorkforce**  
AUSTRALIA



## **Interim Report – Appendix C**

Information Collection Tools

**28 June 2011**

**Health Workforce Australia**

## Contents page

Appendix C	Information collection tools	1
1.	Context	1
2.	Aboriginal and Torres Strait Islander Health Worker Survey	2
3.	Aboriginal and Torres Strait Islander Health Worker Direct Line Manager Survey	26
4.	Interview template: Health Worker focus groups	38
5.	Interview template: Health Worker manager focus groups	41
6.	Interview template: other health professionals focus groups	44
7.	Key informant interview templates	47

## Appendix C Information collection tools

### 1. Context

The information that forms the basis of the Interim Report was collected through consultation with Health Workers, Health Worker managers, other health professionals and key informants. The information collection tools used in this consultation process are included in this appendix.

Six information collection tools were used, as follows:

- Health Worker survey (Section 0)
- Health Worker manager survey (Section 3)
- Health Worker interview template (Section 4)
- Health Worker manager interview template (Section 5)
- other health professionals interview template (Section 6)
- key informant questions (Section 7).

Each tool has been included in this appendix.

The Health Worker and manager surveys were provided in both a paper-based and an online version. The versions included in this appendix are the paper-based versions; an adapted version using the same questions was created to enable online completion.

## 2. Aboriginal and Torres Strait Islander Health Worker Survey

### About You

- In order to keep your responses anonymous, we do not need to know your name or personal details. However, we do need to give your survey a unique code for data analysis purposes. Please fill in the following table. This will allow us to code your survey without knowing who you are, so you can be certain you will remain anonymous.

	First two initials of your first name		First two initials of your surname		Year of birth	Gender (M/F)
Description	If your first name is Peter, "PE"		If your surname is Smith, "SM"		Year	Male (M) or Female (F)
Example	P	E	S	M	1976	M
Your response:						

- Do you identify yourself as: *(Please tick one box)*

<input type="checkbox"/>	An Aboriginal person
<input type="checkbox"/>	A Torres Strait Islander person
<input type="checkbox"/>	An Aboriginal and Torres Strait Islander person
<input type="checkbox"/>	Other (Please specify) _____

- Who is your mob? (E.g. Bardi, Murray, Koori)

\_\_\_\_\_

- What town/location do you usually live in?

Name of town(s)	
State or Territory	
Postcode(s) (if known)	

About your work

5. a. What town/ location do you mainly work in?

Name of town(s)	
State or Territory	
Postcode(s) (if known)	

b. What other town/location(s) do you work in? (You can list more than 1 town/location if required)

Name of town(s)	
State or Territory	
Postcode(s) (if known)	

6. What kind of Health Service is your main employer?

<input type="checkbox"/>	Public Hospital
<input type="checkbox"/>	Private Hospital
<input type="checkbox"/>	Aboriginal Community Controlled Health Organisation or Service
<input type="checkbox"/>	State/Territory Community Health Centre/Clinic
<input type="checkbox"/>	Court or custody/prison location
<input type="checkbox"/>	General Practice (GP office)
<input type="checkbox"/>	Non-Government Organisation (NGO)
<input type="checkbox"/>	Unsure
<input type="checkbox"/>	Other (please specify): _____

7. Do you work in any other Health Services as part of your job (e.g. Outreach work in hospitals or prisons)? (You can tick more than one box if required)

<input type="checkbox"/>	Public Hospital
--------------------------	-----------------

	Private Hospital
	Aboriginal Community Controlled Health Organisation or Service
	State/Territory Community Health Centre/Clinic
	Court or custody/prison location
	General Practice (GP office)
	Non-Government Organisation (NGO)
	Unsure
	Other (please specify): _____

8. What job title best describes your role? E.g. "I am a....." (Note: Later in the survey, we will ask you more about what kind of work you do on a daily basis. So, for example, if you are a "Generalist Aboriginal and Torres Strait Islander Health Worker" but some of your job includes work in sexual health, tick "Generalist" here - you can tell us about your sexual health work later in the survey. Only tick "Sexual Health Worker" if that is the main title of your job. If you have more than one title, you can tick more than one box).

	Health Worker (Generalist)
	Outreach Worker
	Mental Health Worker
	Family Health Worker
	Sexual Health Worker
	Education Officer
	Hospital Liaison Officer
	Drug and Alcohol Worker
	Environmental Health Worker
	Community Worker
	Healthy Living Worker
	Vascular Health Worker
	Pharmacy Health Worker

	Maternal and Perinatal Health Worker
	Otitis Media Health Worker
	Nutrition Health Worker
	Other... (Please specify) _____

9. How many years have you worked in your current role?

	Less than 6 months
	6-12 months
	1-2 years
	3-5 years
	6-10 years
	11+ years

10. Throughout your entire career, how many years have you spent as a Health Worker in total?

	Less than 12 months
	1-2 years
	3-5 years
	6-10 years
	11-20 years
	20+ years

11. What was your last paid job before you became a Health Worker? (We are interested in any kind of job you have had, even if it is not in the health sector. E.g. some Health Workers might have worked at an industrial site in their last job. The reason for this question is to understand all the different career paths towards becoming a Health Worker)

\_\_\_\_\_

12. What is your type of Employment? (Please tick one box only)

<input type="checkbox"/>	Full-Time
<input type="checkbox"/>	Part-Time
<input type="checkbox"/>	Casual

13. What is the basis of your Employment? *(Please tick one box only)*

<input type="checkbox"/>	Permanent
<input type="checkbox"/>	Temporary
<input type="checkbox"/>	Fixed term contract

14. How many paid hours a week do you work as a Health Worker? \_\_\_\_\_

15. On average, how many hours a week do you spend doing work-related travel (excluding travel to and from work)? \_\_\_\_\_

16. Are you currently registered as an Aboriginal Health Worker in the Northern Territory?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Not applicable
<input type="checkbox"/>	Not sure

17. Are you a member of any professional organisation? For example: (Please tick if yes, or leave blank if you are not a member)

<input type="checkbox"/>	National Aboriginal Torres Strait Islander Health Worker Association?
<input type="checkbox"/>	Aboriginal Torres Strait Islander Association in your state/territory?
<input type="checkbox"/>	Union/Industrial association (Please specify) _____
<input type="checkbox"/>	Other professional association (Please specify) _____ _____

Do you have any comments about the support provided?

---



---

Why/Why not?

18. How often do you work as part of a larger health team with other health professionals?

	Never
	Once a month
	Once a fortnight
	Once a week
	A few times a week
	Every day

19. If you work as part of a larger health team, which other health professionals are in your team? (Please write the number of health professionals next to each profession in the columns provided, or leave blank if not applicable)

Approx. number (non-Aboriginal / Torres Strait Islander)	Approx. number (Aboriginal / Torres Strait Islander)	Position
		General practitioner
		Medical Specialist (Please specify) _____
		Nurse Practitioner
		Nurse (Registered Nurse)
		Nurse (Enrolled Nurse)
		Midwife
		Dentist
		Dental therapist/hygienist
		Allied Health (e.g. physiotherapy, occupational therapy, dietician, speech pathologist)
		Aboriginal and Torres Strait Islander Health Workers (including Mental Health Workers and Drug and Alcohol Workers)
		Other (Please specify) _____

20. What type of supervision occurs in your regular work? (Note: There is no right or wrong answer to this question. The reason for asking this question is because Health Workers have very different relationships with their supervisors all over Australia, and we would like to understand what they involve.)

	I don't have any supervision
	Not much – I work on my own most of the time
	When I need help I call someone to ask questions over the phone

<input type="checkbox"/>	When I need help I ask someone at work
<input type="checkbox"/>	There is usually a supervisor available to check my work
<input type="checkbox"/>	A supervisor always checks my work

21. Who is your main supervisor(s)? (Please tick more than one if applicable)

<input type="checkbox"/>	General practitioner
<input type="checkbox"/>	Medical Specialist <i>(Please specify)</i> _____
<input type="checkbox"/>	Practice Manager
<input type="checkbox"/>	Nurse Practitioner
<input type="checkbox"/>	Nurse (Registered Nurse)
<input type="checkbox"/>	Nurse (Enrolled Nurse)
<input type="checkbox"/>	Midwife
<input type="checkbox"/>	Dentist
<input type="checkbox"/>	Dental therapist/hygienist
<input type="checkbox"/>	Allied Health (e.g. physiotherapy, occupational therapy, dietician, speech pathologist)
<input type="checkbox"/>	Other Aboriginal and Torres Strait Islander Health Worker
<input type="checkbox"/>	Other <i>(Please specify)</i> _____

22. What town/location is your supervisor usually based in?

Name of town(s)	
State or Territory	
Postcode(s) (if known)	

23. How often do you have contact with your supervisor(s)? (Please tick one box in each column)

Type of contact	Frequency of contact					
	Never	Once a month	Once a fortnight	Once a week	A few times a week	Every day
Face to face						
Over the phone						
By email						

24. Do you have access to the following resources at work? (Please tick correct boxes)

Resource	Yes	No	Some-times
Landline phone			
Mobile phone			
Desk top computer			
Laptop computer that I can take out of the office if need be			
Internet			
Printer			
Work vehicle			

25. Are there any other resources you need to do your job better? (For example, a sound proof room for hearing tests, laptops for recording client information while doing outreach work, etc. Note: This question is optional. The reason for asking it is to understand what resources would help Health Workers to make a bigger contribution to the health of the communities they work in.)

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Sometimes
<input type="checkbox"/>	I'm not sure

If yes, please describe these resources and tell us why you need them. (If no, skip to the next question).

Your education

26. What year did you leave high school?

<input type="checkbox"/>	Did not attend high school
<input type="checkbox"/>	Year 7
<input type="checkbox"/>	Year 8
<input type="checkbox"/>	Year 9
<input type="checkbox"/>	Year 10
<input type="checkbox"/>	Year 11
<input type="checkbox"/>	Year 12

27. Do you have any of the following qualifications? (Please tick any relevant boxes)

Qualification	Certificate III	Certificate IV	Diploma	Advanced Diploma
Aboriginal and Torres Strait Islander Primary Health Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aboriginal and Torres Strait Islander Primary Health Care (Practice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aboriginal and Torres Strait Islander Primary Health Care (Community Care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please specify): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. What State or Territory did you obtain the above qualification in?

<input type="checkbox"/>	New South Wales
<input type="checkbox"/>	Victoria
<input type="checkbox"/>	Queensland

	South Australia
	Western Australia
	Tasmania
	Northern Territory
	Australian Capital Territory

29. Do you have any other qualifications? (Note: This question is not limited to health qualifications – you can list any other qualification you have done, even if it is not related to the health field).

If yes, what is the name of the qualification? \_\_\_\_\_  
 \_\_\_\_\_

30. What level of qualification is it?

	Certificate I
	Certificate II
	Certificate III
	Certificate IV
	Diploma
	Undergraduate Degree
	Post-graduate Degree
	Other ( <i>please specify</i> ) _____

31. Are you presently undertaking any other health-related educational courses that you have not yet completed?

	Yes
	No

32. If yes, what is the name of the course you are undertaking? (Note: If this question does not apply to you, skip to Question 34)

\_\_\_\_\_

33. What is the level of the qualification you are currently undertaking? (Note : If this question does not apply to you, skip to Question 34)

	Certificate I
	Certificate II
	Certificate III
	Certificate IV
	Diploma
	Undergraduate Degree
	Post-graduate Degree
	Other ( <i>please specify</i> ) _____

a. Are you planning on undertaking any other courses in the next five years?

	Yes
	No

b. If yes, what is the name of the course you are planning on doing in future?  
(Note: If this question does not apply to you, skip to Question 35)

\_\_\_\_\_

c. What is the level of the qualification you are planning on doing in future? (Note: If this question does not apply to you, skip to Question 35)

	Certificate I
	Certificate II
	Certificate III
	Certificate IV
	Diploma
	Undergraduate Degree
	Post-graduate Degree
	Other ( <i>please specify</i> ) _____

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34. If you are not planning on undertaking further study in future, what are some of the reasons for your decision? (Note: Skip this question if it does not apply to you. Please tick more than one if applicable)

	I am happy with the qualifications I already have
	It is too expensive to do more study
	Access to study is a problem
	I can't get time off work to study
	I have family commitments
	The educational approaches are inappropriate
	I prefer to learn on the job
	Other (Please specify): _____ _____

35. Do you participate in any other short-courses/training sessions at your health service or elsewhere?

	Yes
	No

If yes, what kind of training do you participate in and where is it offered? (If no, skip to the next question)

\_\_\_\_\_

\_\_\_\_\_

36. Is there any additional work that you are trained to perform, but you are not currently practicing it as part of your usual job? (For example, as part of your Health Worker qualification you might have been trained to take blood pressure readings, but you don't currently do this in your usual job. Note: This question is optional. If want to respond, please give an outline of this additional work)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

37. What do you think the main reasons are for you not doing this additional work? (For example, there might be other staff that perform those roles, or you might be too

busy doing other kinds of roles. Note: This question is optional. If you want to respond, please outline the reasons why)

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### Thank you, you've finished Section 1! Can you help us with Section 2?

Thank you! You have now completed the first part of this survey.

The next section is also very important – Section 2 tells us about all the different things that Health Workers do as part of their usual job. The reason it is so important is that it will help us to learn whether the Health Worker role changes depending on what part of Australia you are from, or what kind of Health Service you are employed by.

Section 2 should take about 10-15 minutes to complete and then you will be all finished. Section 2 is optional, but we really encourage you to fill it out so that we can learn as much as possible about the role of Health Workers.

### About the role you do at work

Health Workers across Australia perform a range of very different roles with different areas of focus. This section of the survey is about understanding your particular role and how you contribute to your community. It should take about 10-15 minutes for you to complete this section. A number of questions relate to each area of focus. For each question, please tick the relevant box that shows how regularly you perform each activity.

Remember that there is no right or wrong answer to any of these questions. This is a very broad list of possible activities that Health Workers might perform – in real life, most Health Workers will only perform some of them. Some Health Workers might answer “Never” to a lot of the questions; others will do more of the activities. Please answer each question so that we have a complete understanding of your role.

38. How often do you do the following activities in your role?

Activity	How often do you do this activity?					
	Most days	Weekly	Fortnightly	Monthly	Yearly	Never
Improving health and access through patient advocacy, communication and support						
Talk with people in your community to encourage or help them to use health services? (E.g. providing transport, taking people to the clinic, explaining the health worker role, etc.)						
Explain medical terminology, medications and treatments in a way that your Aboriginal and/or Torres Strait Islander patient will understand?						
Visit the community you work in to find people who might be unwell?						
Do outreach activities in the community to provide health care in homes or community settings?						

Activity	How often do you do this activity?					
	Most days	Weekly	Fortnightly	Monthly	Yearly	Never
Organise a traditional healer when the patient wants one?						
Improving health and access through a culturally safe and aware health service						
Speak to other health professionals to explain the patient's health and cultural needs?						
Make recommendations on how health care should be provided to a patient in a culturally appropriate way? (E.g. who the right person is to treat them, what time is appropriate, where is the best place)						
Suggest changes to your health service so that it meets the needs of Aboriginal and/or Torres Strait Islander patients?						
Educate other health staff on Aboriginal and/or Torres Strait Islander history, culture and health needs?						
Seek community involvement in running and/or advising health services so that members of the community contribute to decision-making processes?						
Improving health through community wellbeing and development						
Discuss with the community to help them understand environmental factors that affect their health? (E.g. over-crowded living arrangements, clean water, hygiene, food contamination and insect problems)						

Activity	How often do you do this activity?					
	Most days	Weekly	Fortnightly	Monthly	Yearly	Never
Work with others in the community to improve the health of the community? (E.g. work with local shops to target nutritional issues, work with local school for health education)						
Work in collaboration with other community and welfare services to provide a safe living environment? (E.g. preventing/managing domestic violence or child abuse)						
Work with providers of services to provide access to basic services for the community? (E.g. Centlink, clean water supply, housing, education)						
Feed information back to the community about the general health status of the community you work in?						
Health prevention and promotion activities						
Assess a patient's health risk factors? (E.g. as weight, smoking, eating habits)						
Talk to a patient about how to live a healthier life? (E.g. losing weight, drinking less, stopping smoking, exercising, etc.)						
Run group education sessions about healthy living?						
Run health prevention or promotion campaigns at community events? (E.g. put up a health stall or information poster at a football match, etc.)						

Activity	How often do you do this activity?					
	Most days	Weekly	Fortnightly	Monthly	Yearly	Never
Assess your community and identify the things that will make people unwell? (E.g. the food in the stores, lack of exercise, smoking and drinking habits, etc.)						
Clinical assessment, intervention and monitoring						
Assess, document or follow-up on a patient's medical and health history?						
Assess, document or follow-up on a patient's social and family situation that may affect their health? (E.g. living arrangements, family supports, education/employment)						
Do a physical examination of the patient by looking at, feeling or listening to different parts of the patient's body to assess what the problem is (E.g. looking at eyes and ears, listening with a stethoscope to a patient's chest, feeling for pain in injured arms, etc.)?						
Take and interpret physical observations of a patient's health to work out how unwell the patient is (E.g. temperature, heart rate, respiratory rate, and blood pressure, taking an ECG, urinalysis)?						
Make a decision about which medication to give to patients?						
Give medication that has previously been prescribed by doctors?						
Assess, clean and dress wounds?						

Activity	How often do you do this activity?					
	Most days	Weekly	Fortnightly	Monthly	Yearly	Never
Give immunisation or other injections?						
Give a finger prick test for blood sugar or a heel prick?						
Take blood samples to be sent away for tests? (E.g. for electrolytes, cholesterol, blood count)						
Write or verbally refer patients to other health professionals?						
Stitch a wound or perform suturing?						
Conduct emergency intervention for medical cases such as asthma, or first aid for major injuries?						
Take X-rays?						
Conduct general consultations for vomiting and/or diarrhoea? (E.g. Assessment, treatment and follow-up)						
Conduct general physical assessment for chest infections? (E.g. Assessment, treatment and follow-up)? (Assessment, treatment and follow-up)						
Conduct general physical assessment for eye and ear problems? (E.g. Assessment, treatment and follow-up)? (Assessment, treatment and follow-up)						

Child/Maternal health							
Conduct baby/child wellness and focussed screening activities? (E.g. ear, eye, skin examinations)							
Perform routine childhood immunisations?							
Talk with parents before their baby is born about their health and the birth process?							
Talk with parents after their baby is born? (E.g. to give advice on breast feeding)?							
Assess and refer children at risk of abuse or neglect?							
Sexual Health							
Conduct screening and follow up for sexually transmitted infections? (E.g. taking swabs/samples)							
Provide treatment for sexually transmitted infections?							
Documenting sexual partners of a person with a sexually transmitted infection to identify others at risk of infection?							
Conduct safe sex education sessions with individuals or the community?							
Conduct HIV, Hepatitis B and/or Hepatitis C prevention, screening and counselling?							

<b>Women's Health</b>									
Perform cervical screening/PAP smears?									
Obtain and feedback the results of cervical screening/PAP smears?									
Educate women on the benefits and methods of regular breast examination?									
Educate women about family planning and contraception?									
Work with women in relation to positive family relationships and preventing domestic violence?									
<b>Men's Health</b>									
Conduct groups on men's health business?									
Conduct fathering courses?									
Work to encourage men to get health care?									
Teach men how to examine their testicles/balls for lumps?									
Work with men in relation to positive family relationships and preventing domestic violence?									
<b>Drug and Alcohol</b>									
Deal with patients with a drug and alcohol dependency?									

Deal with patients who are drunk?									
Provide counselling for patients with a diagnosed drug and alcohol problem?									
Assess the level of a patient's drug and alcohol dependency using standardised alcohol and drug screens?									
Medically manage patients withdrawing from drugs and/or alcohol?									
<b>Mental Health</b>									
Conduct a mental health state assessment?									
Assess a patient of risk of harm to self or others?									
Provide emergency intervention for a patient with suicidal thoughts, homicidal thoughts or deep depressions?									
Provide general counselling for patients with a diagnosed mental illness?									
Develop an ongoing management plan to support a person or family of someone with a mental illness?									
Provide support or counselling to families or carers looking after a person with a mental illness?									
<b>Chronic Disease Management</b>									
Do an assessment of the known risk factors for heart disease, kidney disease and diabetes?									

Teach your client about the things they need to do to stop their heart/kidney/diabetes getting worse? (E.g. treatments, healthy living habits, etc.)								
Help clients set their own goals and actions to manage their disease themselves?								
Teach your client how to monitor their symptoms and when to come back to the clinic?								
Doing follow-up checks on patients who are managing chronic diseases?								
Aged and disability care								
Assess the supports required for a person who is aged or has a disability to attend to their daily activities? (E.g. bathing, eating, etc.)								
Adjust the living environment so that it meets the needs of a person who is aged or has a disability?								
Directly provide support services needed by a person who is aged or has a disability?								
Organise other support services needed by a person who is aged or has a disability?								
Work with and educate family members and carers in the management of a person who is aged or has a disability?								

Thank you for participating in this survey. You have made a valuable contribution to this Project which aims to strengthen the Health Worker workforce to better respond to the health needs of Aboriginal and Torres Strait Islander peoples.

Would you like to be kept informed about this project? *(Please tick one box)*

	Yes
	No

If yes, please provide contact details (Note: your contact details will only be used for the purpose of sending you information about this project – your contact details and responses will remain confidential)

	Phone
	Mobile
	Email
	Postal address

### 3. Aboriginal and Torres Strait Islander Health Worker manager survey

#### About You

- In order to keep your responses anonymous, we do not need to know your name or personal details. However, we do need to give your survey a unique code for data analysis purposes. Please fill in the following table. This will allow us to code your survey without knowing who you are, so you can be certain you will remain anonymous.

	First two initials of your first name		First two initials of your surname		Year of birth	Gender (M/F)
Description	If your first name is Peter, "PE"		If your surname is Smith, "SM"		Year	Male (M) or Female (F)
Example	P	E	S	M	1976	M
Your response:						

- Do you identify yourself as: (Please tick one box)

<input type="checkbox"/>	An Aboriginal person
<input type="checkbox"/>	A Torres Strait Islander person
<input type="checkbox"/>	An Aboriginal and Torres Strait Islander person
<input type="checkbox"/>	A person who is not of Aboriginal or Torres Strait Islander descent
<input type="checkbox"/>	Other (Please specify) _____

#### About the Health Service you work at

- What town/location is the Health Service you manage/are a manager at located in?

Name of town(s)	
State or Territory	

Postcode(s) (if known)	
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4. What other town/location(s) does this Health Service cover? (You can list more than one place if required)

Name of town(s)	
State or Territory	
Postcode(s) (if known)	

5. What type of Health Service is the main organisation you manage/are a manager at? (Please tick one box only)

<input type="checkbox"/>	Public Hospital
<input type="checkbox"/>	Private Hospital
<input type="checkbox"/>	Aboriginal Community Controlled Health Organisation or Service
<input type="checkbox"/>	State/Territory Community Health Centre/Clinic
<input type="checkbox"/>	Court or custody/prison location
<input type="checkbox"/>	General Practice (GP office)
<input type="checkbox"/>	Non-Government Organisation (NGO)
<input type="checkbox"/>	Unsure
<input type="checkbox"/>	Other (please specify): _____

6. What level of health service is this organisation? (based on Australian College of Emergency Medicine Statement of Role Delineation - please tick one box only)

<input type="checkbox"/>	Primary care centre or remote rural service
<input type="checkbox"/>	Large rural hospital
<input type="checkbox"/>	Major regional / Rural based hospital
<input type="checkbox"/>	Urban / District hospital
<input type="checkbox"/>	Major referral hospital / Tertiary hospital

	Other (please specify): _____
--	----------------------------------

About the staff at your Health Service

7. At your health service, how many staff identify as being of Aboriginal and/or Torres Strait Islander descent and are employed as any of the following?

*(Please write the number of staff in the appropriate boxes)*

Approx. number of Aboriginal and Torres Strait Islanders (FTE)	Position
	Health Worker
	Outreach Worker
	Mental Health Worker
	Family Health Worker
	Sexual Health Worker
	Education Officer
	Hospital Liaison Officer
	Drug and Alcohol Worker
	Environmental Health Worker
	Community Worker
	Healthy Living Worker
	Vascular Health Worker
	Pharmacy Health Worker
	Maternal and Perinatal Health Worker
	Otitis Media Health Worker
	Nutrition Health Worker

	No
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8. What other staff are employed in your health service? (Please specify how many staff you have in each position, and whether they identify as being of Aboriginal and/or Torres Strait Islander descent).

Approx. number FTE (non-Aboriginal / Torres Strait Islander)	Approx. number FTE (Aboriginal / Torres Strait Islander)	Position
		General practitioner
		Medical Specialist (Please specify) _____
		Nurse Practitioner
		Nurse (Registered Nurse)
		Nurse (Enrolled Nurse)
		Midwife
		Dentist
		Dental therapist/hygienist
		Allied Health (e.g. physiotherapy, Occupational Therapy)
		Other (Please specify) _____

9. Does your health service employ any other staff that identify as being of Aboriginal and/or Torres Strait Islander descent and have not been included in your response to any of the above questions?

*(If yes, please specify how many, and what their title/role is)*

Approx. number (FTE)	Title/role description


10. Does your Health Service have any vacant positions for Aboriginal and Torres Strait Islander Health Workers or other health professionals (If yes, please specify how many, and what the title of the vacant position is – e.g. one x Enrolled Nurse, one x Mental Health Worker)

Approx. number (FTE)	Title/role description

11. Do the Health Workers employed in your service:

Question	Yes / No / Sometimes
a. Work in multidisciplinary health care teams with staff from other health professions?	
b. Act as the <b>primary</b> point of contact for Aboriginal and Torres Strait Islander patients?	
c. Act as the <b>only</b> point of contact for Aboriginal and Torres Strait Islander patients?	
d. Have contact with every patient that accesses your Health Service who is of Aboriginal and/or Torres Strait Islander descent?	
e. Seem to be culturally accepted and respected by Aboriginal and Torres Strait Islander patients?	

12. Do you believe that Health Workers at your Health Service could have a greater role in responding to the health and service needs of Aboriginal and Torres Strait Islanders:

Question	Yes / No / Sometimes
a. In general?	
b. If they had a higher qualification?	
c. If they had additional training in addition to their qualification?	
d. If they developed a specific area of clinical focus or health issue?	
e. If the team structure of your Health Service was different?	
f. If the laws were changed?	

Do you have any other comments or suggestions?

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13. What are some of the challenges for your health service in relation to Health Worker recruitment? (Please give a rating of each challenge, where 0 = "not a challenge" and 10 = "a significant challenge")

Rating	Recruitment challenge
	No applicants for vacancies
	A lack of appropriately qualified applicants for vacancies
	A lack of funding for Health Worker positions
	The geographic location of our Health Service is a disincentive to applicants
	The travel involved is a disincentive to applicants
	Other (please specify): _____

14. What are some of the challenges for your Health Service in relation to Health Worker retention? (Please give a rating of each challenge, where 0 = "not a challenge" and 5 = "a significant challenge")

Rating	Retention challenge
	Health Workers move into other health professions. (If so, please specify which profession): _____
	Health Workers can only be hired on short-term, fixed contracts due to funding arrangements
	Health Workers quit working in the health sector altogether
	Health Workers quit to pursue further education
	Health Workers quit to look after their family
	Health Workers quit because they want to relocate to less remote areas
	Health Workers quit because they want to return to work in their community of origin
	Health Workers quit because there are limited opportunities for career progression within our Health Service
	Other (Please specify): - _____ _____ _____

### About the Health Workers that you directly supervise

15. How many of the Health Workers employed at your Health Service do you directly supervise?

\_\_\_\_\_

16. On average, how frequently do you have contact with the Health Workers that you supervise?

Type of contact	Frequency of contact					
	Never	Once a month	Once a fortnight	Once a week	A few times a week	Every day
Face to face						
Over the phone						
By email						

17. Do you ever delegate supervision of Health Workers to other staff members in your Health Service? If yes, what are their roles?

	No
	Sometimes
	Yes <i>Please specify role(s) (e.g. Nurse):</i> <hr/> <hr/>

18. Please fill in the following table for each staff member employed in your health service that could broadly be described as an Aboriginal and Torres Strait Islander Health Worker (HW). This includes all Aboriginal and Torres Strait Islanders that have a role within the broad Health Worker continuum, from those performing community liaison roles, to those performing more clinical tasks. The purpose of collecting this information is to gain some insights into the type of Health Workers employed across the country, what their level of qualification is and whether they have an area of focus. The information will remain completely anonymous however, we do need the same unique identifier code so that we can differentiate from responses.

Description	First two initials of HW's first name		First two initials of HW's surname		Year of Birth	Gender (M) or female (F)	Job title	Title of role Health Worker is employed to perform	Educational qualification name	Level of education	Specific area(s) of focus
	P	E	S	M							
Example	P	E	S	M	1976	M	Drug and Alcohol Worker	Drug and Alcohol Worker	Aboriginal and Torres Strait Islander Health Worker (Community Care)	Certificate III	Drug and Alcohol
Health Worker 1											

	First two initials of HW's first name	First two initials of HW's surname	Year of Birth	Gender	Job title	Educational qualification name	Educational qualification level	Specific area(s) of focus
Health Worker 2								
Health Worker 3								
Health Worker 4								
Health Worker 5								
Health Worker 6								
Health Worker 7								

	First two initials of HW's first name	First two initials of HW's surname	Year of Birth	Gender	Job title	Educational qualification name	Educational qualification level	Specific area(s) of focus
Health Worker 8								
Health Worker 9								
Health Worker 10								

Thank you for participating in this survey. You have made a valuable contribution to this Project, which aims to strengthen the Health Worker workforce to better respond to the health needs of Aboriginal and Torres Strait Islander peoples.

Would you like to be kept informed about this project? *(Please tick one box)*

	Yes
	No

If yes, please provide contact details *(Note: your contact details will only be used for the purpose of sending you information about this project – your contact details and responses will remain confidential)*

	Phone
	Mobile
	Email
	Postal address

## 4. Interview template: Health Worker focus groups

1. Tell me about your role ...

*Probing questions:*

- a. What do you do at work on a regular basis?
- b. Do you perform clinical tasks?
- c. Do you have an area of specific focus?

2. Tell me about the team that you work with ...

*Probing questions:*

- a. How many other staff do you work with, and what roles do they have?
- b. Do you work in a multidisciplinary health team? Why/why not?
- c. How do you and your team decide which tasks you will do and which tasks the other health professionals you work with will do? How do you feel about this process?
- d. What does the team expect from you?
- e. What do you expect from the team?
- f. Do you receive much supervision? Who from? Why/why not?
- g. Are you ever in a situation where you need to do your best to help a patient but you are worried that you have not been trained to do the task that is required? What do you do?

3. Tell me about the health needs of your community ...

*Probing questions:*

- a. What are the most common health problems that your community faces?
- b. What role do you play in responding to these needs?
- c. In what situations do members of your community prefer to see you in your role as a Health Worker instead of other health professionals? Why?
- d. Are you from the same community as the people you see? How does this help/not help in providing health care?

4. Tell me about the health service available to your community ...

*Probing questions:*

- a. Do you think that your community can always get the health care that they need when they have health problems? Why/why not?
  - b. Does the community come and see you where you work, or do you travel around the community to treat them in their homes or in other towns?
  - c. Are there any other Health Services available in this area?
  - d. Are the other available Health Services accessible to Aboriginal and Torres Strait Islander peoples? Why/why not? (*interviewer to provide explanation eg "Some health services may be available in your community but people may choose not to go there because they don't feel comfortable or they are not open at the right time, etc"*)
  - e. What kinds of additional services could help to improve the health care outcomes of your community?
5. Do you think it is possible for you and other Health Workers to play a different role in responding to the needs of the Aboriginal and Torres Strait Islander population?

*Probing questions:*

- a. Why/why not?
  - b. (If yes) What is stopping you and other Health Workers from having this role at the moment?
  - c. (If yes) What would it take to change the situation so that you could have a bigger role?
6. What level of qualification do you think Health Workers should have so that they can be good at helping their communities?

*Probing questions:*

- a. Why/why not?
  - b. Do you think that there are many Health Workers that are not qualified at this level (in your community and in other communities)?
  - c. (If yes) What do you think would encourage them to do further training to get to this level?
7. Do you receive any training or professional development opportunities on the job?

*Probing questions:*

- a. (If yes) Can you tell us about them?

- b. Do you want access to any other learning and development opportunities? Like what?
  - c. (If yes) What do you think it would take for these opportunities to be introduced in your Health Service?
8. What else would you like to support you in your role?

*Probing questions:*

- a. Do you want to do any further training? Why/why not?
  - b. Do you want to stay in your current role or find a different job? Why/why not?
  - c. Do you ever think about moving into another health profession? Why/why not?
9. If there was one thing you could change about your job, what would it be?

## 5. Interview template: Health Worker manager focus groups

1. Tell me about the role of Health Workers within your Health Service ...

*Probing questions:*

- a. How many are there?
- b. Why does your Health Service employ Health Workers?
- c. What roles do they have?
- d. When in the patient journey are Health Workers involved (eg transport for access, first point of contact, triage, assessment, treatment, follow up)?
- e. Do they perform clinical tasks?
- f. Do any have specific areas of focus?

2. Describe how Health Workers work with the wider health care team ...

*Probing questions:*

- a. What works well?
- b. What could be improved? How?
- c. How do Health Workers fit within the organisational structure of your Health Service?
- d. How are the roles between Health Workers and other staff divided?
- e. Do you think that this division of roles is appropriate?
- f. Do you think that there is a clear understanding of the division of roles by Health Workers and other staff?

3. What quality and safety mechanisms do you have in place around the role and work of Health Workers?

*Probing questions:*

- a. How does your Health Service enable health care to be provided in a safe and high quality manner?
- b. Who directly supervises Health Workers in your service?
- c. Do Health Workers ever work on a shift by themselves? Describe when and why? What indirect supervision is available to Health Workers?

- d. What support is available for Health Workers when they are asked to perform tasks that are outside their scope of practice?
4. Tell me about the health and service needs of the Aboriginal and Torres Strait Islander peoples in your area ...

*Probing questions:*

- a. What are the most common health problems that Aboriginal and Torres Strait Islander peoples in your area face?
  - b. Are there any other Health Services available in this area?
  - c. Are the other available Health Services accessible to Aboriginal and Torres Strait Islander peoples? Why/why not?
  - d. Are there any particular barriers preventing the community from getting the health care they need when they have health problems?
  - e. What role do Health Workers play in responding to the needs of Aboriginal and Torres Strait Islander peoples in your area?
5. How do you think that the health system could better meet the needs of Aboriginal and Torres Strait Islander peoples in your area?

*Probing questions:*

- a. What are the most effective service delivery models you have seen in responding to the needs of Aboriginal and Torres Strait Islander peoples?
  - b. Do you think the role of the Health Worker could be changed to have a greater contribution to the health needs of the community? In what way? Why/why not?
  - c. (If yes) What would it take for these changes to happen? What would stop this change from happening?
6. What qualification and level of qualification do you think Health Workers should have so that they can best contribute to the needs of their communities?

*Probing questions:*

- a. Why that particular qualification / level of qualification?
- b. Do you think that there are many Health Workers that are not qualified at this level?
- c. (If yes) What do you think would encourage them to do further training to get to this level?
- d. What do you think the barriers are for Health Workers in pursuing further education?

7. What kinds of opportunities for on-the-job training or professional development are there for Health Workers in your Health Service?

*Probing questions:*

- a. What other learning and development opportunities should be provided for Health Workers?
  - b. What would it take to introduce them?
8. What opportunities do Health Workers have at your Health Service for career progression?

*Probing questions:*

- a. What is the career structure?
  - b. What are the requirements for career progression?
  - c. Is there any opportunity for Health Workers to move into other health professions?
9. Do you have any challenges recruiting or retaining Health Workers?

*Probing questions:*

- a. What are the challenges of recruitment?
  - b. What strategies work well in attracting Health Workers?
  - c. Where do you recruit Health Workers from?
  - d. What are the main reasons why Health Workers leave the workforce or change jobs?
  - e. What Health Worker retention strategies work well?
10. If there was one thing you could change about the Health Worker workforce, what would it be?
11. Do you have any concerns about potential changes to the Health Worker workforce going forward?

## 6. Interview template: other health professionals focus groups

1. Tell me about the role of Health Workers within your Health Service ...

*Probing questions:*

- a. Why does your Health Service employ Health Workers?
- b. What roles do they perform?
- c. When in the patient journey are Health Workers involved (eg transport for access, first point of contact, triage, assessment, treatment, follow up)?

2. Describe how Health Workers work with the wider health care team ...

*Probing questions:*

- a. What works well?
- b. What could be improved? How?
- c. How do Health Workers fit within the organisational structure of your Health Service?
- d. How are the roles between Health Workers and other staff divided?
- e. Do you think that this division of roles is appropriate?
- f. Do you think that there is a clear understanding of the division of roles by Health Workers and other staff?

3. Do you know of any quality and safety mechanisms in place around the role and work of Health Workers?

*Probing questions:*

- a. How does your Health Service make sure care is provided in a safe and high quality manner?
- b. Who directly supervises Health Workers in your service?
- c. Do Health Workers ever work on a shift by themselves? Describe when and why? What indirect supervision is available to Health Workers?
- d. What support is available for Health Workers when they are asked to perform tasks that are outside their scope of practice?

4. Tell me about the specific health and service needs of Aboriginal and Torres Strait Islander people in your area ...

*Probing questions:*

- a. What are the most common health problems that Aboriginal and Torres Strait Islander peoples in your area face?
  - b. Are there any other Health Services available in this area?
  - c. Are the other available Health Services accessible to Aboriginal and Torres Strait Islander peoples? Why/why not?
  - d. Are there any particular barriers preventing the community from getting the health care they need when they have health problems?
  - e. What role do Health Workers play in responding to the needs of Aboriginal and Torres Strait Islander peoples in your area?
5. How do you think that the health system could better meet the needs of the Aboriginal and Torres Strait Islander peoples in your area?

*Probing questions:*

- a. What are the most effective service delivery models you have seen in responding to the needs of Aboriginal and Torres Strait Islander peoples?
  - b. Do you think the role of the Health Worker could be changed to have a greater contribution to the health needs of the community? In what way? Why/why not?
  - c. (If yes) What would it take for these changes to happen? What would stop this change from happening?
6. What qualification and level of qualification do you think Health Workers should have so that they can best contribute to the needs of their communities?

*Probing questions:*

- a. Why that particular qualification/level of qualification?
  - b. Do you think that there are many Health Workers that are not qualified at this level?
  - c. (If yes) What do you think would encourage them to do further training to get to this level?
  - d. What do you think the barriers are for Health Workers in pursuing further education?
7. Do you think that there is an opportunity for other health professionals to have a greater role in providing on the job training for Health Workers?
8. Do you think there are any opportunities for the Health Worker workforce to be utilised in a different way than it is now?

*Probing questions:*

- a. Are there any roles not currently performed by Health Workers in your Health Service that you think could be assigned to them? Why/why not?
  - b. Could Health Workers be better integrated into routine patient management?
  - c. What would it take to introduce any of the changes you have suggested?
9. Do you have any concerns about potential changes to the Health Worker workforce?

## 7. Key informant interview templates

### ERG Members

1. What is your role in the Aboriginal and Torres Strait Islander Health Worker sphere?
2. How would you define the core scope of practice for Aboriginal and Torres Strait Islander Health Workers?
3. What cultural safety role do Health Workers play?
4. Do you think that there should be minimum qualification standards for Health Workers? If so, what should they be?
5. What are the benefits of the Health Worker workforce to the health outcomes of Aboriginal and Torres Strait Islander peoples?
6. How do you think the Health Worker workforce could be developed to improve health outcomes for Aboriginal and Torres Strait Islander peoples?
7. What are the barriers and enablers for a career as a Health Worker?

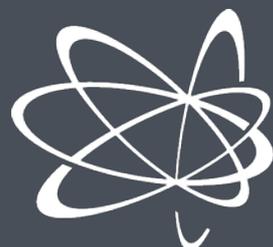
### National Aboriginal Community Controlled Health Organisation and affiliates

1. What is the size, population and location of the Health Worker workforce within your service region and/or jurisdiction?
2. Describe the scope of practice of Health Workers and specific functions (eg mental health, men's health)
3. What cultural safety role do Health Workers play?
4. Are there some forms of clinical practice performed by Health Workers that put the public safety at risk?
5. How is this risk managed?
6. What level of qualification do most Health Workers employed in the Community Controlled sector obtain?
7. Should there be a minimum standard of qualification for Health Workers? What should it be?
8. What are some of the barriers to attainment of higher level qualifications for Health Workers?
9. What is the interface between Health Workers and other health professionals in the Community Controlled sector?

10. What service delivery models involving Health Workers are most effective in addressing the needs of Aboriginal and Torres Strait Islander people?
11. What are the benefits of the Health Worker profession?
12. What are the barriers and enablers of recruitment and retention of Health Workers?
13. What Health Worker workforce development programs have been undertaken and/or are planned for the future?
14. How do you think the Health Worker workforce could be developed to improve health outcomes for Aboriginal and Torres Strait Islander peoples?
15. Update on ACCHO & DoHA project in education gap assessment.

### Registered Training Organisations

1. What courses and qualification levels do you offer Health Workers?
2. How many Health Worker student places do you have?
3. How many of these places are vacant?
4. What proportion of Health Worker students successfully completes their course?
5. What are the key barriers and opportunities to education for Health Workers?
6. What course delivery format is used for Health Workers (eg intensive block sessions, semester basis, on-the-job training)?
7. Do you actively try to recruit students to train to be a Health Worker? What challenges do you face?
8. Have there been any recent developments in course direction and curriculum for Health Workers?
9. What process do you have to go through to become a registered training organisation in your jurisdiction?
10. Do you know of any other training providers that train Health Workers but are not registered?



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**Interim Report – Appendix D**

Self-reported titles: additional data analysis

**28 June 2011**

**Health Workforce Australia**

## Contents page

Appendix D	Self-reported titles: additional data analysis	3
1.	Context	3
2.	The national profile	3
3.	Jurisdictional profile	5
4.	Area of remoteness profile	7

## Appendix D Self-reported titles: additional data analysis

### 1. Context

As this workforce moves towards a national model, it is important to understand how Health Workers describe themselves.

In the Health Worker survey administered in this project, a number of survey questions asked the Health Workers to describe their role. 321 Health Workers (91% of the total cohort of 351) provided a response. There were 30 surveys with incomplete data or no response to this question.

Respondents were asked to select one or more titles when asked, “What job title best describes your role?” Definitions were purposefully not provided for each category, as the aim was to obtain respondents’ self-reported view of their title/job role. An ‘other’ category was also provided. Responses to the ‘other’ category were coded and validated by two project team members to be in line with identified categories on the basis of minor wording differences or moved into a separate category.

The self-reported roles and titles were analysed from the following perspectives:

- national (Section 2)
- jurisdictional (Section 0)
- geographic (Section 4).

### 2. The national profile

Figure 1: Self-reported Health Worker roles and titles (Health Worker survey) (n=351)

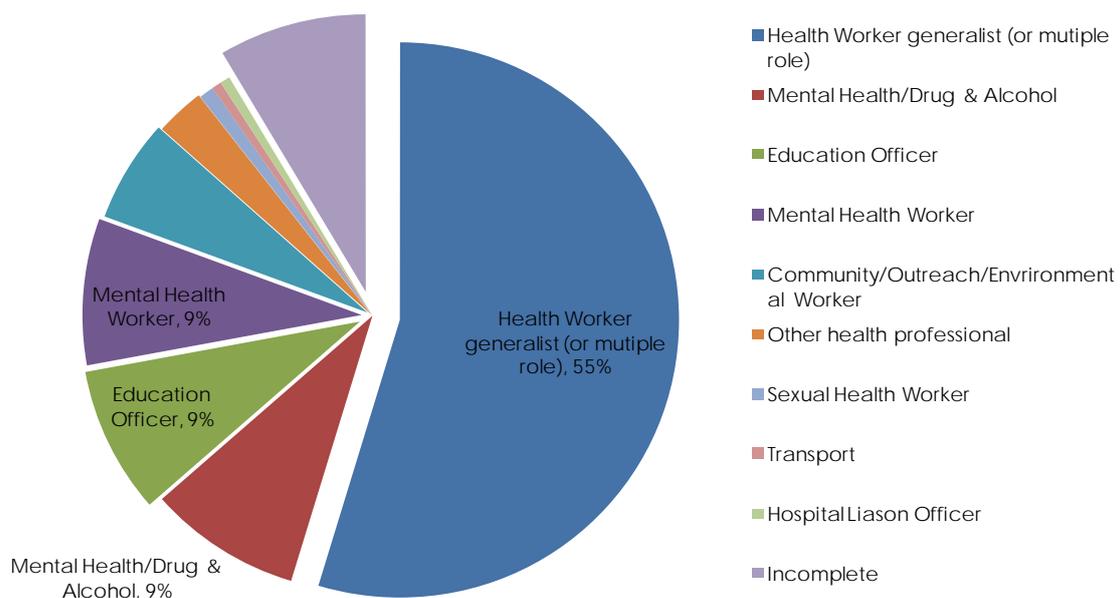


Figure 1 shows that:

- 55% of respondents (n=351) considered themselves a Health Worker generalist
- 9% of respondents identified themselves as being Drug and Alcohol Workers, Mental Health Workers or Aboriginal Education Officers
- 3% of respondents (n=10) identified as being an 'other health professional'; however, these respondents also selected the Health Worker generalist category.

### 3. Jurisdictional profile

The survey results were compared by jurisdiction to determine if there were differences in how Health Workers reported their roles. Differences are evident between each jurisdiction; however 'Health Worker generalist' was consistently reported as the role most Health Workers identified with nationally. Table 1 provides an overview of the responses.

Table 1: Health Worker self reported roles and titles by jurisdiction (Health Worker survey)

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Unknown	National
	N=121	N=29	N=56	N=48	N=23	N=5	N=3	N=37	N=29	N=351
Health Worker generalist (or multiple roles)	45%	59%	63%	60%	65%	100%	67%	86%	7%	55%
Drug & Alcohol	11%	21%	16%	4%	0%	0%	0%	3%	0%	9%
Education Officer	12%	3%	9%	6%	17%	0%	0%	3%	3%	9%
Mental Health Worker	13%	3%	11%	13%	0%	0%	0%	3%	0%	9%
Outreach/ Environmental Worker	8%	7%	0%	8%	13%	0%	33%	3%	0%	6%
Other health professional	4%	7%	2%	4%	0%	0%	0%	0%	0%	3%
Sexual Health Worker	2%	0%	0%	0%	0%	0%	0%	3%	0%	1%
Transport	2%	0%	0%	0%	0%	0%	0%	0%	0%	1%
Hospital Liaison Officer	1%	0%	0%	2%	0%	0%	0%	0%	0%	1%
Incomplete	2%	0%	0%	2%	4%	0%	0%	0%	90%	9%

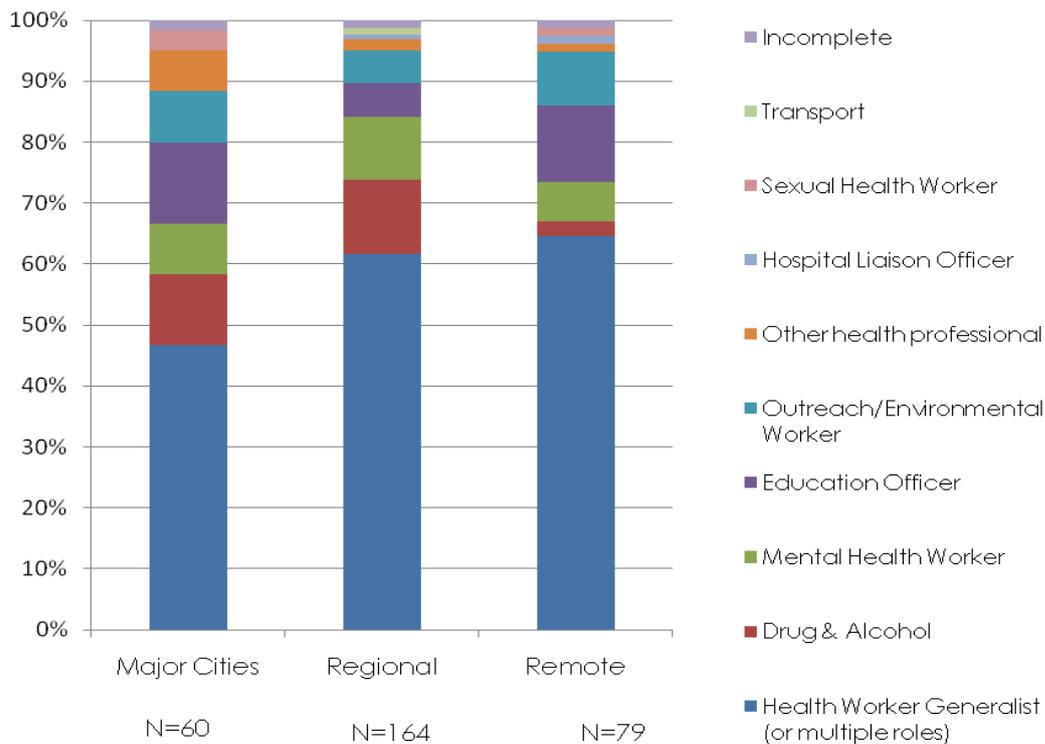
From Table 1 it can be seen that:

- the highest proportion of those who identified as being Mental Health Worker were in NSW and QLD (13%) and 11% were in SA
- VIC had the highest proportion (21%) of respondents identifying with the role/title of Drug and Alcohol Worker

- SA had the highest proportion of respondents identifying as Aboriginal Education Officer (17%), followed by 12% in NSW.
- in TAS all respondents (n=5) reported being Health Worker generalists
- in the NT, 86% of Health Workers reported being Health Worker generalists.

## 4. Area of remoteness profile

Figure 2: Health Worker self-reported roles and titles by geographical location (Health Worker Survey)



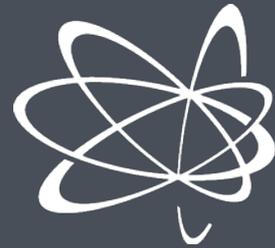
From Figure 2 it can be seen that:

- Health Worker generalist was the most commonly reported role across all geographical locations
- there were more respondents identifying as Education Officers in major cities and remote areas than regional areas
- the proportion of Health Workers who reported their role as Drug and Alcohol Workers is relatively the same in major cities and the regional setting but much less in the remote setting
- those identifying as Mental Health Worker were slightly greater in regional locations.

Overall, the survey results support the widely held perception that there are a variety of roles and titles in existence nationally and that the titles in use to describe Health Worker roles vary by jurisdiction.

More specifically, Mental Health Worker and Drug and Alcohol Worker titles were found more commonly in major city settings. Organisations based in major cities may have been larger, allowing for employment of positions focusing on a specific area of clinical practice. The results align with the Environmental Scan description of programmatic funding to support these areas of clinical focus.

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## Interim Report – Appendix E

The Health Worker scope of practice: additional data analysis

28 June 2011

Health Workforce Australia

## Contents page

Appendix E	The Health Worker scope of practice: additional data analysis	3
<b>1.</b>	<b>Context</b>	<b>3</b>
<b>2.</b>	<b>Methodology for collecting Health Worker scope of practice data</b>	<b>3</b>
2.1	Developing the conceptual map of the Health Worker scope of practice	3
2.2	Collecting data via surveys	8
2.3	Interpreting the data	8
<b>3.</b>	<b>Survey data analysis: summary of the Health Worker scope of practice</b>	<b>10</b>
<b>4.</b>	<b>Survey data analysis: national variation of the Health Worker scope of practice</b>	<b>12</b>
4.1	Survey results: variation in the Health Worker scope of practice by jurisdiction	12
4.2	Survey results: variation in the Health Worker scope of practice by level of remoteness	14
4.3	Survey results: variation in the Health Worker scope of practice by place of employment	16
<b>5.</b>	<b>Survey data analysis: clinical activities performed by Health Workers</b>	<b>18</b>
5.1	Interpreting the survey results in relation to clinical practice: the clinical score	18
5.2	Variation in clinical activity by jurisdiction	19
5.3	Variation in clinical activity by level of remoteness	21
5.4	Variation in clinical activity by place of employment	22
5.5	The relationship between clinical score and face-to-face supervision	23
5.6	The relationship between clinical score and ATSHIC qualifications	24
<b>6.</b>	<b>Survey data analysis: other reported functions</b>	<b>25</b>

## Appendix E The Health Worker scope of practice: additional data analysis

### 1. Context

In order to understand the Health Worker scope of practice it was necessary to first develop a conceptual map in consultation with key stakeholders. Once this had been done, survey questions were designed to collect quantitative data from Health Workers in relation to the activities they performed at work.

The Health Worker survey was undertaken by 351 Health Workers in November and December 2010. Of these participants, 200 Health Workers responded to the full set of questions in relation to the Health Worker scope of practice. This evidence base was used to create the national picture of the Health Worker scope of practice presented in this appendix. To date, this data represents the most comprehensive national body of evidence in relation to the Aboriginal and Torres Strait Islander Health Worker scope of practice.

This appendix first describes the methodology for collecting the survey data, before presenting an analysis of the key data areas:

- the national scope of practice
- national variation in the scope of practice – by jurisdiction, level of remoteness and place of employment
- clinical activities performed by Health Workers
- other reported functions.

### 2. Methodology for collecting Health Worker scope of practice data

#### 2.1 Developing the conceptual map of the Health Worker scope of practice

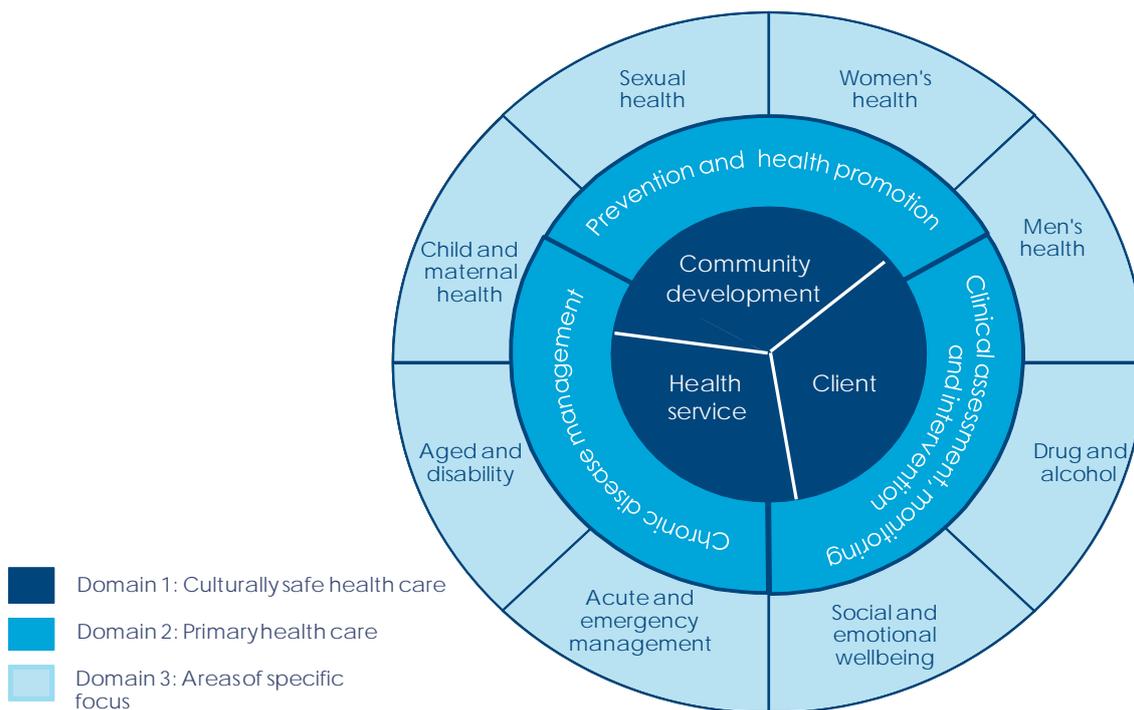
The first step was to develop an initial conceptual map representing the broader Health Worker scope of practice. From the outset, there were no expectations that all Health Workers would be performing to this full scope of practice – it was highly likely that most would be performing only some of the roles included within the broader scope of practice.

This conceptual map was developed using evidence collected via key informant interviews, project reference groups (Expert Reference Group, Jurisdiction Planning Group & the NACCHO workforce planning group) and literature identified in the Environmental Scan. An initial 'scope of practice wheel' was created, consisting of several intersecting domains or functions that represent the unique Health Worker scope of practice. The identification of these intersecting domains was also informed by the content of the National Aboriginal and Torres Strait Islander Health Worker Qualification Framework that was introduced in 2008 (Community Services & Health Industry Skills Council, 2008).

This initial conceptual map was then tested and further developed in consultation with relevant stakeholders.<sup>1</sup>

The final Health Worker scope of practice conceptual map contained three overarching domains. Each domain was divided into a number of elements which grouped similar types of activities performed by Health Workers. These domains and elements are illustrated in Figure 1.

Figure 1: The conceptual map of the Health Worker scope of



The elements associated with each domain area are summarised below. A more detailed description of each domain area and its elements is provided in Chapter 5. In addition, Table 1 in this appendix provides some examples of the activities that each element refers to.

#### Domain 1: Culturally safe health care

This domain consists of the following elements:

- **Client:** Improving health and access through patient advocacy, communication and support.
- **Health service:** Improving health and access through a culturally safe and aware health service.
- **Community development:** Improving health through community wellbeing and development affecting social determinants of health.

<sup>1</sup> These stakeholders included key informant interview participants, Expert Reference Group members, Jurisdictional Planning Group members and Professor Cindy Shannon.

### Domain 2: Primary health care

This domain consists of the following elements:

- **Prevention and health promotion activities**, including activities affecting broad social determinants of health.
- **Clinical assessment, intervention and monitoring.**
- **Chronic disease management.**

Some elements within the 'Primary health care' domain overlap with specific areas of primary health focus (Domain 3).

### Domain 3: Specific areas of primary health focus

This domain consists of the following elements:

- Acute and emergency
- Child and maternal health
- Sexual health
- Women's health
- Men's health
- Drug and alcohol
- Social and emotional wellbeing
- Aged and disability.

Table 1: Health Worker survey – domains and elements

Domain	Element	Example activities/questions
Culturally safe health care	Client – Improving health and access through patient advocacy, communication and support	<ul style="list-style-type: none"> <li>• Encourage/assist people to access health services</li> <li>• Explain medical terminology</li> <li>• Outreach activities to provide health care in the community</li> </ul>
	Health Service – Improving health and access through a culturally safe and aware health service	<ul style="list-style-type: none"> <li>• Speak to other health professionals to explain the patient's health and cultural needs</li> <li>• Make recommendations on how health care should be provided to a patient in a culturally appropriate way</li> <li>• Suggest changes to your health service so that it meets the needs of Aboriginal and Torres Strait Islander patients</li> </ul>
	Community development – Improving health through community wellbeing and development affecting social determinants of health	<ul style="list-style-type: none"> <li>• Discuss with the community to help them understand environmental factors that affect their health</li> <li>• Work with others in the community to improve the health of the community</li> <li>• Work with community to provide a safe living environment</li> </ul>
Primary health care	Prevention and promotion activities, including activities affecting broad social determinants of health	<ul style="list-style-type: none"> <li>• Assess a patient's health risk factors</li> <li>• Run group education sessions about healthy living</li> <li>• Assess and identify the things that will make people unwell</li> </ul>
	Clinical assessment, intervention and monitoring	<ul style="list-style-type: none"> <li>• Assess, document or follow-up on a patient's medical and health history</li> <li>• Conduct physical examination and patient referral</li> <li>• Clinical activities – venepuncture, immunisations, wound management, medication management</li> </ul>
	Chronic Disease Management	<ul style="list-style-type: none"> <li>• Assess the known risk factors for heart disease, kidney disease and diabetes</li> <li>• Self management – goal setting and actions, self-monitoring of symptoms</li> <li>• Conduct follow-up checks on patients who are managing chronic diseases</li> </ul>

Domain	Element	Example activities/questions
Specific areas of primary health focus		
	Acute and emergency	<ul style="list-style-type: none"> <li>• Emergency intervention for medical issues eg asthma, chest infections, vomiting</li> <li>• Trauma management, suturing, X-rays</li> </ul>
	Child/Maternal health	<ul style="list-style-type: none"> <li>• 'Well baby' check</li> <li>• Immunisations</li> <li>• Ante-natal education</li> </ul>
	Sexual health	<ul style="list-style-type: none"> <li>• Contact tracing</li> <li>• Sexual health education</li> <li>• STI treatment</li> </ul>
	Social and emotional wellbeing	<ul style="list-style-type: none"> <li>• Assess people at self-harm risk</li> <li>• Conduct mental health assessment</li> <li>• Provide support and counselling</li> </ul>
	Women's health	<ul style="list-style-type: none"> <li>• Conduct and provide result feedback on Pap smears</li> <li>• Educate women about breast examination, family planning and contraception</li> <li>• Domestic violence prevention and management</li> </ul>
	Men's health	<ul style="list-style-type: none"> <li>• Testicular examination</li> <li>• Positive parenting</li> <li>• Domestic violence prevention and management</li> </ul>
	Drug and alcohol	<ul style="list-style-type: none"> <li>• Assess and manage intoxication, withdrawals from alcohol and other drugs</li> <li>• Alcohol and other drug counselling</li> </ul>
	Aged and disability care	<ul style="list-style-type: none"> <li>• Assess and organise the supports required for a person who is aged or has a disability</li> <li>• Assist in activities of daily living</li> <li>• Adjust home environment</li> </ul>

## 2.2 Collecting data via surveys

The final section of the Health Worker survey dealt with activities contributing to the broader Health Worker scope of practice (eg those provided in Table 1 above). The aim was to build an accurate picture of the regular tasks that form the national Health Worker scope of practice. Obviously, there are some activities performed on an ad hoc basis or on rare occasions that do not form part of the core scope of practice. The survey was designed to distinguish between activities performed on a frequent basis and those performed infrequently in order to represent the actual scope of practice.

There were 78 activity-based questions. To distinguish between the core scope of practice and ad hoc activities, Health Workers were asked to state how frequently they performed each activity. Response options were:

- most days
- weekly
- fortnightly
- monthly
- yearly
- never.

The actual questions used in the survey are provided in Appendix C (Health Worker survey, Question 39).

## 2.3 Interpreting the data

The data collected was extremely complex. The following notes have therefore been included to assist with understanding the sample group and appropriately interpreting the information presented in the following pages.

Of the 351 survey respondents, 200 (57%) provided responses to all 78 of the scope of practice questions. For consistency and accuracy purposes, respondents who only partially completed the scope of practice section of the survey were excluded from the data analysis.

The exception to this rule is where respondents provided complete responses for all questions within a particular element of the scope of practice conceptual map, even if they did not answer all 78 in total.

For example, Respondent A did not respond to any questions relating to the 'Clinical assessment, intervention and monitoring' element but responded to all questions relating to the 'Health prevention and promotion element'. In cases like this, it was possible to include Respondent A's answers in data analysis relating to the Health prevention and promotion' element without compromising the integrity of the data. However, it would not be possible to include Respondent A in any analysis of the broader scope of practice given that their total data set was incomplete.

This approach allows as much information as possible to be included in the evidence base while also retaining data quality and integrity. However, it does mean that the total responses for each element vary. Attention should therefore be given to the "n=x" values in the interpretation of the graphs, where "n" represents the total number of responses being represented in the data.

Responses were divided into “frequent” and “infrequent” practice. When interpreting the graphs, the following definitions of ‘frequent’ and ‘infrequent’ practice should be referred to:

- **frequent** practice refers to activities that were reportedly performed ‘most days’, ‘weekly’ or ‘fortnightly’. These activities were summed up and reported as the proportion of the total questions for that element of the scope of practice that could be scored as frequent. In other words, if all respondents had reported all activities for the ‘chronic disease management’ element of the scope of practice as a ‘frequent’ part of practice, this would be reported as “100% of the activities related to the Chronic disease management element were reported as a frequent part of practice”.
- **infrequent** practice refers to activities that are performed ‘monthly’, ‘yearly’ or ‘never’. These activities have not been analysed in as much detail as those that are practised frequently and are only described where important themes emerged.

#### Visually displaying the results

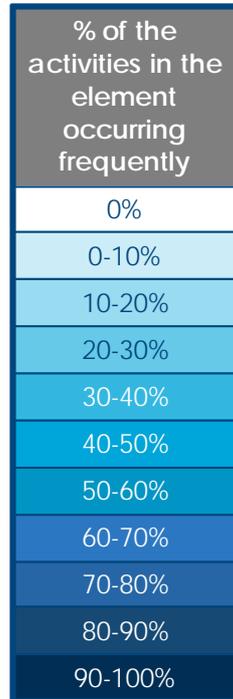
The results are displayed against the conceptual scope of practice wheel, also described in Chapter 5. The wheel provides a simplified method for summarising and displaying the broad and unique scope of practice of Health Workers by each element. Variation of particular factors such as employing organisation, level of remoteness and jurisdiction are also presented.

A colour scale is used to provide a visual ‘heat map’ of the percentage of activities which relate to elements that were reported as being performed frequently, as follows:

- the **darker** the blue, the more frequent the element within the scope of practice
- the **lighter** the blue, the less frequent the element within the scope of practice.

This visual representation, including the colour scale, was endorsed by the Expert Reference Group, the Jurisdictional Planning Group and a meeting including NACCHO and ACCHO workforce development representatives. The colour scale is shown in Figure 2.

Figure 2: Colour scale for Health Worker scope of practice conceptual diagram

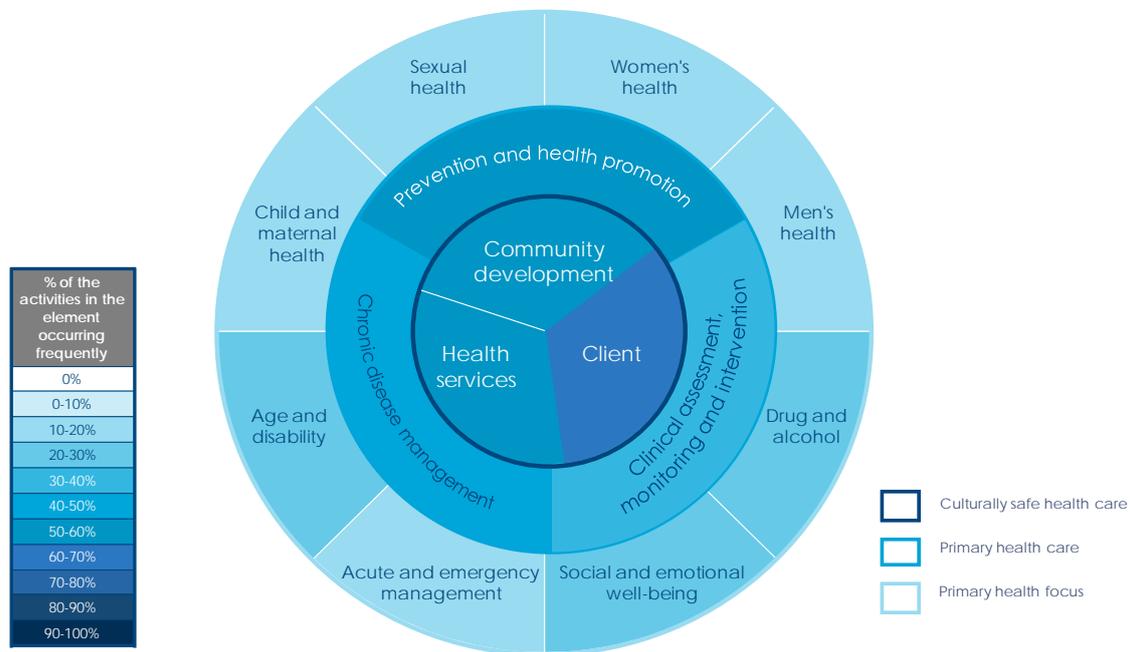


### 3. Survey data analysis: summary of the Health Worker scope of practice

The Health Worker survey results provide a picture of the common and frequent elements of the Health Worker scope of practice. As expected, the results demonstrate that the scope of practice varies significantly across Australia. However, there are certain elements that are more common across the nation.

A summary of the elements is visually represented in Figure 3. This shows the national average, while the sections that follow explore how the picture varies across the country. As mentioned above, the darker blue colours represent activities that are more common and performed more frequently across Australia.

Figure 3: The National Health Worker scope of practice



From this picture of the national Health Worker scope of practice, it is evident that:

- culturally safe health care roles are a defining characteristic of the national Health Worker scope of practice. The element of the Health Worker scope of practice that is most common and performed most frequently across Australia relates to the provision of direct cultural support to clients; activities that help to make health services more culturally secure, and relating to community development, are the second most common and frequent elements of the Health Worker scope of practice
- prevention and health promotion activities are a core part of the Health Worker role. Activities contributing to this element are reportedly performed almost as frequently as those within the 'culturally safe health care' domain
- chronic disease management activities are frequently performed, although slightly less frequently than cultural safety roles and health prevention and promotion activities
- clinical assessment, monitoring and intervention is an element of the Health Worker scope of practice that is currently performed less frequently than other primary health care roles or culturally safe health care roles. This is not surprising given that only some Health Workers are qualified to perform clinical roles.

Further analysis of the quantitative data in relation to each domain of the Health Worker scope of practice is provided below.

#### Domain 1: The national picture of the 'culturally safe health care' role

The inner circle of Figure 3 focuses on the 'culturally safe health care' role of Health Workers. Culturally safe health care was confirmed as having a strong focus within the Health Worker scope of practice.

Key findings include:

- cultural brokerage for the 'client' element was a frequent part of the scope of practice, with 62% of the activities related to the element performed frequently
- 60% of the activities in the culturally safe health service ('Health service') element were reported as a frequent part of the scope of practice
- 51% of the activities in the 'community development' element were reported as being a frequent part of a Health Worker's role.

### Domain 2: The national picture of the 'Primary health care' role

The middle circle of Figure 3 represents areas of a 'Primary health care' model of care.

Key findings in relation to the national scope of practice include:

- 51% of the activities relating to the 'Prevention and promotion' element were reported as a frequent aspect of Health Worker scope of practice
- 44% of the activities related to the 'Chronic disease management' element were reported as a frequent aspect of Health Worker scope of practice
- 32% of the activities related to the 'Clinical assessment, monitoring and intervention' element were reported as a frequent aspect of Health Worker scope of practice.

### Domain 3: The national picture of areas of specific focus

The outer circle of Figure 3 represents frequent practice in relation to specific areas of primary health care. Key findings in relation to the national scope of practice include:

- the predominant areas of specific primary health focus are 'Drug and alcohol' (28% of activities reported as frequent); 'Social and emotional wellbeing' (27% of activities reported nationally as frequent); and 'Age and disability' (24% of activities reported as frequent)
- 18% of 'Acute and emergency management' activities were reported as frequent
- less than 20% of activities in other elements were reported as being undertaken frequently for all other elements of the scope of practice.

## 4. Survey data analysis: national variation of the Health Worker scope of practice

The survey results were analysed further to understand patterns of variation across Australia. In particular, this analysis focused on variation by:

- jurisdiction
- level of remoteness
- place of employment (ie Aboriginal Community Controlled health sector or government sector).

The findings from this analysis are presented below.

### 4.1 Survey results: variation in the Health Worker scope of practice by jurisdiction

The Health Worker scope of practice was considered through a jurisdictional lens in order to understand how the Health Worker role varies between states and territories. This evidence confirms reports of significant variation in the Health Worker role across

Australia. The results are outlined in Table 2, which shows the percentage of activities in each element that are performed frequently, by jurisdiction.

While interpreting the jurisdictional data, it is important to be aware of the jurisdictional representativeness of the survey participant groups. While broadly representative of their Health Worker population, results from Tasmania and ACT should be treated with caution due to the very low number of survey respondents. In addition, the estimated response rate of Northern Territory health workers was only 17% of the total Health Worker workforce. Therefore, the results for the Northern Territory may not be representative of all Health Workers in this jurisdiction.

Table 2: Percentage of activities related to the element being reported as 'Frequent' by jurisdiction

Element/Jurisdiction	NSW	ACT	NT	QL D	SA	WA	TAS	VIC	AUS
Cultural – Health Services	53%	43%	62%	67%	63%	57%	72%	84%	60%
Cultural – Client	58%	67%	69%	69%	67%	53%	64%	77%	62%
Cultural – Community development	40%	7%	49%	64%	62%	52%	80%	58%	51%
Prevention and promotion	41%	31%	53%	66%	67%	43%	64%	65%	51%
Chronic disease management	34%	47%	61%	49%	56%	41%	44%	43%	44%
Clinical assessment, monitoring and intervention	20%	11%	60%	39%	47%	25%	33%	35%	32%
Acute and emergency	10%	0%	44%	14%	14%	16%	27%	27%	18%
Child & maternal health	11%	7%	40%	21%	29%	20%	24%	12%	19%
Sexual health	8%	0%	39%	23%	23%	12%	0%	17%	16%
Women's health	12%	0%	22%	20%	30%	13%	20%	16%	16%
Men's health	15%	7%	25%	23%	26%	14%	20%	22%	19%
Drug and alcohol	21%	27%	35%	34%	39%	22%	40%	39%	28%
Social and emotional wellbeing	24%	0%	30%	32%	30%	23%	30%	32%	27%
Aged and disability	19%	0%	38%	30%	30%	18%	24%	28%	24%

Key findings in relation to the scope of practice by jurisdiction are:

- activities that relate to the 'Culturally safe health care' domain are performed frequently in every state and territory

- in the 'Primary health care' domain, 'Prevention and promotion' and 'Chronic disease management' were similar across most jurisdictions and close to the national respondent percentage, except in NSW where they were slightly lower
- 32% of the activities relating to the 'Clinical assessment, monitoring and intervention' element were reported as a frequent part of the Health Worker nationally; the highest intensity was in the Northern Territory (60%) and the lowest intensity was in the ACT (11%) and NSW (20%)
- in relation to the 'Areas of specific clinical focus' domain, 'Child and maternal health' and 'Sexual health' featured strongest in the Northern Territory (40% and 39% of the activities related to these elements were respectively reported as a frequent role). 'Drug and alcohol', 'Men's health' and 'Women's health' were highest in South Australia
- 18% of 'Acute and emergency' activities were reported as being a frequent role nationally; the Northern Territory had the highest intensity (44% of the activities being reported as a frequent role), followed by Victoria and Tasmania who continued above the national average at 27% of activities.

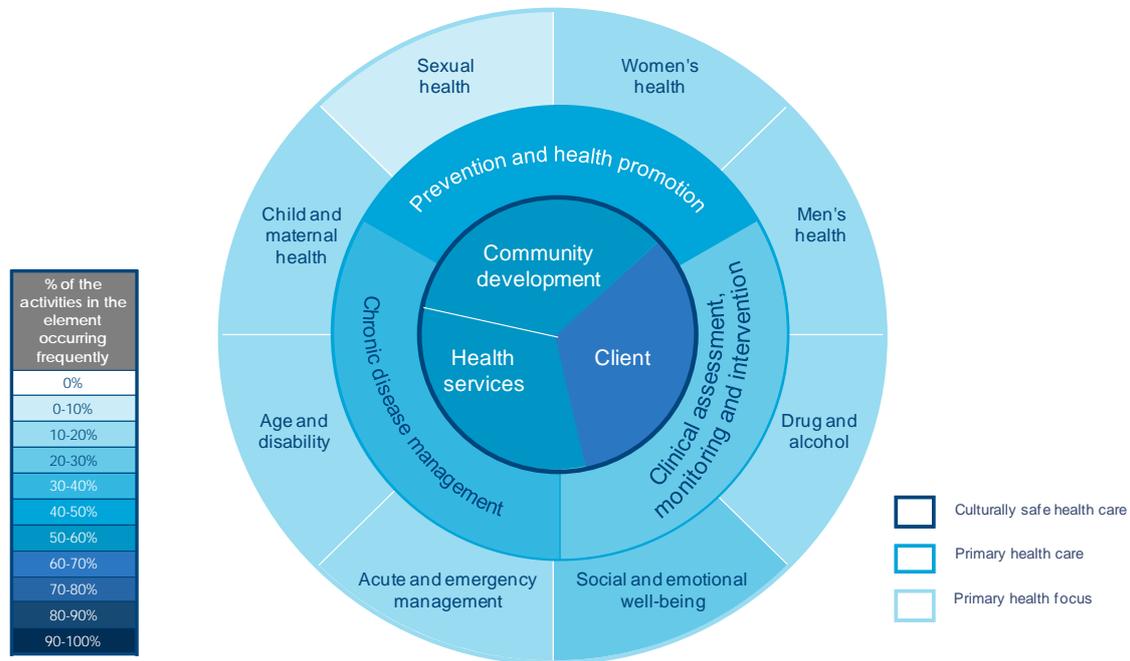
#### 4.2 Survey results: variation in the Health Worker scope of practice by level of remoteness

The level of remoteness of a Health Worker is perceived to be one factor that influences the type of role the Health Worker performs. Data collected from the survey corroborates this view. Three conceptual maps have been created to visually represent the differences between Health Worker scopes of practice depending on level of remoteness.<sup>2</sup> Figure 4 shows the scope of practice for Health Workers located in urban areas, for those in regional areas and for those in remote locations.

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<sup>2</sup> The Australian Standard Geographic Classification (ASGC) system has been used to define remoteness.

Figure 4: The Health Worker scope of practice – major cities



Interpretation of this data highlighted that:

- some elements of the Health Worker practice were not influenced by the level of remoteness. Regardless of location, similar patterns of activity were identified in the following elements: 'Culturally safe health care', 'Prevention and promotion', 'Social and emotional wellbeing' and 'Chronic disease management'
- there was an increasing focus on 'Clinical assessment, intervention and monitoring' the more remote the location; 22% of the activities related to this element being reported as frequent in urban settings compared to 32% in regional locations and 40% in remote locations
- 16% of the activities for the 'Acute and emergency' element were reported as occurring frequently in urban and regional settings, while 22% were in remote settings
- there was an increasing focus on sexual health activities the more remote the location; 9% of the activities in the 'Sexual health' element were reported as frequent in urban settings, compared to 15% in regional, and 23% in remote locations
- there was an increasing focus on activities grouped under the 'drug and alcohol' element the more remote the location; 19% of the activities in the 'drug and alcohol' element were reported as frequent in urban settings, compared to 30% in regional and 32% in remote locations.

### 4.3 Survey results: variation in the Health Worker scope of practice by place of employment

The activities reported by Health Workers in the scope of practice section of the survey were also analysed by place of employment. Results from Health Workers employed by government health services were compared with those employed by Aboriginal Community Controlled Health Organisations (ACCHOs). These results are visually represented in Figure 5 (ACCHO-employed) and Figure 6 (government health service-employed).

Figure 5: The Health Worker scope of practice – ACCHO-employed

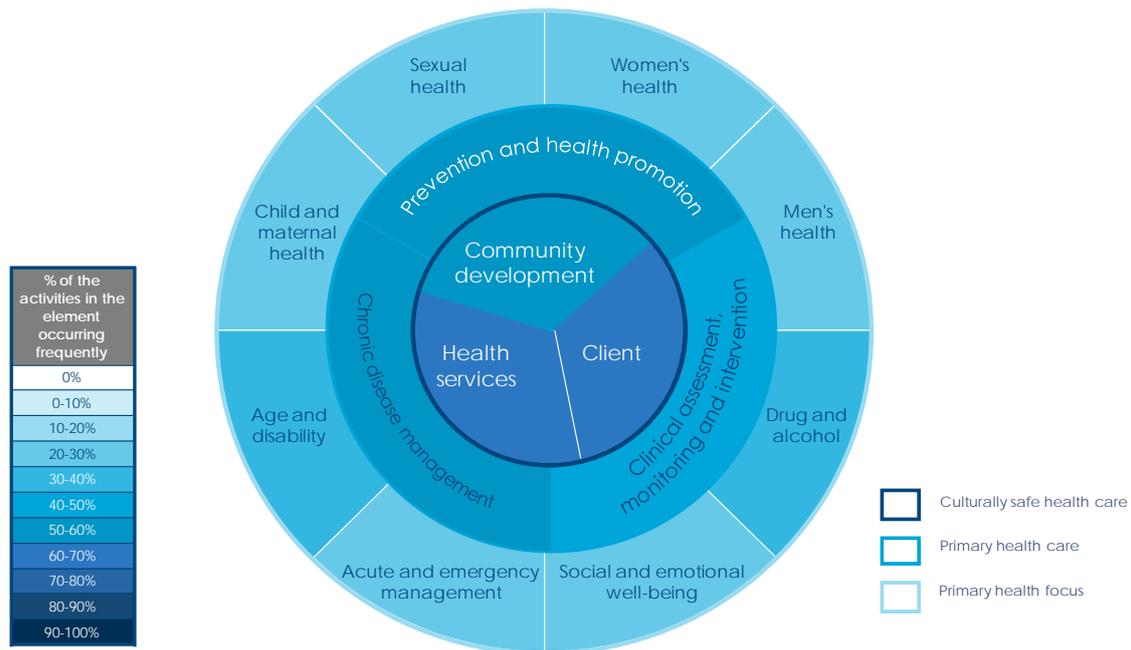
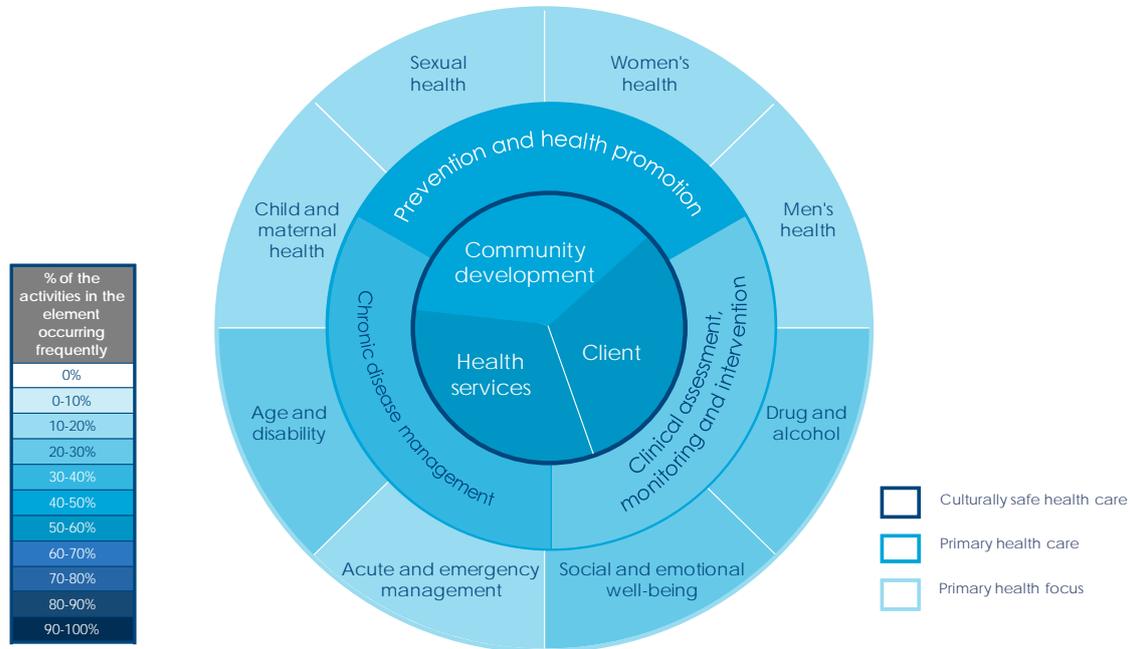


Figure 6: The Health Worker scope of practice – government health service-employed



The data analysis shows that there is variation between the roles performed by Health Workers in each sector. In comparison to government-employed Health Workers, ACCHO-employed Health Workers reported that they perform more activities in relation to the following: all elements within the 'Culturally safe health care' domain; 'chronic disease management'; 'Health prevention and promotion'; and 'clinical practice'.

These key findings are discussed below in more detail.

- ACCHO-employed respondents reported more frequent activity in relation to the 'culturally safe health care' domain of the scope of practice than government-employed respondents. ACCHO-employed Health Workers reported that 67% of the activities relating to both the 'Health service' and 'client' elements were performed frequently, compared with government-employed Health Workers reporting 59% and 57%, respectively.
- There was a stronger focus on 'chronic disease management' in ACCHOs when compared to Health Workers employed at government health services. ACCHO-employed Health Workers reported that 53% of the activities related to the 'chronic disease management' element were frequent, while government-employed Health Workers reported 40%.
- ACCHO-employed Health Workers also reported more frequent activity in relation to the 'Prevention and promotion' element – 59% (ACCHO-employed) and 46% (government-employed) of activities relating to this element were reported as frequent.
- ACCHO-employed Health Workers reported that they perform clinical tasks more frequently than government-employed Health Workers. 43% of activities within the 'clinical assessment, intervention and monitoring' element were reported as frequent by ACCHO respondents, compared to 28% for government-employed respondents.

- ACCHO-employed Health Workers also perform more 'acute and emergency management' activities, with 25% of the activities in this element being reported as frequent in comparison to the 13% of activities reported by government-employed respondents.
- Few differences can be observed between the reported roles of Health Workers employed in each sector with regard to the frequency of practice in some of the specific areas of primary health care, including 'drug and alcohol', 'child and maternal health' and 'emotional and social wellbeing'.

## 5. Survey data analysis: clinical activities performed by Health Workers

Clinical practice is just one part of Health Workers' overall scope of practice. The type of clinical activities being performed by Health Workers has been explored in order to understand how significant clinical roles are within broader scope of practice. The findings demonstrate that, across the workforce, clinical roles are less common than health prevention and promotion roles or roles that relate to culturally safe health care. However, for some individual Health Workers, clinical roles are a significant part of their scope of practice.

A clinical score was developed to assess the clinical roles performed. This is explained below to assist with interpreting the data. The results are then presented using the same points of comparison used above (variation by jurisdiction, level of remoteness and place of employment).

This section provides additional data to supplement the information reported in Section 5.5 of the main report.

### 5.1 Interpreting the survey results in relation to clinical practice: the clinical score

Of the 78 scope of practice questions in the Health Worker survey, 33 examined clinical tasks (see Appendix C, Health Worker survey, Question 39 for these questions). These clinical tasks were divided into three different categories:

- **Clinical assessment** (11 of 33 questions): these questions refer to activities in which a Health Worker might determine the nature, cause, and potential effects of a patient's injury, illness, or wellness. No breaking of the skin with minimal to any immediate risk to patient.
- **Clinical intervention** (14 of 33 questions): these questions referred to tasks carried out to improve, maintain, or assess the health of a person in a clinical situation. Breaking the skin is often involved, with an associated clinical risk present.
- **Acute and emergency management** (8 of 33 questions): these questions referred to tasks carried out during an acute or life-threatening episode. Often breaking the skin is involved and a high risk to life is present.

In order to analyse the responses to these 33 clinical questions, a clinical score metric was developed. This is explained below.

#### The clinical score metric

A clinical score was developed to enable a more detailed assessment of clinical practice. The development of the clinical scores enabled more robust statistical analysis at the granular level to be conducted. Each question was assigned a score

from 0 (never) to 5 (most days) (see Table 3). A total score was then derived by adding all the scores from question. For example, if a person indicated they performed all clinical tasks “most days” (33 questions) the maximum score would be 100. To allow for direct comparisons across the three clinical areas, the clinical scores have all been standardised to a score of 0-100.

Table 3: Method for calculating clinical scores

Frequency	Most days	Weekly	Fortnightly	Monthly	Yearly	Never
Category	Frequent			Infrequent		
Clinical score	5	4	3	2	1	0

Of the 351 survey participants, 200 (20% of the Health worker population based on 2006 ABS data) provided answers to all 33 clinical activity questions. These respondents were included in the total clinical score measure; 151 respondents did not complete all the 33 clinical activity-related questions. For the accuracy of the statistical analysis it was considered more robust to analyse only the fully completed 200 responses. Higher response rates occurred for sub-sets of the total clinical score. The analysis of the three clinical sub-scores includes between 240 and 248 participants. The response rates used in the total clinical score and sub-sets are provided in each of the figures below.

Using the clinical score methods explained above, the results of the self-reported clinical survey questions are provided below. In particular, the analysis focuses on any differences observed across jurisdiction, employer type, remoteness, face-to-face supervision and levels of qualifications.

Under each of these headings, a brief description of the key findings is provided and where possible an indication of whether any differences detected are of statistical significance. Statistical significance was determined by p values less than 0.05 (ie  $p < 0.05$ ).

Given the variation in the number of questions for each clinical area, each score has been standardised to a scale of 0 (worst score) to 100 (best score) to enable comparisons across each clinical area. In addition, to minimise the bias due to under-representation of the sample by age, gender, place of employment, jurisdiction and area of remoteness, a weighting criteria was applied. The ‘weights’ were calculated via a method called ‘sample balancing’ (also known as ‘raking’) based on the data from the 2006 ABS Census and the 2009 ATSIHWG.

## 5.2 Variation in clinical activity by jurisdiction

Figure 7 looks at the comparison by jurisdiction of frequency of clinical tasks using the clinical score method as described above. The higher the score the more frequent the respondent self-reported they perform those tasks. Table 4 outlines the number of survey responses included to calculate the clinical score.

Figure 7: Average clinical score – by jurisdiction (n=305)

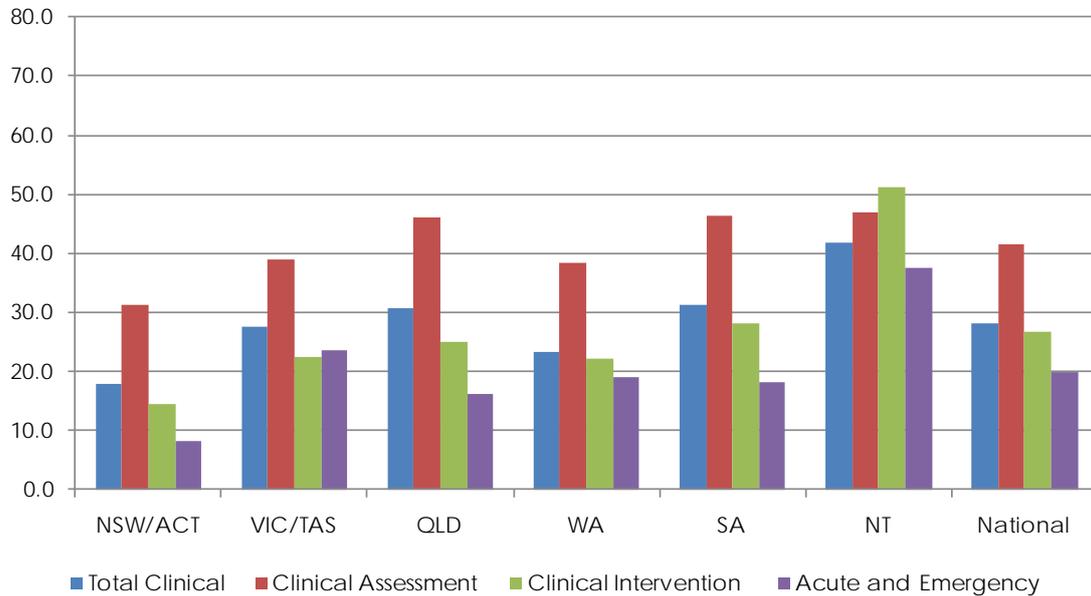


Table 4: Number of survey responses included to calculate the clinical score (n=305)

Number of responses	NSW/ACT	VIC/TAS	QLD	WA	SA	NT	AUS	One or more weighting factor* unknown	Did not complete all questions
All clinical	66	20	27	21	16	13	163	37	105
Clinical Assessment	76	23	32	27	18	19	195	45	65
Clinical Intervention	80	20	31	30	18	18	197	43	65
Acute and Emergency	81	24	32	30	17	21	205	43	57

\*weighting factors: gender, age, organisation, jurisdiction and area of remoteness.

Figure 7 shows that:

- the average clinical score for the ‘clinical assessment’ element was highest compared to all other categories in every jurisdiction, with the exception of the NT where clinical intervention scored the highest
- the highest average clinical score for all three elements was in the NT, with ‘acute and emergency’ recording significantly higher than all other jurisdictions
- a statistically significant difference was found between the jurisdictions in the area of ‘clinical intervention’ ( $p < 0.0001$ ), where the NT had the highest clinical score of 51.3, compared to NSW/ACT which had a score of 14.6.

The high clinical scores recorded by respondents from the Northern Territory are consistent with the information collected during the key informant interviews which refer to the fact that more clinical activities are performed as part of the Health Worker role in the NT. This is partly due to the geographical reality of the Northern Territory, where health services are geographically distant. Consequently, this may mean that a single health service is the only source of health care in a particular population/ community, or that there are not as many other health professionals available to deliver clinical care. Moreover, the Certificate IV (Practice) is a minimum requirement for registration in the Northern Territory. These factors may contribute to the fact that Health Workers perform more clinical roles in the NT than in other jurisdictions.

### 5.3 Variation in clinical activity by level of remoteness

Figure 8 looks at the comparison by remoteness of frequency of clinical tasks using the clinical score method as described above. The higher the score the more frequent the respondent self-reported they perform those tasks. Table 5 outlines the number of survey responses included to calculate the clinical score.

Figure 8: Average clinical score – by area of remoteness (n=305)

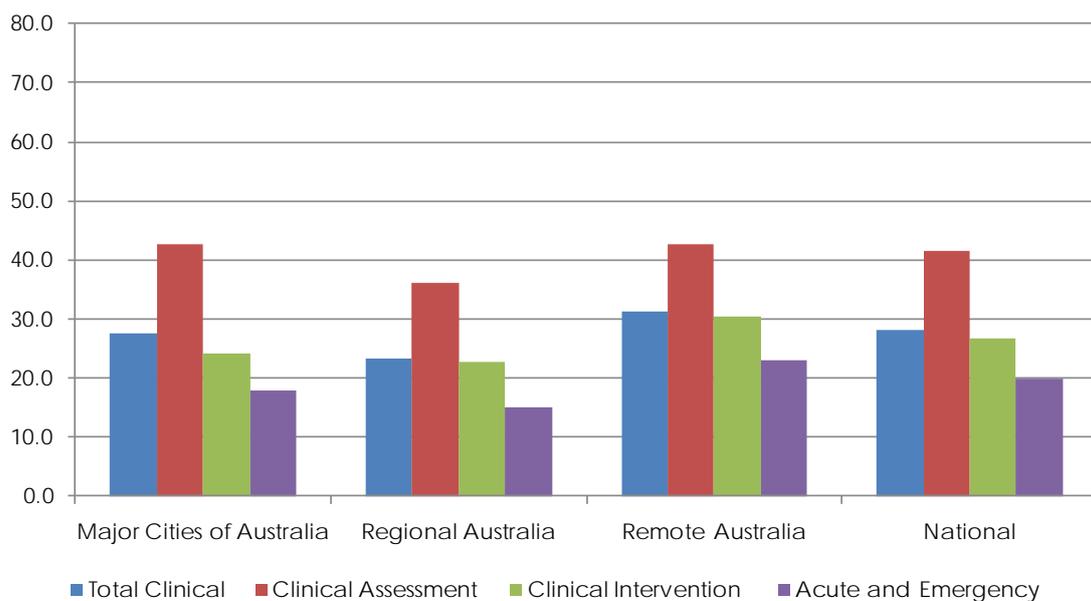


Table 5: Number of survey responses included to calculate clinical score (n=305)

Number of responses	Major cities	Regional	Remote	AUS	One or more weighting factors* not known	Did not complete all questions
All clinical	30	96	37	163	37	105
Clinical Assessment	36	111	48	195	45	65
Clinical Intervention	34	112	51	197	43	65

Number of responses	Major cities	Regional	Remote	AUS	One or more weighting factors* not known	Did not complete all questions
Acute and Emergency	37	115	53	205	43	57

\*weighting factors: gender, age, organisation, jurisdiction and area of remoteness.

Figure 8 shows that:

- the highest average clinical score for all clinical activities recorded was in remote Australia ( 31.4/100); this was not considered statistically significant compared to the lowest clinical score recorded in major cities at 27.5/100
- remote Australia scored highest in all elements of clinical activity compared to major cities and regional Australia
- regional Australia scored the lowest in all elements of clinical activity compared to major cities and remote Australia.

#### 5.4 Variation in clinical activity by place of employment

Figure 9 provides a comparison of clinical score by employer organisation. Essentially, the higher the score the more frequent the respondent self-reported they perform those tasks. Table 6 outlines the number of survey responses included to calculate the clinical score.

Figure 9: Average clinical score – by employer organisation (n=305)

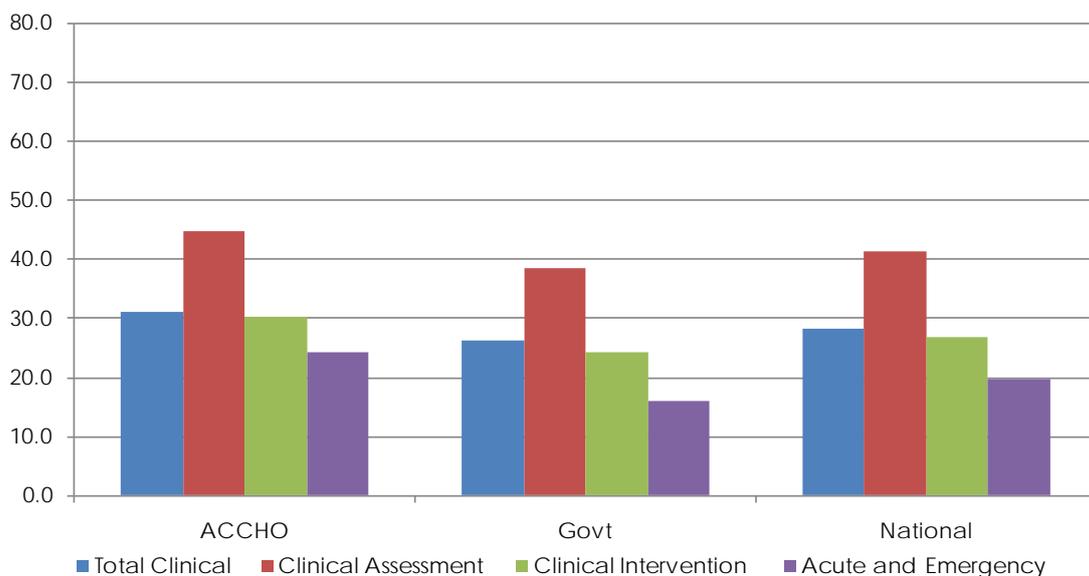


Table 6: Number of survey responses included to calculate clinical score (n=305)

Number of responses	ACCHO	Govt	National	One or more weighting factors* not known	Did not complete all questions
All clinical	65	98	163	37	105
Clinical Assessment	81	114	195	45	65
Clinical Intervention	76	121	197	43	65
Acute and Emergency	82	123	205	43	57

\*weighting factors: gender, age, organisation, jurisdiction and area of remoteness.

Figure 9 shows that:

- the average clinical score for all clinical of ACCHO (31.1/100) was not significantly higher than that of the government sector (26.2/100) (p=0.1565)
- despite the higher average clinical scores for the ACCHO sector compared to the government sector, none of the differences were found to be statistically significant.

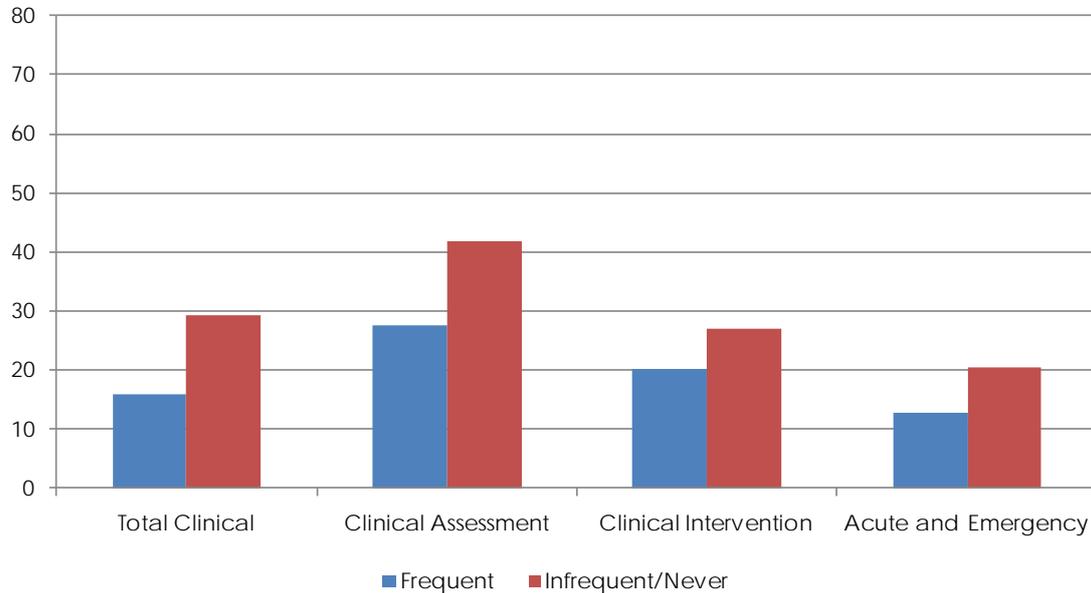
### 5.5 The relationship between clinical score and face-to-face supervision

Good practice would suggest that Health Workers who are frequently performing clinical practice, that is, higher clinical scores, should also have regular and frequent access to face-to-face supervision which would indicate that they have adequate support when performing their clinical practices.

Figure 10 shows the relationship between clinical score and frequency<sup>3</sup> of face-to-face supervision. The level of clinical score seems to correspond somewhat to the frequency of face-to-face supervision available to survey respondents. For example, survey respondents reporting higher frequencies of face-to-face supervision also received higher clinical scores. This is true for all the three clinical areas of clinical assessments, clinical interventions and acute and emergency. It is worth noting, however, that once the statistical analysis was complete the differences across the clinical areas were not significant.

<sup>3</sup> 'Frequently' is defined by this project as tasks that are performed most days or on a weekly or fortnightly basis; 'Infrequently' is defined as tasks that are performed on a monthly or yearly basis

Figure 10: Relationship between clinical score and frequency<sup>4</sup> of face-to-face supervision (n=305)



The results suggest that even though there is a perception that Health Workers, particularly those in remote locations, often work in isolation. On average, Health Workers do work as part of a team and receive frequent face-to-face supervision, particularly when performing clinical tasks. However, even though the clinical score is only small (that is 3.9), a number of survey respondents report performing acute and emergency activities and also report infrequent/never face-to-face supervision. This would be likely to have implications for risk mitigation and patient safety.

### 5.6 The relationship between clinical score and ATSHIC qualifications

A comparison of the level of survey respondent qualifications against the calculated clinical scores was conducted (Figure 11). This was in order to determine whether there was any relationship between the qualification levels of those survey respondents who also reported conducting clinical assessments, interventions and acute and emergency activities frequently.

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<sup>4</sup> 'Frequently' is defined as tasks that are performed most days or on a weekly or fortnightly basis;  
'Infrequently' is defined as tasks that are performed on a monthly or yearly basis

Figure 11: Relationship between clinical score and level of qualification<sup>5</sup> (n=305)

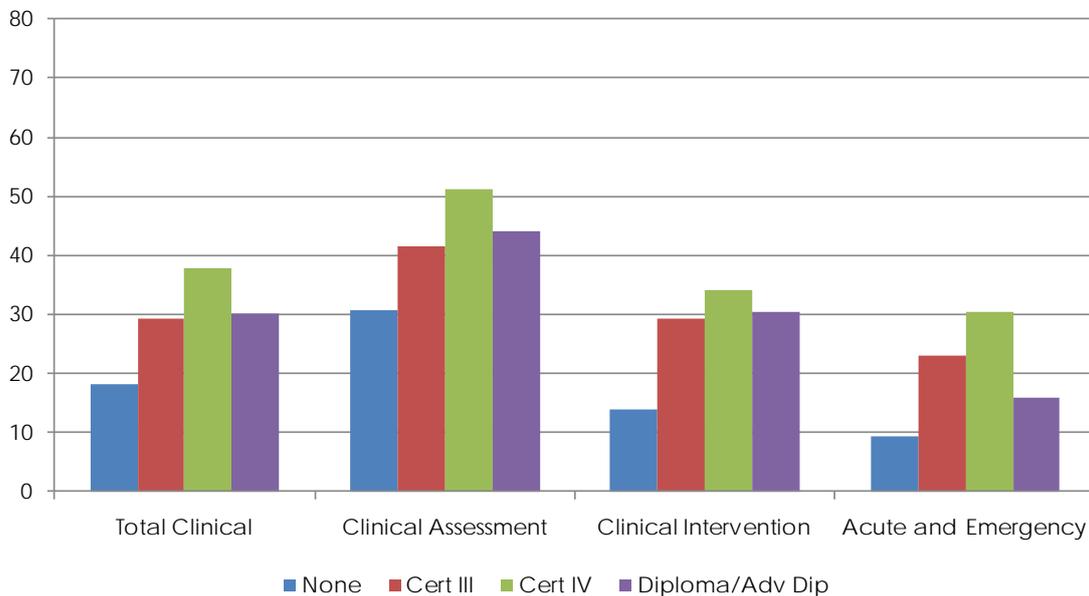


Figure 11 shows that:

- the highest clinical score was obtained by survey respondents who also reported having Certificate IV (37.8) and Diploma/Advanced Diploma (30.1) qualifications. This means that, on average, those with higher levels of qualifications are performing more clinical assessments, interventions and acute/emergency activities (p=0.0010)
- survey respondents reporting no qualifications recorded a clinical score of 18.3. This suggests that unqualified health workers are currently performing some clinical activities
- the differences in clinical scores across all the different levels of qualifications are statistically significant, that is p<0.001.

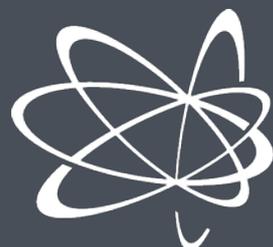
## 6. Survey data analysis: other reported functions

The Health Worker scope of practice data collected via the survey provides the first national, quantitative body of evidence in relation to the Health Worker role. The risk of adopting a quantitative approach is that important information might not be captured if it does not fit within the conceptual map that was developed, or the predefined survey options.

In order to ensure that all the various functions of Health Workers were appropriately captured, Health Workers were also given two opportunities to provide qualitative information in relation to their scope of practice. The first was in a free text field in the survey and the second was via focus groups during Community Mapping focus groups.

Analysis of this qualitative information demonstrates that the conceptual map does capture the vast majority of roles that are performed by the Health Worker workforce.

<sup>5</sup> Only respondents who reported having the Aboriginal and Torres Strait Islander Primary Health Care qualification have been included in this analysis



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**Interim Report – Appendix F**

Jurisdictional Snapshots

**28 June 2011**

**Health Workforce Australia**



## Contents page

<b>1. Context</b>	<b>3</b>
1.1 Jurisdictional snapshots	3

## Appendix F Education and qualification: additional data analysis

### 1. Context

This appendix provides data to supplement Sections 7.2.2 and 7.3.3 relating to the existing education and qualification levels of the Health Worker survey participants along with an assessment of the educational intentions of Health Workers in the next five years.

The key areas addressed are jurisdictional snapshots of survey respondents who currently report having ATSIPHC qualifications, and projected number of respondents from each jurisdiction who will likely hold an ATSIPHC Certificate IV as their highest level of qualification in 2012 and 2016. The national comparison has been provided along with caveats to these projected figures in Section 7.3.3 of the report.

### 2. Jurisdictional snapshots

#### 2.1 New South Wales

There were 56 respondents from New South Wales. Table 1 presents the qualifications profile of those respondents.

Table 1 Number of respondents from New South Wales with ATSIPHC qualifications

Qualification level	Stream (if applicable)	NSW	% of total respondents from NSW
<b>ATSIPHC qualification</b>			
Certificate III		12	10%
Certificate IV	Community Care	11	9%
	Practice	3	2%
	Pathway not specified	6	5%
Diploma and above	Community Care	4	3%
	Practice	1	1%
	Pathway not specified	18	15%
<b>Other Non-ATSIPHC qualification</b>			
Certificate II or III		5	4%
Certificate IV or above		4	3%
Other qualification not specified/ incomplete		27	22%
<b>No qualification indicated</b>			
No qualification		30	25%
<b>Total</b>		<b>121</b>	<b>100%</b>

Table 2: Looking forward – projected number of respondents from New South Wales that will hold an ATSIPHC Certificate IV as their highest level of qualification

Qualification level	NSW	% of total respondents from NSW
<b>2012</b>		
<b>Total Certificate IV</b>	<b>24</b>	<b>20%</b>
<i>Community Care</i>	13	11%
<i>Practice</i>	5	4%
<i>Pathway not specified</i>	6	5%
<b>2016</b>		
<b>Total Certificate IV</b>	<b>38</b>	<b>31%</b>
<i>Community Care</i>	14	12%
<i>Practice</i>	18	15%
<i>Pathway not specified</i>	6	5%

Table 1 and

Table 2 show that of the 56 respondents from NSW:

- 16% have the ATSIPHC qualification at the Certificate IV level (n=20)
- the majority of those 16% are qualified in the Community Care stream (11). Only three indicated that they undertook the Practice stream, and six did not specify their qualification stream
- 29% of the respondents have a non-ATSIPHC qualification (n=36)
- 30 did not indicate whether or not they have a qualification, which is much higher than in other jurisdictions
- by 2012, it is possible that the proportion of respondents with an ATSIPHC qualification at the Certificate IV level may increase to 20%, with a further increase to 31% by 2016.

## 2.2 Victoria

There were 29 respondents from Victoria, which is a relatively small sample. Table 3 shows the type and level of qualification held by those respondents.

Table 3: Number of respondents from Victoria with ATSIPHC qualifications

Qualification level	Stream (if applicable)	VIC	% of total respondents from VIC
<b>ATSIPHC qualification</b>			
Certificate III		9	31%
Certificate IV	Community Care	0	0%
	Practice	3	10%
	Pathway not specified	2	7%
Diploma and above	Community Care	2	7%
	Practice	0	0%
	Pathway not specified	0	0%
<b>Other Non-ATSIPHC qualification</b>			
Certificate II or III		2	7%
Certificate IV or above		1	3%
Other qualification not specified/ incomplete		7	24%
<b>No qualification indicated</b>			
No qualification		3	10%
<b>Total</b>		<b>29</b>	<b>100%</b>

Table 4: Looking forward – projected number of respondents from Victoria that will hold an ATSIPHC Certificate IV as their highest level of qualification

Qualification level	VIC	% of total respondents from VIC
<b>2012</b>		
<b>Total Certificate IV</b>	<b>7</b>	<b>24%</b>
Community Care	0	0%
Practice	5	17%
Pathway not specified	2	7%
<b>2016</b>		
<b>Total Certificate IV</b>	<b>8</b>	<b>28%</b>
Community Care	0	0%
Practice	6	21%
Pathway not specified	2	7%

Table 3 and Table 4 show that of the respondents from Victoria:

- 17% have the ATSIPHC qualification at the Certificate IV level (n=5)
- three are qualified in the Practice stream, and two did not specify their qualification stream
- 10 respondents (34%) have a non-ATSIPHC qualification
- three respondents did not indicate whether or not they have a qualification
- by 2012, it is possible that 24% may have a ATSIPHC qualification at the Certificate IV level, while by 2016, this may increase to 28%.

## 2.3 Queensland

There were 56 respondents from Queensland.

A profile of their qualifications is provided in Table 5.

Table 5: Number of respondents from Queensland with ATSIPHC qualifications: Qualification level and Practice and Community Care Streams.

Qualification level	Stream (if applicable)	QLD	% of total respondents from QLD
<b>ATSIPHC qualification</b>			
Certificate III		18	32%
Certificate IV	Community Care	1	2%
	Practice	2	4%
	Pathway not specified	12	21%
Diploma and above	Community Care	2	4%
	Practice	0	0%
	Pathway not specified	9	16%
<b>Other Non-ATSIPHC qualification</b>			
Certificate II or III		2	4%
Certificate IV or above		2	4%
Other qualification not specified/ incomplete		3	5%
<b>No qualification indicated</b>			
No qualification		5	9%
<b>Total</b>		<b>56</b>	<b>100%</b>

Table 6: Looking forward – projected number of respondents from Queensland that will hold an ATSIPHC Certificate IV as their highest level of qualification

Qualification level	QLD	% of total respondents from QLD
<b>2012</b>		
<b>Total Certificate IV</b>	<b>18</b>	<b>32%</b>
Community Care	1	2%
Practice	5	9%
Pathway not specified	12	21%
<b>2016</b>		
<b>Total Certificate IV</b>	<b>24</b>	<b>43%</b>
Community Care	1	2%
Practice	11	20%
Pathway not specified	12	21%

Table 5 and Table 6 show that of the 56 respondents:

- 27% have the ATSIPHC qualification at the Certificate IV level (n=15)
- only two stated that they hold the ATSIPHC Certificate IV (Practice) qualification; the majority (12) did not specify their ATSIPHC stream

- 13% have a non-ATSIPHC qualification (n=7)
- five did not indicate whether or not they have a qualification
- by 2012, it is possible that 32% of respondents may have an ATSIPHC qualification at the Certificate IV level, and this may increase to 43% in 2016.

## 2.4 South Australia

There were 23 respondents from South Australia, which is a relatively small sample. Table 7 shows the type and level of qualification held by those respondents.

Table 7: Number of respondents from South Australia with ATSIPHC qualifications

Qualification level	Stream (if applicable)	SA	% of total respondents from SA
<b>ATSIPHC qualification</b>			
Certificate III		14	61%
Certificate IV	Community Care	0	0%
	Practice	1	4%
	Pathway not specified	3	13%
Diploma and above	Community Care	1	4%
	Practice	1	4%
	Pathway not specified	0	0%
<b>Other Non-ATSIPHC qualification</b>			
Certificate II or III		0	0%
Certificate IV or above		0	0%
Other qualification not specified/ incomplete		2	9%
<b>No qualification indicated</b>			
No qualification		1	4%
<b>Total</b>		<b>23</b>	<b>100%</b>

Table 8: Looking forward – projected number of respondents from South Australia that will hold an ATSIPHC Certificate IV as their highest level of qualification

Qualification level	SA	% of total respondents from SA
<b>2012</b>		
<b>Total Certificate IV</b>	<b>8</b>	<b>35%</b>
Community Care	0	0%
Practice	5	22%
Pathway not specified	3	13%
<b>2016</b>		
<b>Total Certificate IV</b>	<b>14</b>	<b>61%</b>
Community Care	0	0%
Practice	11	48%
Pathway not specified	3	13%

Table 7 and Table 8 show that of these respondents from SA:

- 17% have the ATSIPHC qualification at the Certificate IV level (n=4)
- only one reported being qualified in the Practice streams, and three did not specify their qualification stream
- only two have a non-ATSIPHC qualification
- one respondent did not indicate whether or not they have a qualification
- by 2012, it is possible that 35% will have an ATSIPHC qualification at the Certificate IV level and this may increase to 61% in 2016.

## 2.5 Western Australia

There were 48 respondents from Western Australia. Table 9 shows the type and level of qualification held by those respondents.

Table 9: Number of respondents from Western Australia that currently hold ATSIPHC qualifications

Qualification level	Stream (if applicable)	WA	% of total respondents from WA
<b>ATSIPHC qualification</b>			
Certificate III		7	15%
Certificate IV	Community Care	0	0%
	Practice	4	8%
	Pathway not specified	16	33%
Diploma and above	Community Care	1	2%
	Practice	2	4%
	Pathway not specified	6	13%
<b>Other Non-ATSIPHC qualification</b>			
Certificate II or III		0	0%
Certificate IV or above		2	4%
Other qualification not specified/ incomplete		6	13%
<b>No qualification indicated</b>			
No qualification		4	8%
<b>Total</b>		<b>48</b>	<b>100%</b>

Table 10: Looking forward – projected number of respondents from Western Australia that will hold an ATSIPHC Certificate IV as their highest level of qualification

Qualification level	WA	% of total respondents from WA
<b>2012</b>		
<b>Total Certificate IV</b>	<b>20</b>	<b>42%</b>
<i>Community Care</i>	0	0%
<i>Practice</i>	4	8%
<i>Pathway not specified</i>	16	33%
<b>2016</b>		
<b>Total Certificate IV</b>	<b>20</b>	<b>42%</b>
<i>Community Care</i>	0	0%
<i>Practice</i>	4	8%
<i>Pathway not specified</i>	16	33%

Table 9 and Table 10 show that of the respondents from WA:

- 41% have the ATSIPHC qualification at the Certificate IV level (n=20)
- four are qualified in the Practice stream; most did not specify their qualification stream (16%)
- eight have a non-ATSIPHC qualification (17%)
- four did not indicate whether or they have a qualification
- by 2016, it is possible that 42% of respondents will have ATSIPHC qualification at the Certificate IV level.

## 2.6 Tasmania

Only five survey respondents were from Tasmania. Due to the small sample size, it is not possible to draw conclusive findings from this data. However, it is relevant to note that zero respondents from Tasmania reported being qualified at the Certificate IV level or above. The qualifications of these respondents are shown in Table 15 below.

Table 11: Number of respondents from Tasmania with ATSIPHC qualifications

Qualification level	Stream (if applicable)	TAS	% of total respondents from TAS
<b>ATSIPHC qualification</b>			
<b>Certificate III</b>		1	20%
<b>Certificate IV</b>	<i>Community Care</i>	0	0%
	<i>Practice</i>	0	0%
	<i>Pathway not specified</i>	0	0%
<b>Diploma and above</b>	<i>Community Care</i>	0	0%
	<i>Practice</i>	0	0%

Qualification level	Stream (if applicable)	TAS	% of total respondents from TAS
	<i>Pathway not specified</i>	1	20%
<b>Other Non-ATSIPHC qualification</b>			
Certificate II or III		0	0%
Certificate IV or above		0	0%
Other qualification not specified/ incomplete		1	20%
<b>No qualification indicated</b>			
No qualification		2	40%
<b>Total</b>		<b>5</b>	<b>100%</b>

Table 12: Looking forward – projected number of respondents from Tasmania that will hold an ATSIPHC Certificate IV as their highest level of qualification

Qualification level	TAS	% of total respondents from TAS
<b>2012</b>		
<b>Total Certificate IV</b>	<b>2</b>	<b>40%</b>
<i>Community Care</i>	0	0%
<i>Practice</i>	2	40%
<i>Pathway not specified</i>	0	0%
<b>2016</b>		
<b>Total Certificate IV</b>	<b>2</b>	<b>40%</b>
<i>Community Care</i>	0	0%
<i>Practice</i>	2	40%
<i>Pathway not specified</i>	0	0%

## 2.7 Northern Territory

There were 37 respondents from the Northern Territory. Table 13 shows the qualification types and levels held by those respondents.

Table 13: Number of respondents from Northern Territory with ATSIPHC qualifications

Qualification level	Stream (if applicable)	NT	% of total respondents from NT
<b>ATSIPHC qualification</b>			
Certificate III		10	27%
Certificate IV	<i>Community Care</i>	0	0%
	<i>Practice</i>	4	11%
	<i>Pathway not specified</i>	11	30%
Diploma and above	<i>Community Care</i>	2	5%
	<i>Practice</i>	3	8%
	<i>Pathway not specified</i>	4	11%
<b>Other Non-ATSIPHC qualification</b>			
Certificate II or III		1	3%

Qualification level	Stream (if applicable)	NT	% of total respondents from NT
<b>ATSIPHC qualification</b>			
Certificate IV or above		0	0%
Other qualification not specified/ incomplete		0	0%
<b>No qualification indicated</b>			
No qualification		2	5%
<b>Total</b>		<b>37</b>	<b>100%</b>

Table 14: Looking forward – projected number of respondents from Northern Territory that will hold an ATSIPHC Certificate IV as their highest level of qualification

Qualification level	NT	% of total respondents from NT
<b>2012</b>		
<b>Total Certificate IV</b>	<b>27</b>	<b>73%</b>
Community Care	0	0%
Practice	6	16%
Pathway not specified	11	30%
Certificate III (recognised as equivalent to Certificate IV)	10	27%
<b>2016</b>		
<b>Total Certificate IV</b>	<b>30</b>	<b>81%</b>
Community Care	0	0%
Practice	9	24%
Pathway not specified	11	30%

The response rate of 37 from the Northern Territory is fairly low when compared to the 340 Aboriginal Health Workers registered in the NT in 2010 (Northern Territory Aboriginal Health Worker Registration Board, October 2010). This data must therefore be interpreted with care. However, the results show that:

- 41% have the ATSIPHC qualification at the Certificate IV level (n=15)
- four of those respondents specified that they have ATSIPHC Certificate IV (Practice); the other 11 did not specify their stream
- only two did not indicate any qualification; and only one had a qualification that was not ATSIPHC at some level
- by 2012, the proportion of respondents with an ATSIPHC qualification at the Certificate IV level may increase to 73%, with a further increase in 2016 to 81%.

## 2.8 Australian Capital Territory

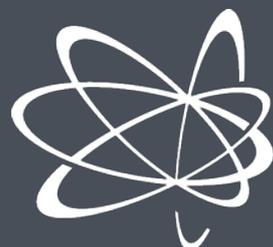
There were only three survey respondents from the ACT. Their qualifications are presented in Table 15 below. Due to the small sample size, it is not possible to draw conclusive findings from this data.

Table 15: Number of respondents from Australian Capital Territory with ATSIPHC qualifications

Qualification level	Stream (if applicable)	ACT	% of total respondents from ACT
<b>ATSIPHC qualification</b>			
Certificate III		1	33%
Certificate IV	Community Care	0	0%
	Practice	1	33%
	Pathway not specified	0	0%
Diploma and above	Community Care	0	0%
	Practice	0	0%
	Pathway not specified	1	33%
<b>Other Non-ATSIPHC qualification</b>			
Certificate II or III		0	0%
Certificate IV or above		0	0%
Other qualification not specified/ incomplete		0	0%
<b>No qualification indicated</b>			
No qualification		0	0%
<b>Total</b>		<b>3</b>	<b>100%</b>

Table 16: Looking forward – projected number of respondents from Australian Capital Territory that will hold an ATSIPHC Certificate IV as their highest level of qualification

Qualification level	ACT	% of total respondents from ACT
<b>2012</b>		
<b>Total Certificate IV</b>	<b>1</b>	<b>33%</b>
<i>Community Care</i>	0	0%
<i>Practice</i>	1	33%
<i>Pathway not specified</i>	0	0%
<b>2016</b>		
<b>Total Certificate IV</b>	<b>1</b>	<b>33%</b>
<i>Community Care</i>	0	0%
<i>Practice</i>	1	33%
<i>Pathway not specified</i>	0	0%



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## Interim Report – Appendix G

Supervision practice: additional data analysis

28 June 2011

Health Workforce Australia

## Contents page

Appendix G	Supervision practice: additional data analysis	3
<b>1.</b>	<b>Context</b>	<b>3</b>
<b>2.</b>	<b>Availability of supervision</b>	<b>4</b>
2.1	Availability of supervision: the national picture	4
2.2	Availability of supervision: by jurisdiction	5
2.3	Availability of supervision: by area of remoteness	6
2.4	Availability of supervision by place of employment	7
<b>3.</b>	<b>Frequency of face-to-face supervision</b>	<b>7</b>
3.1	Frequency of face-to-face supervision: the national picture	8
3.2	Frequency of face-to-face supervision: by jurisdiction	9
3.3	Frequency of face-to-face supervision: by area of remoteness	9
3.4	Frequency of face-to-face supervision: by place of employment	10

## Appendix G Supervision practice: additional data analysis

### 1. Context

This appendix provides additional data relating to the supervision practice of Health Workers, supplementing Chapter 8. The data was derived from the results of the Health Worker survey.

The key areas addressed relate to:

- the availability of supervision by jurisdiction, area of remoteness and place of employment (Section 0)
- the frequency of supervision by jurisdiction, area of remoteness and place of employment (Section 3)

Some of the data was statistically analysed and in those cases, the sample was weighted to compensate for biases by age, gender, place of employment, jurisdiction and area of remoteness. The 'weights' were calculated via a method called 'sample balancing' (also known as 'raking') based on the data from the 2006 ABS Census and the 2009 ATSIHWWG.

## 2. Availability of supervision

### 2.1 Availability of supervision: the national picture

The availability of supervision as reported by Health Worker survey respondents is provided below, first at a national level then broken down by jurisdiction.

Figure 1: Availability of supervision nationally

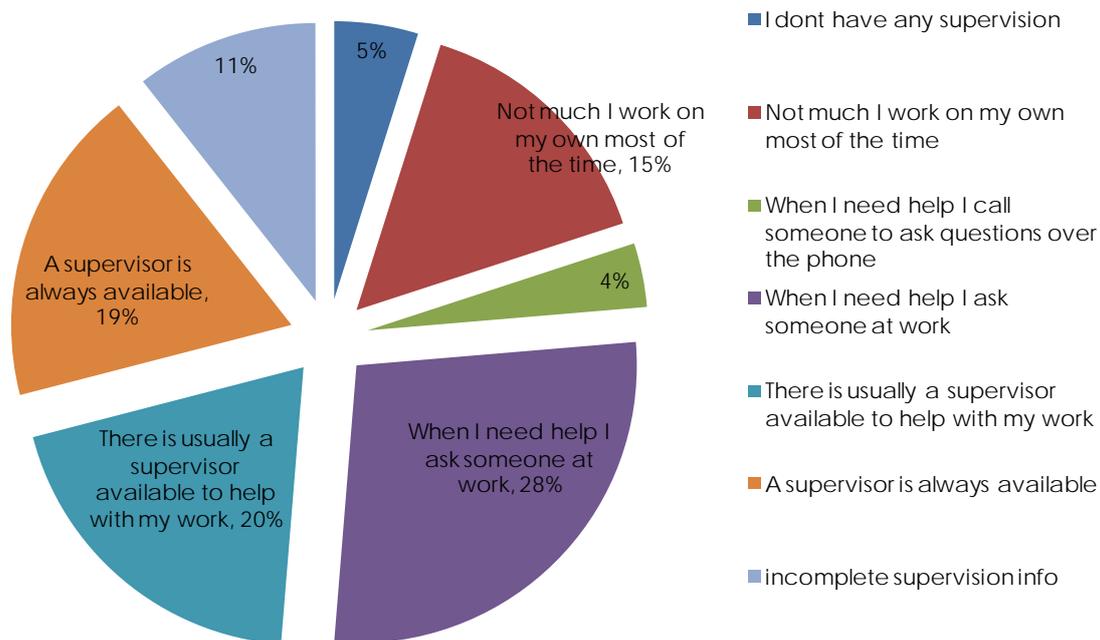


Figure 1 shows that:

- 70% of the 351 Health Workers surveyed reported that they have direct or indirect (by phone or colleague support) access to supervision
- a supervisor is 'always' or 'usually' available for two-fifths (39%) of survey respondents
- approximately one-third of survey respondents have access to supervision on request (28%)
- 15% of Health Workers surveyed reported receiving 'no regular supervision' or 'work on their own most of the time'.

## 2.2 Availability of supervision: by jurisdiction

Table 1: Availability of supervision by jurisdiction

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	In Complete	National
I don't have any supervision	3%	7%	5%	4%	4%	0%	0%	8%	0%	5%
Not much, I work on my own most of the time	16%	10%	11%	29%	22%	0%	67%	11%	0%	15%
When I need help I call someone to ask questions over the phone	6%	3%	0%	0%	9%	40%	0%	8%	0%	4%
When I need help I ask someone at work	26%	45%	32%	31%	22%	0%	0%	38%	0%	28%
There is usually a supervisor available to help with my work	23%	21%	29%	19%	13%	0%	0%	11%	33%	20%
A supervisor is always available	21%	14%	21%	15%	30%	40%	0%	19%	33%	19%
Incomplete supervision info	6%	0%	2%	2%	0%	20%	33%	5%	33%	11%

Table 1 shows that:

- VIC (83%) & QLD (82%) have the highest proportion of respondents indicating direct or indirect (by phone or colleague support) access to supervision
- WA has the lowest proportion (65%)
- the NT recorded the highest proportion of respondents (8%) reporting 'I don't have any supervisor'.

### 2.3 Availability of supervision: by area of remoteness

Figure 2: Availability of supervision by level of remoteness

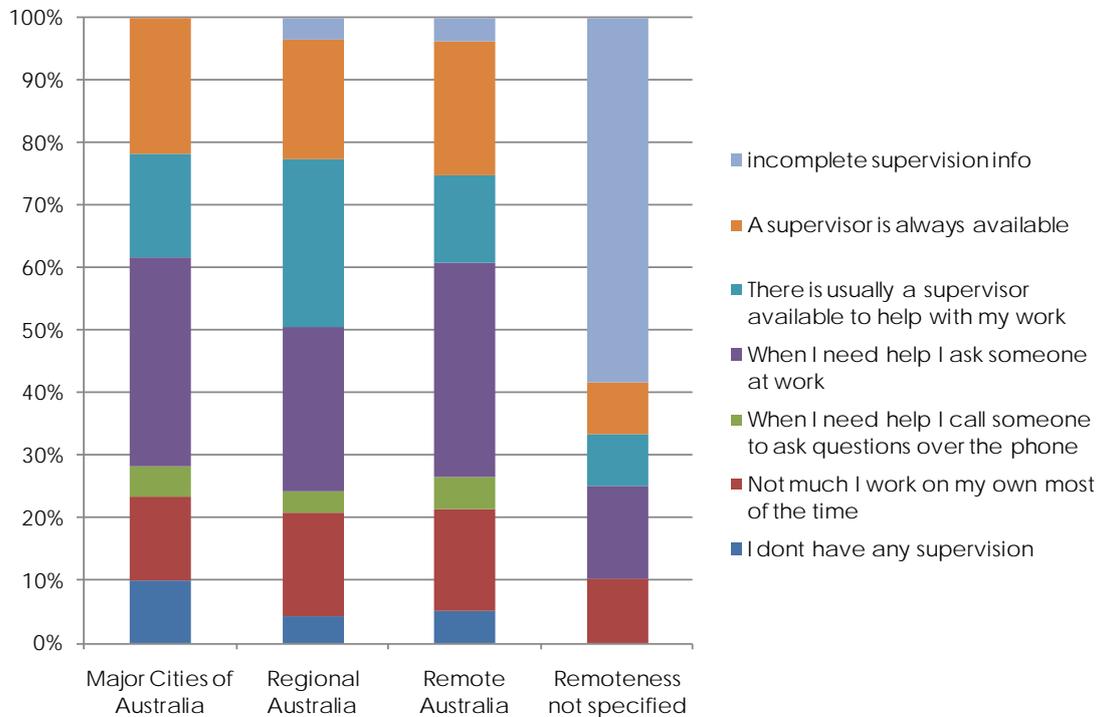


Figure 2 shows:

- the availability of supervision does not change much in relation to area of remoteness
- in all three levels of remoteness the majority of Health Workers either have 'a supervisor always or usually available', or when needed 'I ask someone at work'

## 2.4 Availability of supervision by place of employment

Figure 3: Availability of supervision by employer organisation

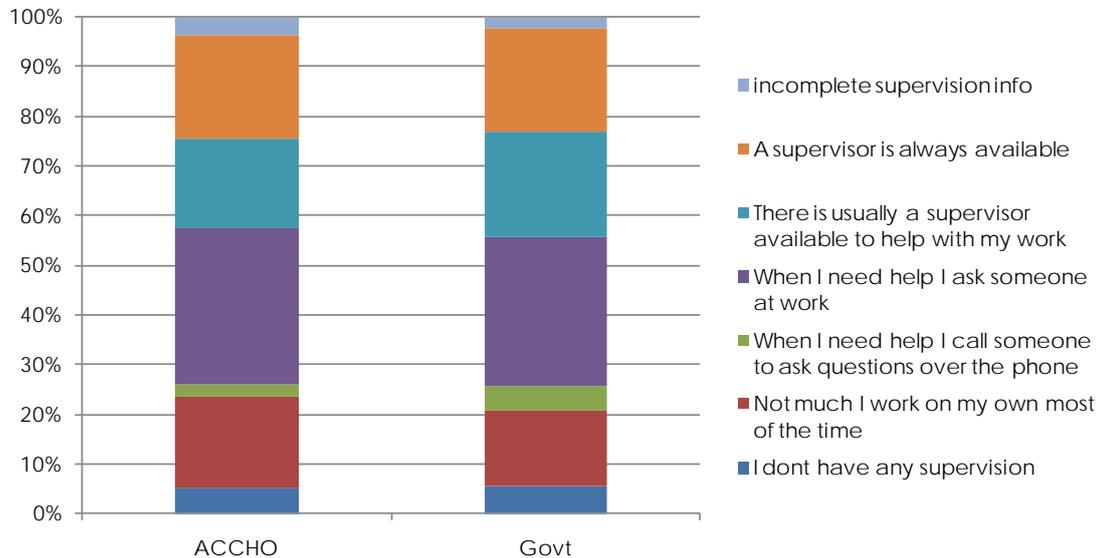


Figure 3 shows that:

- the availability of supervision does not change much in relation to place of employment
- in both places of employment, the majority of Health Workers either have 'a supervisor always or usually available', or when needed 'I ask someone at work'.

## 3. Frequency of face-to-face supervision

Direct face-to-face supervision is expected to have a higher impact on the safety and quality of patient care than supervision provided over the phone or via email. For this reason, the frequency of face-to-face supervision was analysed in more detail.

As above, this analysis was conducted at the national level and then broken down by jurisdiction, area of remoteness and place of employment.

### 3.1 Frequency of face-to-face supervision: the national picture

Figure 4: Frequency of face-to-face supervision nationally

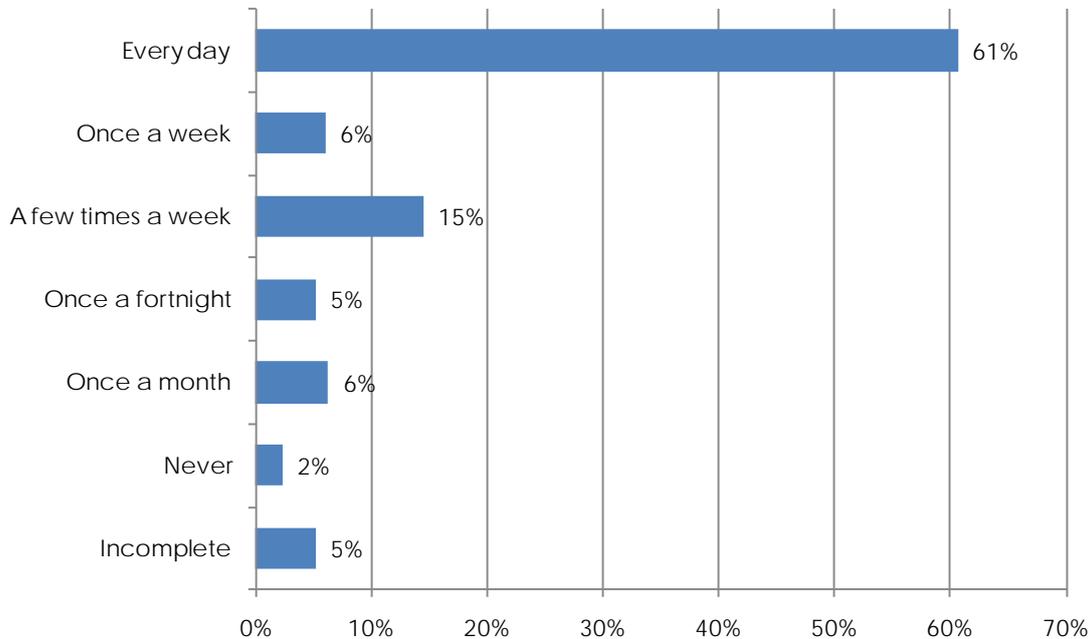


Figure 4 shows that:

- almost two-thirds of the total Health Workers surveyed reported that they receive face-to-face supervision every day (61%)
- only 2% indicated they never receive face to face supervision.

A series of statistical tests were performed to determine whether the frequency of face-to-face supervision varies significantly on the basis of organisation, jurisdiction and remoteness.

For the purposes of this analysis, face-to-face supervision was grouped into two categories:

- frequent (every day and a few times a week) = 285 participants
- infrequent/never<sup>1</sup> (once a week/fortnight/month and never) = 48 participants.

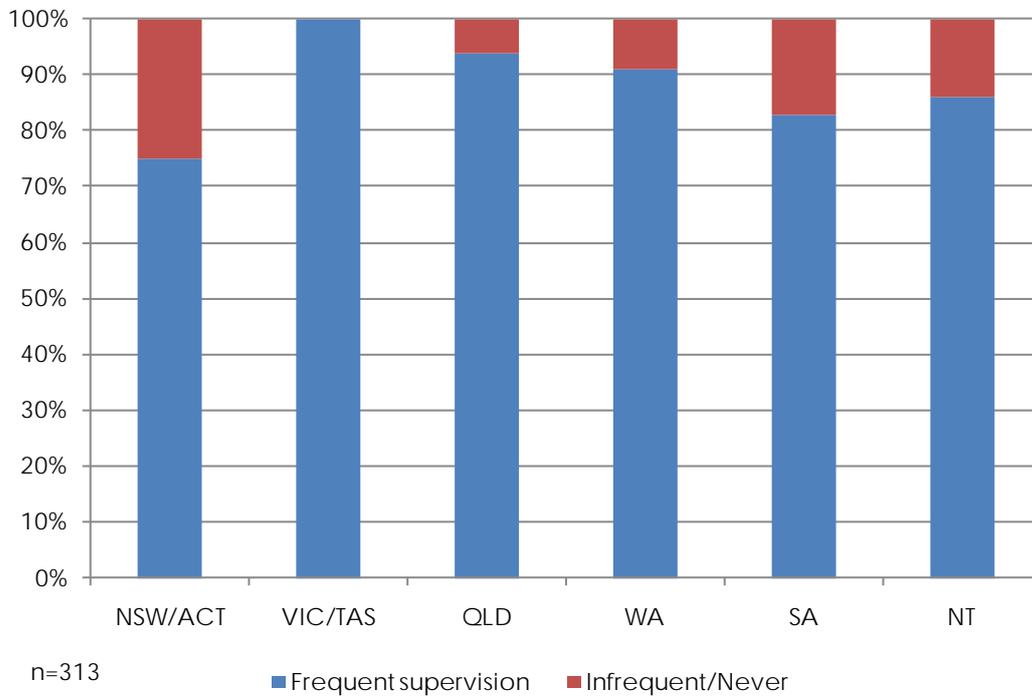
See below for the results.

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<sup>1</sup> The categories 'never' and 'infrequent' had to be grouped because of the low number of participants in the 'never' category, which would have compromised statistical testing.

### 3.2 Frequency of face-to-face supervision: by jurisdiction

Figure 5: Face-to-face supervision by jurisdiction



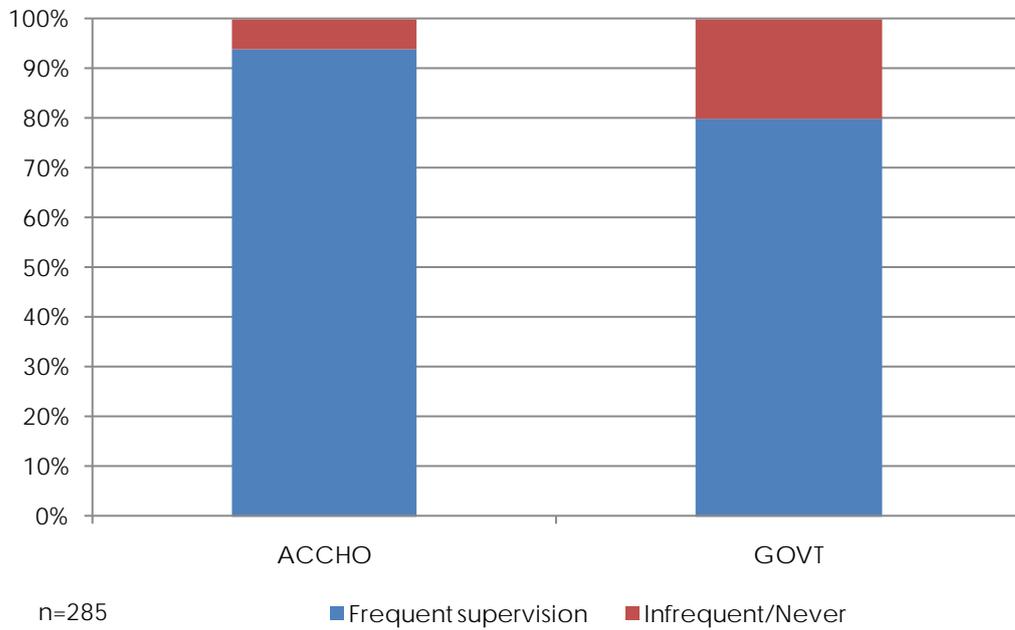
There is a significantly lower frequency of face-to-face supervision in NSW/ACT than in the other jurisdictions ( $p= 0.0006$ ); only 75% of the total respondents from NSW/ACT receive frequent face-to-face supervision (ie every day or a few times a week).

### 3.3 Frequency of face-to-face supervision: by area of remoteness

The area of remoteness of a Health Worker does not appear to have a statistically significant influence on the frequency of face-to-face supervision ( $P = 0.0743$ ).

### 3.4 Frequency of face-to-face supervision: by place of employment

Figure 6: Face-to-face supervision by employer organisation 'other'



There is a significantly lower frequency ( $p= 0.0064$ ) of face-to-face supervision of Health Workers employed by government organisations than for those employed by ACCHOs. Only 80% of respondents from government organisations receive frequent face-to-face supervision, while it is available to 93% of those employed by ACCHOs.



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**Interim Report – Appendix H**

Reference Group members

**Health Workforce Australia**

## Expert Reference Group

NAME	JOB TITLE	ORGANISATION
Mark Cormack	Chief Executive Officer (Chair ERG)	Health Workforce Australia
Ann Newchurch	Workforce Issues Project Officer	Aboriginal Health Council, SA
Bernadette Walker	Acting Assistant Secretary, Nursing, Allied and Indigenous Workforce Branch	Department of Health & Ageing
Bronwyn Nardi	Executive Director, Clinical Workforce Planning & Development Branch	Old Department of Health
Carole Taylor	Chief Executive Officer	Council of Remote Area Nurses of Australia Plus
Chris Robertson	Director National Board Services	Australian Health Practitioner Regulation Agency
Professor Cindy Shannon	Pro-Vice Chancellor, University of Queensland	Shannon Consulting Services
Darrien Bromley	National Coordinator	Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network
Erin Lew Fatt	Workforce Information Policy Officer	Aboriginal Medical Services NT
Janet Schmitzer	Head of Faculty	Bachelor Institute of Indigenous Tertiary Education
Janine Engelhardt	Senior Policy Officer	National Aboriginal Community Controlled Health Organisation
Jenny Poelina	Chairperson	National Aboriginal & Torres Strait Islander Health Worker Association
Dr Kali Hayward	Director	Australian Indigenous Doctors Association
Katrina Fanning	Branch Manager, Program Development & Support Branch	Department of Education, Employment and Workplace Relations
Liz Farmer	Executive Director	Health Workforce Australia
Paula Arnol	Committee Member	National Indigenous Health Equality Council
Peter Pangquee	Principal Aboriginal Health Worker Advisor, Workforce Strategy	NT Department of Health and Families

Renee Williams	National Workforce Issues Policy Officer	National Aboriginal Community Controlled Health Organisation
Robyn Burley	Director of Workforce, Development and Innovation Branch	NSW Health
Seriako Stephens	Board Member	National Aboriginal & Torres Strait Islander Health Worker Association
Shaun Ewen	Deputy Director Academic Programs	Australian Health Workforce
Warren Locke	Manager, Aboriginal and Torres Strait Islander Workforce Unit	Qld Department of Health
<b>Health Workforce Australia staff</b>		
Pat Maher	Program Manager	Health Workforce Australia
Anna Leditschke	Senior Project Officer	Health Workforce Australia
Elaine Treloar	Senior Project Officer	Health Workforce Australia
<b>Pricewaterhouse Coopers staff</b>		
Caitlin Francis	Principal	PricewaterhouseCoopers
Craig Gear	Senior Manager	PricewaterhouseCoopers
Matt Cleary	Manager	PricewaterhouseCoopers
Liz Cameron-Smith	Consultant	PricewaterhouseCoopers

## JURISDICTIONAL PLANNING GROUP

NAME	JOB TITLE	ORGANISATION
Vickie Dodd	Acting Manager – Workforce	Aboriginal Health Division, South Australian Department of Health
Graeme Rossiter	Director, Aboriginal & Torres Strait Islander Health Workforce Section	Department of Health & Ageing
Jeanette James	Policy Officer Aboriginal Health	Tasmanian Department of Health
Warren Locke	Manager, Aboriginal Torres Strait Islander Workforce Unit	Queensland Department of Health
Peter Pangquee	Principal Aboriginal Health Worker Advisor, Workforce Strategy	Northern Territory Department of Health & Families
Anna Sinclair	Manager, Statewide Policy & Strategy	Office of Aboriginal Health, WA Health
Donna Cruikshank	Co-ordinator Aboriginal Workforce Enhancement	NSW Health
Sue Davey	Senior Policy Advisor	VIC Department of Health
Karen Cook	Director, Workforce Policy & Planning	ACT Department of Health

## ABORIGINAL COMMUNITY CONTROLLED HEALTH SECTOR REFERENCE GROUP

NAME	JOB TITLE	ORGANISATION
Renee Williams	National Workforce Issues Policy Officer	National Aboriginal Community Controlled Health Organisation
Erin Lew Fatt	Workforce Information Policy Officer	Aboriginal Medical Services Association NT
Ann Newchurch	Workforce Issues Project Officer	Aboriginal Health Council, SA
Tyson Murphy	Workforce Issues Unit Manager	Victorian Aboriginal Community Controlled Health Organisation
Chris Eldridge	Workforce Policy Officer	Queensland Aboriginal and Islander Health Council Brisbane
Clare Anderson	Workforce Information Project Officer	Winnunga Nimmityjah ACT
Sharon Bushby	Manger, Workforce Development Unit	Aboriginal Health Council, WA
James Porter	Workforce Initiatives	Aboriginal Health & Medical Research Council
Wendy Moore	Health Promotions Coordinator	Tasmanian Aboriginal Centre



Health Workforce Australia  
GPO Box 2098, Adelaide SA 5001  
T +61 8 8409 4500 F +61 8 8212 3841  
E [hwa@hwa.gov.au](mailto:hwa@hwa.gov.au)  
[hwa.gov.au](http://hwa.gov.au)