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# **A National Training and Employment Strategy**

**for Aboriginal and Torres Strait  
Islander Health Workers and  
professionals working in  
Aboriginal and Torres Strait  
Islander health**

National Health and Medical Research Council

**NHMRC**

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The strategic intent of the NHMRC is to work with others for the health of all Australians, by promoting informed debate on ethics and policy, providing knowledge based advice, fostering a high quality and internationally recognised research base, and applying research rigour to health issues.

RESCINDED

National Health and Medical Research Council documents are prepared by panels of experts drawn from appropriate Australian academic, professional, community and government organisations. NHMRC is grateful to these people for the excellent work they do on its behalf. This work is usually performed on an honorary basis and in addition to their usual work commitments.

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# Foreword

The need to establish a working party to consider workforce issues relevant to Aboriginal and Torres Strait Islander health was identified as a key priority by the Aboriginal and Torres Strait Islander Health Standing Committee and was endorsed by National Health Advisory Committee on 8 February 1995.

A Workforce Issues Working Party and Reference Group were established. The first meeting of the Working Party was held on the 4-5 September 1995. During this meeting, members endorsed the overall aims of the Working Party to develop a national training strategy and implementation plan for health professionals who work in the area of Aboriginal and Torres Strait Islander Health. It was further agreed that the strategy would initially focus on Aboriginal and Torres Strait Islander Health Workers.

The Strategy provides an overview of the purposes for the development of such a strategy and outlines its benefits in terms of improved health outcomes for Aboriginal and Torres Strait Islander people.

Acknowledgment is given to Mr Joseph Murphy, Assistant Secretary in the Office for Aboriginal and Torres Strait Islander Health Services, who supervised the progress and work developments of the Working Party and ensured that logistical resources were available to complete the work required. Acknowledgment is also given to the input provided by Reference Group Members and to Members of the Working Party, specifically for their role in directing, writing of relevant parts of the document and editing. Finally, but not least, acknowledgment is given to the Secretariat, provided by the Office for Aboriginal and Torres Strait Islander Health Services, who served as a central point for all input to the strategy, with special thanks to Ms Alison Rodway for her diligence and commitment to the work required.

The National Training and Employment Strategy for Aboriginal and Torres Strait Islander Health Workers and Professionals Working in Aboriginal and Torres Strait Islander Health would not have been achieved without the valuable contributions of the above persons.

Glenis Grogan  
Chairperson  
Workforce Issues Working Party

David Rathman  
Chairperson  
Aboriginal and Torres Strait Islander  
Health Standing Committee

# Glossary

## Acronyms used

AHMAC	Australian Health Ministers' Advisory Council
ABS	Australian Bureau of Statistics
AHS	Aboriginal Health Service
AMA	Australian Medical Association
ANTA	Australian National Training Authority
AQF	Australian Qualifications Framework
ASF	Australian Standards Framework
ATR	Aboriginal Terms of Reference
ATSIC	Aboriginal and Torres Strait Islander Commission
BAS	Bachelor of Applied Science
BHS	Bachelor of Health Science
BIHS	Bachelor of Indigenous Health Science
CBT	Competency Based Training
CPSU	Community and Public Sector Union
JHPC	Joint Health Planning Committee
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NHMRC	National Health and Medical Research Council
NTRA	National Training Regulation Authority
PHC	Primary Health Care
RACGP	Royal Australian College of General Practitioners
RCIADIC	Royal Commission Into Aboriginal Deaths In Custody
RHSET	Rural Health Support, Education and Training
RPL	Recognition of Prior Learning
TAFE	Technical and Further Education
VEETAC	Vocational Employment, Education and Training Advisory Council

# Workforce Issues Working Party

## Terms of reference

### Aims

The **long term aim** of the working party is to develop a national training strategy and implementation plan for Aboriginal and Torres Strait Islander health professionals. Particular reference should be given to training issues for Aboriginal and Torres Strait Islander peoples in health professions and health professionals who work in Aboriginal and Torres Strait Islander health, in both primary health care and public health settings. The **short term aim** of the working party is to develop a broad national training strategy for Aboriginal and Torres Strait Islander health professionals in primary health care settings.

### Objectives

- To identify the main components of a national training strategy for Aboriginal and Torres Strait Islander peoples in health professions and health professionals who work in Aboriginal and Torres Strait Islander health. This should include examination of the following issues:
  - To identify a suitable model for a practical primary health care training program for Aboriginal and Torres Strait Islander Health Workers;
  - The development of teaching health centres for Aboriginal and Torres Strait Islander Health Workers to:
    - recognise and give status to AHWs;
    - develop a model in PHC for Aboriginal and Torres Strait Islander health service professionals; and
    - explore the concept of registered teaching health centres for applied learning at the point of service delivery.
  - Setting of employment targets for Aboriginal and Torres Strait Islander health professions in existing programs within 10 and 15 year time frames;
  - To identify requirements for in service training of Aboriginal and Torres Strait Islander Health Workers;
  - The provision of short courses for non-indigenous staff;
  - Appropriate peer review of medical and other health practitioners within Aboriginal and Torres Strait Islander communities;
  - Professional issues for Aboriginal and Torres Strait Islander health practitioners in health delivery teams, intersectoral relations and career development; and
  - The diversity of circumstances facing Aboriginal and Torres Strait Islander peoples in a range of urban, rural and remote settings.
- To undertake a review of existing activities and initiatives within the training and education field for the target health professionals.
- To identify the numerous players and stakeholders in this area.
- To identify issues which require further research and/or policy development.
- To develop goals and targets, including appropriate implementation strategies for a national training strategy for workers in primary health care settings.

- To develop a model (best practice guidelines) for community control of issues relevant to Aboriginal and Torres Strait Islander health practitioners including integration into non-Aboriginal and Torres Strait Islander health systems. This would include:
  - giving priority to Aboriginal and Torres Strait Islander cultural ways where these do not compromise health;
  - taking account of the realities of local diversity within the consistency of standards;
  - defining professional health practices and roles at the cultural interface, eg. the role of the Aboriginal and Torres Strait Islander health professional in health delivery teams; and
  - recognition of influences of customary law and social relationships on health service delivery.
- To develop standards of best practice for monitoring and evaluation of established and proposed training and education programs which promote consistency in training standards at a local, State and national level.

### Action plan

- To liaise with the National Community Services and Health Industry Training Advisory Board regarding the development of national competencies for Aboriginal and Torres Strait Islander Health Workers and remote area nurses.
- To liaise with the appropriate organisations and personnel regarding the Joint Health Planning Committee consultancy to develop a National Aboriginal and Torres Strait Islander Health Workers' Forum.
- To liaise with the Presidential Taskforce on Indigenous Health established by the Royal Australian College of General Practitioners.
- To establish formal links with the relevant stakeholders including Aboriginal and Torres Strait Islander Health and Medical Services, Aboriginal and Torres Strait Islander Health Workers, NACCHO, the Peninsula and Torres Strait Regional Health Authority, the Torres Strait and Northern Peninsula Area Health Council, Commonwealth, State/ Territory governments and other relevant professional and training organisations/institutions.

### Time scale

Prepare a preliminary report to the Standing Committee by February 1996 on:

- the identification of the main components of a national training strategy for Aboriginal and Torres Strait Islander peoples in health professions and health professionals who work in Aboriginal and Torres Strait Islander health;
- the review of existing activities and initiatives within the training and education field for the target health professionals;
- the identification of the numerous players and stakeholders in this area;
- the identification of issues which require further research and/or policy development; and
- the development of goals and targets, including appropriate implementation strategies for a national training strategy for workers in primary health care settings.

Consideration of the preliminary report was scheduled as follows:

- |                      |               |
|----------------------|---------------|
| • Standing Committee | February 1996 |
| • NHAC               | April 1996    |
| • NHMRC Council      | June 1996     |

## Working party membership

The membership reflects issues for Aboriginals and Torres Strait Islanders in rural, remote and urban areas. Expertise was drawn from the following areas: Aboriginal and Torres Strait Islander Health Workers and Administrators; General Practitioners; Nurses; NACCHO: Training institutions; Australian Nursing Federation; Department of Employment, Education, Training and Youth Affairs; ATSIC.

Name	Role
Glenis Grogan	Chair
Sonia Waters	Health Administration Expertise
Prof. Stephen Leeder	Public Health Expertise
Gary Tongs and Helen Kay	Department of Employment, Education, Training and Youth Affairs Representatives
Sally Goold	Nursing/Training Expertise
Anne-Marie Scully	Australian Nursing Federation Representative
Haylene Grogan	Council of Remote Area Nurses of Australia Representative
John Mallard	Training/Education Expertise
Mary Martin	NACCHO representative
Dr F Soong	Public Health/Aboriginal Health Worker Training Expertise
Irene Fisher	Training/Education Expertise
Steve Christian	Health Worker Training Expertise
John Cairns	ACTU Representative
Irene Wanganeen	CPSU Representative

## Reference group membership

Name	Organisation
Ms Heather Martin	Workforce Policy Expertise
Mr Barry Thorne	NSW Health Department
Ms Lee Edgar	NSW Health Department
Mr Paul Ferguson	NSW Health Department
Ms Dot Morrison	NT Department of Health and Community Services
Mr Joe Dalby	NT Department of Health and Community Services
Ms Sue Fox	TAS Department of Community and Health Services
Dr Bob Cooter	Royal Australian College of General Practitioners
Mr Michael Sullivan	SA Health Commission
Mr Ron James	VIC Department of Health and Community Services
Mr Sol Bellear	QLD Health
Commissioner	Marion Hansen ATSIC
Mr Les Turner	ATSIC
Ms Barbara Schmidt	Torres Strait and Peninsula Health Authority
Ms Sally Davis	NCS&H ITAB
Ms Margaret Halid	WA Health Department
Ms Gwen Byrne	WA Health Department
Mr David Exton	QLD Health
Ms Sue Andrews	ACT Health
Ms Grace Fischer	Torres Strait and Northern Peninsula Area Health Council
Ernest Drozdt	TAS Department of Community and Health Services

## Secretariat

Secretariat and supervisory services have been provided throughout the duration of the Working Party by various personnel from the Department of Health and Family Services, Office for Aboriginal and Torres Strait Islander Health Services. These include Ms Mary Scott, Ms Lisa Lawrence, Ms Jennifer James, Ms Alison Leitch, Ms Alison Rodway, Ms Trish Carling, Ms Leigh Cupitt, Ms Mary Buckskin, and Mr Tim Agius.

# 1. Executive summary

This report begins with a discussion of the philosophies underpinning the Strategy to improve the health status of Aboriginal and Torres Strait Islander peoples by improving the education and training of the Aboriginal and Torres Strait Islander health workforce. These include: a holistic, Aboriginal concept of health; community control; Aboriginal Terms of Reference; a public health framework; and a primary health care approach.

A summary of factors leading to the poor health status of Aboriginal and Torres Strait Islander peoples; the development of the Aboriginal and Torres Strait Islander health workforce; and information about a number of nationwide initiatives regarding workforce recruitment, training, occupational and professional development, and health service policy, planning and development, provides the background for subsequent consideration of the strategic issues and action areas for the Strategy.

These strategic issues and areas for action are considered in the main body of the document and formed the basis for the development of the Strategic Framework which concludes the document.

In health terms, Aboriginal and Torres Strait Islander peoples are seriously disadvantaged by poor living conditions, limited service access and a health workforce that is often insufficient to their needs. They are affected also by removal from land, sea, waterways, culture and community and by lack of understanding by other Australians. Despite attempts in recent years to address their low health status, and apart from reduced infant mortality rates, mortality and morbidity rates remain at unacceptable levels.

Health services for Aboriginal and Torres Strait Islander peoples should be provided by an adequately resourced, appropriately trained and qualified multidisciplinary team of health care workers.

It is important first to determine the number of workers, the mix of skills and the distribution of workers required to meet community health care needs. Workforce planning involves identifying the current workforce, assessing community requirements for different types of health practitioners and estimating future workforce requirements. It is also important to develop strategies to recruit, retain and develop workers and to establish sufficient employment places and appropriate training courses to meet the identified need.

The roles and responsibilities of Aboriginal and Torres Strait Islander Health Workers and non-Aboriginal and Torres Strait Islander medical, nursing and allied health professionals are considered as part of multidisciplinary team services to Aboriginal and Torres Strait Islander people. The recruitment of more Aboriginal and Torres Strait Islander people into the full range of health care professions is also considered. Health care teams will be more likely to achieve successful outcomes if they provide services in a manner which is culturally appropriate to Aboriginal and Torres Strait Islander peoples. The education and training of all team members needs to address this aspect of knowledge, skills and attitudes.

Currently there are around 1,300 Aboriginal and Torres Strait Islander Health Workers working in Aboriginal and Torres Strait Islander communities. They work in many settings, sometimes alone, sometimes as part of a health care team. What they do varies greatly according to the practice setting and there are a range of emerging worker roles, such as in specialist areas of social, environmental and women's and men's health.

Aboriginal and Torres Strait Islander Health Workers are often the first point of contact for Aboriginal and Torres Strait Islander people with the health system, and play a key role in the delivery of health care. Little attention has been paid by the wider health system to their important contribution to the health and well being of Aboriginal and Torres Strait Islander communities. Their role is poorly understood by governments, other health professionals and the wider community and attempts at role definition have been a source of contention, with differing view points and no agreed outcome.

However, there is a core set of knowledge, skills and attitudes, or 'competencies', which form the basis for their practice in all settings. Definition of the skills they need in order to meet diverse community needs is central to developing appropriate training and educational support for them. A national project has recently defined and articulated this common core of competencies. This will influence the design and delivery of training programs.

Lack of recognition of the role of Aboriginal and Torres Strait Islander Health Workers has meant that:

- there is no reliable data on the number needed in communities;
- training has developed on an ad hoc basis, and does not reflect a set of recognised core skills which are transferable between states/territories or even regions;
- secure, ongoing funding for training has been difficult to access;
- wages and conditions vary markedly between states/territories;
- communities are not always aware of their range of skills; and
- other health professionals are not always clear about their role and expertise.

Progress has been made toward the strengthening of the Aboriginal and Torres Strait Islander Health Worker workforce through a feasibility study into the establishment of a national forum to enhance their status and self-esteem through collegial interaction, representation and advocacy on behalf of professional interests. If established, this Forum will have an important role in:

- defining the role of Aboriginal and Torres Strait Islander Health Workers;
- defining work roles which fall within the definition, taking into account specialist areas such as substance misuse, environmental health, hospital liaison, and so on;
- developing a preferred model illustrating how their role fits within the wider health system and its relationship to other health occupations;
- developing a professional code of ethics for Aboriginal and Torres Strait Islander Health Worker practitioners;
- exploring the parameters of any legislation which would facilitate the operation of Aboriginal and Torres Strait Islander Health Workers as both autonomous practitioners and as multidisciplinary health care team members; and
- contributing to national debate on significant health issues and initiatives.

This Strategy proposes ways of strengthening the Aboriginal and Torres Strait Islander health workforce through training, employment initiatives, working conditions, and professional development. In particular, it seeks to ensure that all categories of health professionals receive vocationally and locally relevant training and orientation in relation to the clinical and cultural needs of their Aboriginal and Torres Strait Islander client communities as a means of improving working relationships and services provided and to enable them to impact more positively on health outcomes.

Mechanisms needed to monitor and evaluate the quality of outcomes of strategies and the means of funding their implementation are considered.

## 2. Purpose of the strategy

It often appears that action in Aboriginal health comes as a response to intermittent political pressure, rather than as a formal commitment to effect long term solutions for future generations. Often, responses last only until media attention eases or until the next election.<sup>1</sup> An alternative approach must be taken to improve the situation.

The NHMRC Workforce Issues Working Party believes that positive outcomes will result from implementing a National Training and Employment strategy, focusing on Aboriginal and Torres Strait Islander Health Workers and other professionals working in Aboriginal and Torres Strait Islander health. This would evidence a long term commitment to improving the situation, enabling changes to health care delivery and contributing to improved health outcomes.

**This Strategic Framework aims to improve Aboriginal and Torres Strait Islander peoples' health status by developing an appropriately skilled and acculturated workforce able to meet their health needs. It is underpinned by the principles and processes of public health, primary health care, and Aboriginal Terms of Reference.**

It outlines:

- the skills needed by Aboriginal and Torres Strait Islander Health Workers;
- their important role within the health care system;
- the need to identify the numbers and types of health workers required in the field;
- current training arrangements and how these need to develop to ensure appropriate training and support to meet community needs and expectations;
- issues emerging as workers approach national recognition of their skills.

The focus on Aboriginal and Torres Strait Islander Health Workers does not discount the roles of medical, nursing and allied health professionals. The Strategic Framework will outline ways in which cross cultural awareness training and the recruitment of Aboriginal and Torres Strait Islander people into a range of health professions can be implemented.

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<sup>1</sup> National Aboriginal Health Strategy Working Party. A National Aboriginal Health Strategy. 1989, p 11.

## 3. The strategic framework

### **Objective 1**

Identify the main components of a national training strategy for Aboriginal and Torres Strait Islander peoples in health professions; and for health professionals who work in Aboriginal and Torres Strait Islander Health.

### **Strategies**

1. Review current initiatives and identify examples of best practice in the areas of cross cultural training and orientation to Aboriginal and Torres Strait Islander Health practice for non-Aboriginal and Torres Strait Islander health professionals and Aboriginal and Torres Strait Islander health professionals.
2. Develop, fund and implement regionally relevant and vocationally relevant, cross cultural training and orientation programs for all practitioners in Aboriginal and Torres Strait Islander health in different types of service and/or community settings.
3. Develop relevant post-basic courses for Aboriginal and Torres Strait Islander Health Workers in consultation with workers, employers and communities.

### **Objective 2**

Undertake a review of existing activities and initiatives within the training and education field for the target health professionals.

### **Strategies**

4. Recognise competency standards as the framework for the development of curriculum for providing accredited Aboriginal and Torres Strait Islander Health Worker Training.
5. Compile a register of existing affirmative action initiatives which encourage and support the entry and retention of Aboriginal and Torres Strait Islander students in medical, nursing and allied health professional education and training courses.
6. Examine existing Aboriginal and Torres Strait Islander education and training courses to assess:
  - the capacity to integrate the proposed national competency standards within existing curricula; and
  - the level of financial and other resources necessary to support such integration.

### **Objective 3**

Identify the numerous players and stakeholders in this area.

### **Strategies**

7. Develop a register of key stakeholders in the areas of education, training, funding, policy, planning, delivery and evaluation of health services to Aboriginal and Torres Strait Islander communities, identifying the relevant policies, guidelines, processes and funding cycles.
8. Develop a model of the roles and relationships of key stakeholders, related initiatives and linkages in relation to the implementation of the Strategic Framework.
9. Promulgate the Strategic Framework and Action Plan to the individuals, groups, services and agencies who/which will have a role in implementing the Strategic Framework and Action Plan.

### **Objective 4**

Identify issues which require further research and/or policy development.

### **Strategies**

10. Provide this Strategic Framework to the Workforce Issues Sub-Committee of the National Aboriginal and Torres Strait Islander Health Council as a planning document in support of their ongoing policy development tasks.
11. Provide this Strategic Framework to the Aboriginal and Torres Strait Islander Health Council to develop an Action Plan for its implementation in consultation with key stakeholders.
12. Commission a study to examine the appropriate number and mix of skill levels needed to improve the health status of Aboriginal and Torres Strait Islander peoples to derive a formula taking into account the factors likely to impact on health status, including the overall population, age groups, location factors, culture, health status and environmental conditions.
13. Identify funding stakeholders responsible for implementing the findings of the study in Strategy 12.
14. Refer the findings of Strategies 12 and 13 to the State Forums for action as part of their regional planning processes.
15. Review the current education/training Strategic Framework and modify it, if necessary, to ensure that it is appropriate to the identified workforce needs.
16. Investigate the development and introduction of consistent legislation covering Aboriginal and Torres Strait Islander Health Worker practice in all States/Territories.

### Objective 5

Develop goals and targets, including appropriate implementation strategies for a national training strategy for workers in primary health care settings.

### Strategies

17. Develop workforce plans at the national, state/territory and regional levels in consultation with key stakeholders, including projections for the next decade and subject to triennial revisions.
18. Develop a support program to facilitate effective local workforce planning.
19. As an interim measure, increase the number of training and employment places available for Aboriginal and Torres Strait Islander Health Workers and adjust this number, if necessary, when the findings of the study referred to in Strategy 12 become available.
20. Review in 2000, and adjust if necessary in 2002, the number of training and employment places available for Aboriginal and Torres Strait Islander Health Workers, to reflect workforce requirements.

### Objective 6

Develop a model (best practice guidelines) for:

- community control of issues relevant to health practitioners in Aboriginal and Torres Strait Islander health;
- integration into non-Aboriginal health systems;
- monitoring and evaluation of established and proposed training and education programs; and
- promoting consistency in training standards at a local, state and national level.

### Strategies

21. Disseminate the Aboriginal Terms of Reference for wide discussion, comment and endorsement as best practice guidelines for community control of the planning, design, delivery and evaluation of Aboriginal and Torres Strait Islander:
  - public health and primary health care strategies and services; and
  - employment, education and training programs.
22. Support the establishment and maintenance of a National Forum of Aboriginal and Torres Strait Islander Health Workers and other professional development initiatives, including options and arrangements for their funding.
23. Commission the National Forum of Aboriginal and Torres Strait Islander Health Workers, if established, to develop recommendations in relation to the following issues:
  - define the role of Aboriginal and Torres Strait Islander Health Workers;
  - define the Forum's membership in terms of work roles which fall within the definition, taking into account specialist areas such as substance misuse, environmental health, hospital liaison, and so on;
  - develop a preferred model illustrating how their role fits within the wider health system and its relationship to other health occupations;

- develop a professional code of ethics for Aboriginal and Torres Strait Islander Health Worker practitioners;
  - explore the parameters of any legislation which would facilitate the operation of Aboriginal and Torres Strait Islander Health Workers as both autonomous practitioners and as multidisciplinary health care team members; and
  - contribute to national debate on significant health issues and initiatives.
24. Develop and introduce a national training program for Aboriginal and Torres Strait Islander Health Workers, taking into account the following factors:
- community control and the diversity of worker roles, levels and practice settings;
  - maintenance of standards and monitoring and evaluation of delivery and assessment;
  - curriculum design to allow for multiple entry points, the selection of relevant study pathways and flexible course delivery and assessment methods;
  - literacy and numeracy prerequisites for course entry or the integration of vocational literacy and numeracy education into course structures;
  - Recognition of Prior Learning;
  - relevant industrial and legislative issues in states/territories and the relationship of training qualifications to:
    - industrial award structures and occupational career structures;
    - workplace staffing structures and operational budgets; and
  - funding of curriculum development, course accreditation, resource development and course delivery, monitoring and evaluation.

## 4. Underpinning philosophies and processes

### 4.1 A holistic, Aboriginal approach to health

#### 4.1.1 Aboriginal perspectives on health

It is difficult from an Aboriginal perspective to conceptualise a western understanding of health.<sup>2</sup> Aboriginal people are concerned with quality of life and health is a matter of determining all aspects of their lives, including control over their community environment, self-esteem, dignity and justice, not merely the supply of doctors, hospitals and medicines or the absence of disease and incapacity.<sup>3</sup>

An example of an Aboriginal community oriented perspective on health is provided by the Fitzroy Valley Cultural Health Project. This project includes many dimensions of community life, including Human Services, Physical, Cultural and Economic Services that have a significant impact on Aboriginal health. It demonstrates a coordinated approach that goes much further than a narrow focus on curative clinical services and the health system.<sup>4</sup>

#### 4.1.2 Community control

Aboriginal people wish to be able to control their destiny again and accept responsibility for their decision making.<sup>5</sup>

The NAHS provides a definition: *'Community Control is the local community having control of issues that directly affect their community... Aboriginal people must determine and control the pace, shape and manner of change and decision-making at local, regional, state and national levels'*.<sup>6</sup>

The Aboriginal Deaths in Custody Overview of the Response by Governments to the Royal Commission supports this view of empowerment: *'There is no other way. Only the Aboriginal people can, in the final analysis, assure their own future'*.<sup>7</sup>

NACCHO provides a draft definition: *'... community control has its genesis in Aboriginal peoples right to self-determination... the right of all peoples, as distinct cultural, economic, social and political institutions to make collective decisions in all matters relating to their own affairs... self-determination, or community control, is central to achieving and maintaining... 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... Community Control is the local community having control of issues that directly affect the health of their community. As a minimum, this requires that:*

- *the health and well-being of Aboriginal peoples must be approached in a context which comprehends the political, cultural, spiritual, emotional, environmental, structural, economic and biological factors which impinge on our well-being;*

<sup>2</sup> Mobbs R, In *Sickness and Health: the Sociocultural Context of Aboriginal Well-being, Illness and Healing*, p 302.

<sup>3</sup> National Aboriginal Health Strategy Working Party. *A National Aboriginal Health Strategy*. 1989, p ix.

<sup>4</sup> Fitzroy Valley Cultural Health Project. Marra Worra Worra Aboriginal Corporation, Fitzroy Crossing., WA. 1996.

<sup>5</sup> National Aboriginal Health Strategy Working Party. *A National Aboriginal Health Strategy*. 1989, p xiii.

<sup>6</sup> National Aboriginal Health Strategy Working Party. *A National Aboriginal Health Strategy*. 1989, p xiv.

<sup>7</sup> Aboriginal Deaths in Custody Overview of the Response by Governments to the Royal Commission, 1992, p.19.

- *health services must be culturally valid, with special health services being controlled by local communities to ensure they are provided in forms, settings, structures and languages with which local Aboriginal communities identify;*
- *non-Aboriginal health care providers must develop a valid comprehension of Aboriginal health; and*
- *Aboriginal communities must be properly funded to operate their health services with acknowledgment of historical impairment, existing inequalities, cultural and geographical isolation and cultural imperatives such as men's and women's business'.*

Community control also involves, but is not limited to, the following features:

- each autonomous health service is controlled by the community it serves, in order to meet it's needs in a manner it determines;
- participation in decision-making, for practical reasons, varies according to settings, but remains key. Membership should be open to all community members so that they may contribute to the selection/election of office bearers, at regular intervals as established by communities; and
- community control, not control of the community by service/office bearers.

Community control is a dynamic, evolving concept operationally defined at the local level. It implies that the community determines and controls the pace and nature of decisions affecting them at local levels and has representation at regional, state and national levels. Community control must be central to any framework used to address Aboriginal and Torres Strait Islander health issues.

## 4.2 Aboriginal terms of reference (ATR)

Terms of Reference usually means the scope of inquiry – the things to be considered in order to make decisions in specific contexts. The Centre for Aboriginal Studies, Curtin University of Technology, Perth, developed the following general meaning: *'ATR encompasses the cultural knowledge, understanding and experiences that are associated with a commitment to Aboriginal ways of thinking, working and reflecting. ATR incorporates specific and implicit cultural values, beliefs and priorities from which Aboriginal standards are derived, validated and practised. These standards vary according to the diverse range of cultural values, beliefs and priorities from within local settings and specific contexts'*.<sup>8</sup>

The principles of ATR include:

- appreciation of Aboriginal diversity;
- reaffirmation of Aboriginal culture;
- confirmation of identity in the context of own Aboriginal environment;
- identification of Aboriginal issues coming out of or relating to that environment;
- recognition of historical, cultural, political and economical realities;
- validation by group for assessment of achieving a negotiated standard; and
- developing individual and collective options for the future.

ATR is a process oriented way of working and learning to:

- build a picture of their internal environment and of external forces;
- identify and analyse the issues from the picture and assess the resources available within and without to deal with them;

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<sup>8</sup> Community Services, Health & Education Industry Training Council, Perth. Aboriginal Terms of Reference Competency Standards Report. 1995, p1.

- plan – including developing an ability to assess information provided from the process and using it to develop short and long term goals;
- implement the plan by identifying approaches which fit with the culture;
- evaluate outcomes to determine the gaps and barriers;
- redefine the plan to incorporate appropriate changes; and
- recycle the above stages as and when necessary in accordance with ATR.

ATR is important because it:

- is a process of learning and working that reflects the reality of the group;
- is an effective way to transfer skills and knowledge to achieve government policy goals, such as self management and self determination; and
- incorporates community development principles which facilitate re-empowerment to explore choices based on group values and beliefs.

ATR sets the framework for discussion, determines what should be reality, what is acceptable within that reality, the ways in which to achieve what is acceptable, and the ways in which to evaluate these processes and results.

Kickett (1992), at the National Aboriginal and Torres Strait Islander Higher Education Conference, put forward the position that incorporation and recognition of ATR is an important and necessary paradigm for the future of Aboriginal people and, ultimately, of this country. He goes on to say: *‘One of the key factors which needs to be properly considered when operating in a cross-cultural setting is values. Program and curriculum developers will not deal effectively with Aboriginal realities if they do not incorporate processes which enable Aboriginal participants or students to come to terms with their own value system... (requiring) an opportunity to systematically explore options as they move through their tasks in decision-making and problem solving. In doing so they will be able to place terms and conditions on transactions in order to retain that which is important to their own lives’.*<sup>9</sup>

ATR considers that which is valued by Aboriginal people and ways in which to work, explore options and prioritise decisions. It is a clear process and can be seen as beneficial in terms of outcomes not only for Aboriginals but also for non-Aboriginal people involved in Aboriginal services. It can be a powerful implementation tool. Particularly so in the area of Aboriginal and Torres Strait Islander health if its principles and processes underlie the frameworks of public health and primary health care.

## 4.3 Public health and Primary Health Care

### 4.3.1. Public health framework

Public health is a social and political way of thinking about health, based on scientific evidence such as that used to investigate population health (epidemiology), the use of health dollars (health economics), and activities to promote health and prevent illness (health promotion). It recognises that environmental, cultural and socio-economic factors such as access to education, employment, transport, good food and clean water affect health. It provides a basis for health services to plan and organise to meet community health needs. One way to put this into action is through primary health care, using public health evidence (research) to bring about positive change in a population’s health status.

<sup>9</sup> Centre for Aboriginal Studies, Curtin University of Technology. Aboriginal Terms of Reference: A Paradigm for the Future. Perth, 1992.

<sup>10</sup> National Aboriginal Health Strategy Working Party. A National Aboriginal Health Strategy. 1989, p x.

### 4.3.2 Primary Health Care (PHC) philosophy

The NAHS advocates a PHC philosophy as the appropriate approach to Aboriginal and Torres Strait Islander health programs, drawing on the approach developed by WHO (Alma Ata, 1978) and defined as: '*... essential health care based upon practical, culturally acceptable methods ... easily accessible to... the community, through their full participation to promote self-reliance and self determination*'.<sup>10</sup>

PHC puts control of health activities into the hands of those whose health is acted upon. This must be control, not just involvement.<sup>11</sup> PHC emphasises self-determination in all aspects of health care, from the first level of contact with the health system, to acute care in hospitals and specialist services. This contrasts with the commonly held view that people's health is the domain of the specific agencies established to provide health care.<sup>12</sup>

The PHC principles advocated by WHO and further developed by NAHS are:

- a whole of community approach recognising broader determinants of health;
- community control/accountability;
- intersectoral collaboration;
- increased emphasis on prevention, education and early intervention;
- recognition of Aboriginal and Torres Strait Islander Health Workers as the link between community and health system and as central to continuity of care and to community development and education towards self management;
- recognition of the diversity of needs within rural, remote and urban needs;
- sustainable development; and
- a framework for monitoring and evaluation.

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<sup>11</sup> Report to the AHMAC Working Party on the Health Services Workforce in Rural and Remote Australia, May 1994.

<sup>12</sup> National Aboriginal Health Strategy Working Party. A National Aboriginal Health Strategy. 1989, pp x-xi.

## 5. Background

### 5.1 Historical context

Commissioner Elliott Johnston QC writes thus of the historical process of dispossession and disempowerment of Aboriginal and Torres Strait Islander peoples: *‘That Aboriginal people were dispossessed of their land without benefit of treaty, agreement or compensation is generally known. But I think little known is the amount of brutality and bloodshed that was involved in enforcing on the ground what was pronounced by the law. Aboriginal people were deprived of their land and if they showed resistance they were summarily dealt with. The loss of land meant the destruction of the Aboriginal economy which every where was based upon hunting and foraging. And the land use adopted by the settlers drastically reduced the population of animals to be hunted and plants to be foraged. And the loss of the land threatened the Aboriginal culture which all over Australia was based upon land and relationship to the land. These were the most dramatic effects of European colonisation supplemented by the decimating effects of introduced disease to which the Aboriginal people had no resistance. These matters are understood to a very imperfect degree by non-Aboriginal society’.*<sup>13</sup>

Having reduced the original inhabitants to a condition, in many places, of abject dependency, colonial governments decided on a policy of Aboriginal protection in which:

- people were swept into reserves and missions and supervised in every detail of their lives within a deliberate policy of undermining their spiritual and cultural beliefs;
- children of mixed race descent were removed from family and land, placed in institutions and trained as European labourers or domestics; and
- people outside reserves were usually to be found camping on river banks or the outskirts of country towns, under the eyes of non-Aboriginal police.

Legislation varied according to place and time but the effect was the same: control over people’s lives. Without permission, a person could not live on a reserve, leave or return after leaving, have a relative to live with them, or work, except under supervision. It was an offence to encourage or assist an Aboriginal person to leave a reserve. There were special laws about alcohol. Reserve supervisors and missionaries had all the power.<sup>14</sup>

As a result of these and other factors, it is unsurprising that Aboriginal and Torres Strait Islander peoples’ health status is at a level commensurate with third world conditions.

### 5.2 Health status and health care

Aboriginal and Torres Strait Islander death rates greatly exceed total Australians rates at all ages, with life expectancy at birth being 16-18 years less. For most diseases, particularly cardiovascular diseases and diabetes, the adult prevalence rate exceeds 30 percent in some communities, with aged standardised mortality rates more than seven times that of other Australians. In 1991-92, Aboriginal and Torres Strait Islander males’ hospital admission rate was 60 percent higher than for other Australians. For Aboriginal and Torres Strait Islander women (including childbirth), it was 50 percent higher.

<sup>13</sup> Johnston QC, E. Royal Commission into Aboriginal Deaths in Custody: National Report: Overview and Recommendations. 1991, p 7.

<sup>14</sup> Johnston QC, E. Royal Commission into Aboriginal Deaths in Custody: National Report: Overview and Recommendations. 1991, p 8.

Improved health status should result from better access to culturally appropriate care.<sup>15</sup> Sustainable gains require improvements to social, physical and economic environments.<sup>16</sup>

## 5.3 The health workforce

An important component in improving the health status of Aboriginal and Torres Strait Islander peoples is access to a highly trained workforce which has deep insights into their cultural sensitivities and beliefs.

### 5.3.1 Aboriginal and Torres Strait Islander Health Workers

Aboriginal and Torres Strait Islander Health Workers have been employed in Aboriginal and Torres Strait Islander communities for many years, providing a range of health care services.

Aboriginal people were employed as 'medical assistants' in the NT from the 1960s. In the 1970s, the term changed to 'Aboriginal Health Worker' or 'Aboriginal and Torres Strait Islander Health Worker'. These workers were employed by government and non government organisations (mainly community controlled services) across the country.

Bureaucrats tended to understand their role as that of assistants, interpreters or cultural brokers employed to introduce non-Aboriginal health professionals to Aboriginal and Torres Strait Islander communities. Community controlled health services employed them in roles which included direct clinical care and related responsibilities. Aboriginal and Torres Strait Islander Health Workers tend to place less emphasis on their cultural brokerage role than do non-Aboriginal colleagues, who tend to consider translation and cultural information as their most obvious and important functions.<sup>17</sup> Their work has expanded to a broad, varied role in delivering health care to Aboriginal communities.

This can be attributed to many factors, namely: *'Many non-Aboriginal health professionals at all levels are poorly informed about Aboriginal people, their cultural differences, their specific socio-economic circumstances and their history with Australian society..... The rotation of staff through country hospitals means that many professional staff are ill-prepared to provide appropriate health care services to Aboriginal people..... The primary health care approach... is highly appropriate in the Aboriginal health field, but health professionals are not well trained in this area'*.<sup>18</sup>

The power of Aboriginal and Torres Strait Islander Health Workers lies not just in their role as agents of Western medicine but in their being from and of the community, sharing its aspirations and burdens. They are in a position to take what is useful from Western medicine, blend it with community understandings, and achieve better health outcomes. They can achieve this best as autonomous practitioners.<sup>19</sup> The capacity to practise both autonomously and as a member of a team along with other health professionals has legislative and industrial implications. These will need to be addressed in any Aboriginal and Torres Strait Islander Health Worker occupational development initiatives.

#### 5.3.1.1 Role definition

Aboriginal and Torres Strait Islander Health Workers are team members, working with other health professionals and must be given due recognition by other team members. Attempts at defining their role and identifying their functions have been a source of contention, with differing viewpoints and no agreed outcome, for example:

<sup>15</sup> Mobbs, R. In *Sickness and Health: the Sociocultural Context of Aboriginal Well-being, Illness and Healing*. pp 292-96.

<sup>16</sup> Torzillo, P. and Kerr, C. *Contemporary Issues in Aboriginal Public Health*. pp 374-5.

<sup>17</sup> Tregenza, J. Abbott, K. *Rhetoric and Realty*. 1995, p 22.

<sup>18</sup> Johnston, QC, E. *Royal Commission into Aboriginal Deaths in Custody: National Report: Overview and Recommendations*. 1991, pp 87-88.

<sup>19</sup> Bartlett, B. *An Aboriginal Health Workers' Guide to Family, Community and Public Health*. Central Australian Aboriginal Congress, Alice Springs.

- the 1994 NAHS Evaluation (Appendix A-7) recognised their importance as ‘an integral part of the clinical staff of the Aboriginal Health Services’, with their roles evolving along with those services;
- a report by the Working Party on the Health Services Workforce in Rural and Remote Areas, focused on these workers as the first point of contact with clients and other workers, stressed their role in providing primary care and ensuring community control, and described the clinical, management and education aspects<sup>20</sup> of their role;
- a report to the RHSET Program on the recruitment, retention and education of NT workers gives the following definition: ‘An Aboriginal Health Worker is one who is selected by the community to deliver Primary Health Care, for the spiritual, mental and physical well being of the community’ (Background, 1.2); and
- the Aboriginal and Torres Strait Islander Health Worker Training Program in Central Australia (1980, p7) describes their role as: ‘... treatment of common sicknesses; implementation of preventative programs... community education programs; promotion of environment sanitation measures; and the management of the health centre’.

Tregenza and Abbott write about Aboriginal and Torres Strait Islander Health Workers as follows: ‘Within the range of their Aboriginal Knowledge, medical training and constraints of the system, they deliver the best health care that they can.... aware that not enough is being done... (and) of the level of illness, death and social crisis that exists. (They) are ideally placed to affect the health status of the community. (They) are the only health resource which is constant...’<sup>21</sup>

They classify the functions of the role under eight areas:

- traditional health;
- cultural brokerage;
- clinical care and western medicine;
- health education and promotion;
- environmental health;
- community care;
- administration, management and control; and
- policy development and program planning.

They believe that role definitions have proved inadequate and controversial due to:

- attempts to fit workers into western health system administrative structures;
- disputes about the role between bureaucrats, health services, community members, non-Aboriginal health professionals and the workers themselves;
- retrospectivity, describing a past situation in a society undergoing great change; and
- the variety of situations within which roles developed and the personal preferences and skills of individual workers.

### 5.3.2 Medical, nursing and allied health workers

The roles of these health care providers in mainstream health settings are generally understood. However, specific knowledge and skills are required when working in Aboriginal and Torres Strait Islander health settings. In rural and remote areas, these roles usually expand to include support of Aboriginal and Torres Strait Islander Health Workers, coordination of programs, cross cultural

<sup>20</sup> Report to the AHMAC Working Party on the Health Services Workforce in Rural and Remote Australia. May 1994. p 10-15.

<sup>21</sup>Tregenza, J. Abbott, K. Rhetoric and Reality. 1995.

awareness, broader clinical responsibilities and involve a higher level of community involvement and continuity of contact than in urban areas.<sup>22</sup>

### 5.3.2.1 Nurses

The report to AHMAC on the health workforce in rural and remote Australia defines nursing as follows: *'Nursing... is a continuum of care from birth to death, with a focus on wellness. It includes health promotion, health education, illness prevention, health maintenance, illness care, rehabilitation and palliative care. It is holistic in nature and relevant to all the life experiences of individuals and their environments. Nursing generally takes place in a variety of settings including communities, homes, schools, and work sites. Remote area nursing (which includes additional responsibilities for coordination of programs and community development) may occur in any of these settings within a variety of communities...Most remote situations involve interaction between Aboriginal and non-Aboriginal people and demand skills in cross cultural communication and awareness.'*

Defining the role of the remote area nurse is also problematic: *'The diverse nature of the nurse roles makes definition difficult. Services provided by the nurse differ considerably from place to place because of the diversity of geographic, climatic, demographic, socio-economic, cultural and political factors within remote Australia's communities and regions. Efforts must be made to reach consensus on a comprehensive role definition. Not to do so may reinforce and perpetuate the lack of recognition of nurses, continued poor resource allocation, unrealistic expectations, inadequate educational preparation of nurses, lack of understanding and the ad hoc extension of nurse functions which is currently occurring.'*

However the following definition is given: *'The nurse is a registered nurse whose day to day practice encompasses all or most aspects of primary health care. This practice most often occurs in an isolated or geographically remote location. The nurse is responsible, either solely or as a member of a small team, for the continuous coordinated and comprehensive care in that location.'*

Further: *'An important part of the nurse's role in an Aboriginal and Torres Strait Islander community is to support indigenous health workers in the development of an informed, involved population which can identify its own priorities and design appropriate health care interventions.'*<sup>23</sup>

Two sets of competency standards for nurses are currently being developed. They are competency standards for the advanced nurse and competency standards for the remote area nurse.

### 5.3.2.2 Doctors

The same report defines a remote area doctor as: *...(providing) a general medical service to a remote community. Normally the doctor is isolated from other medical contact at the point of service delivery. The most usual circumstance is a town or community with only one doctor... in some instances... the doctor may not be permanently resident within the community. The remote area doctor is by nature a generalist who ideally has specialised training and experience in rural medicine and, appropriately, Aboriginal health.'*<sup>24</sup>

<sup>22</sup> The specific roles of Allied Health professionals have not been outlined in this Strategy.

<sup>23</sup> Report to the AHMAC Working Party on the Health Services Workforce in Rural and Remote Australia. May 1994, pp 16-17.

<sup>24</sup> Report to the AHMAC Working Party on the Health Services Workforce in Rural and Remote Australia, May 1994, pp 20-21.

## 6. Related initiatives

A range of recent initiatives has bearing on this Strategic Framework. Linkages with related policies and programs need to be taken into account in planning its implementation.

### 6.1 National Training Reform Agenda (NTRA)

The NTRA has implications for all course curricula and for the development of education and career pathways. Its key elements include:

- competency based training, including industry developed standards;
- integrated curricula for on and off the job training;
- standardised training recognition and credentials through the National Framework for the Recognition of Training, the Australian Qualifications Framework and the Australian Standards Framework;
- a more open market for Vocational Education and Training services; and
- a new entry-level system which integrates and expands on apprenticeship and traineeship systems – the Australian Vocational Training System.

#### 6.1.1 Australian Qualifications (AQF) and Standards (ASF) Frameworks

In 1995, Commonwealth, State and Territory education and training Ministers decided that an updated system of nationally consistent qualifications was needed. The requirements for qualifications have been nationally agreed and issued to bodies developing or approving courses or issuing qualifications. No matter what the State or Territory, it will be easier for employers to assess what a person with a particular qualification can do.

#### 6.1.2 Competency Based Training (CBT)

Competencies are the skills, knowledge and attitudes a person needs to successfully perform a given job. Standards are levels at which these competencies are performed.

CBT was developed to ensure that training produces appropriately skilled workers who can meet industry needs. It means that industry helps develop training courses. CBT is relevant and appropriate to the training of Aboriginal and Torres Strait Islander Health Workers since programs can be developed according to client groups' cultural values and beliefs. Community and industry involvement and ownership are integral to program design and delivery. Regular evaluation and review with student, community and employer allows for continuous program development to reflect changing needs.

#### 6.1.3 Recognition of Prior Learning (RPL)

RPL is the acknowledgment of skills and knowledge obtained through formal training, work experience and/or life experience (VEETAC Working Party on Recognition of Training, Nov, 1991). Education and training institutions have developed, or are developing, methods by which applicants for entry to courses may apply for RPL and, to the extent that their application is successful, reduce their formal study or training load.

### 6.1.4 Accreditation of training

Courses are developed to meet occupational competency standards and then submitted to State/Territory recognition authorities for accreditation. This involves:

- course development using competency standards as benchmarks;
- accreditation for content and quality assurance purposes;
- delivery in a wide variety of training models to ensure flexibility;
- assessment against more explicit competency standards; and
- certification of the achievement of competency.

## 6.2 Development of the occupation of 'Aboriginal and Torres Strait Islander Health Worker'

### 6.2.1 National Aboriginal and Torres Strait Islander Health Worker Competency Development Project

This project began in 1995. A Project Management Committee was established and Project Officers employed to consult with workers and employers. Following broad consultation, the Committee prepared a draft document: 'Aboriginal Health Worker and Torres Strait Islander Health Worker National Competency Standards Levels A to D'.

These competency standards provide:

- information on the breadth and depth of worker roles and responsibilities;
- a benchmark for practice within the occupation and against which training courses can be accredited, assessed and reviewed.

They also form the basis for developing:

- an integrated and consistent national approach to training and employment, and to the development of career and education paths and an award structure;
- local level training programs with progression to other vocational and higher education programs, with articulation and credit transfers to related programs;
- the development of an RPL system for worker assessment against the standards;
- increased recognition of worker roles and increased awareness and confidence in their skills on the part of community members and other professionals; and
- an improved ability to work in a range of locations and practice settings

The Standards describe what is commonly needed to work in different services, with different communities and clients. They do not require all workers to have identical knowledge or to work in the same way, and can be changed according to industry needs. They can be modified, validated and then endorsed by the Standards and Curriculum Council.

There are 79 'units of competency' which, when grouped into related subject areas, combine to make up jobs. All jobs have core units, some have optional units. The units are grouped into six streams and most workers will need a unit from each:

1. Clinical care: eg, provide first aid, provide a screening service;
2. Specific care: eg, deliver health care to children, nutritional health care;
3. Community care: eg, deliver counselling, respond to emergencies;
4. Management/teams: eg, manage finances, supervise team, provide training;

5. Administration: eg, maintain records, use equipment and technology; and
6. Research: eg, collect information on community health.

Units are grouped across all streams into the levels of skill needed and the support available for a job. If the job requires more knowledge and skills, or the worker has less support to do it, it is classified at a higher level. Lower level jobs requires less knowledge and skills and are carried out by workers who have more support. The levels correspond to the ASF and these then correspond to the ASQ (see Table 3, Appendix).

Aboriginal and Torres Strait Islander Health Worker competency levels are:

- Level A: eg, has a supervisor and works within a team.
- Level B: eg, uses more competencies (or more difficult competencies), needs to use them in more situations and is less likely to have a supervisor.
- Level C: eg, works independently, may supervise others, may represent the organisation and/or community and may do some program management.
- Level D: eg, has high level responsibility, must manage difficult situations with little support from others, manages other staff and manages programs.

Employers can assess a worker's level by asking the worker and supervisor about:

- what they are expected to do and to know in their day to day job;
- what level these skills and competencies are: whether they work alone or with others, supervise others' work, do routine work, or routine and unexpected work.

For example, to reach 'Level A', a worker must demonstrate competency in all 13 'Level A Core Units' and at least 6 of the 17 'Level A Optional Units'. Most will have a supervisor and carry out their work in a team environment. If a worker does not meet all required competencies at a particular level, they may require some training.

## 6.2.2 National Aboriginal and Torres Strait Islander Health Worker Forum Project

In response to concerns about the lack of a national identity for Aboriginal and Torres Strait Islander Health Workers as an occupational group, AHMAC agreed at its February 1994 meeting, to: *'request ATSIC in consultation with ACTU to examine and advise AHMAC on the feasibility of establishing, and options for resourcing, a representative and ongoing national forum for Aboriginal and Torres Strait Islander health workers together with suggestions as to the reporting lines for such a forum'*.

The Project commenced in July 1995, overseen by a working group representing: DHFS, DEETYA, Industrial Relations, ATSIC, ACTU and NACCHO. Aboriginal and Torres Strait Islander Health Workers and other stakeholders were consulted to establish a preferred model for a national forum including roles, responsibilities, relationships, structure, membership and areas of activity. From work to date, it is considered that:

- there are marked differences across states/territories in recognition of workers, career structures, union coverage and educational opportunities;
- although many changes have occurred for the benefit of workers more needs to occur to ensure that they have a recognised role in health service delivery; and
- a national body which looks after workers' professional interests should be created with a structure that begins at local level and has regional and state input.

### 6.2.3 National Aboriginal and Torres Strait Islander Health Worker Training Provider Workshop

In February 1996, this Workshop was held in Alice Springs, bringing a range of education and training providers together, representing a range of courses currently offered to Aboriginal and Torres Strait Islander Health Workers. Discussion was directed toward avoiding duplication and filling gaps in the light of the draft competency developments.

Participants identified a need to align programs with community needs and educational challenges emerging from the competency project, including the definition of responsibilities and contributions of stakeholders other than education and training providers (all governments, non-government agencies, community controlled organisations, industry, training authorities, health associations/federations, unions and funding agencies).

There were differences in identified priorities, with a community based focus on the need for funding and support for specialised training, and a greater university/TAFE focus on the need for national cohesion and consistency. There was general support for articulation and resource sharing in the development and delivery of education and training.

## 6.3 Health planning and service development

### 6.3.1 The National Aboriginal and Torres Strait Islander Health Council (NATSIHC)

In 1996, NATSIHC was created to advise the Minister for Health and Family Services on matters relating to health and substance misuse services for Aboriginal and Torres Strait Islander peoples. Council membership includes representatives from NACCHO, ATSIC, TSRA, DHFS, NHMRC and the AMA. The Council will monitor implementation of the Framework Agreements between the Commonwealth, States and Territories.

#### 6.3.1.1 The NATSIHC Sub-Committee on Workforce Issues

To address key issues in Aboriginal and Torres Strait Islander health, the Council established a number of sub-committees. The Workforce Issues Sub-Committee will look at developing a health workforce able to provide a high standard of care and more culturally appropriate services to Aboriginal and Torres Strait Islander clients. To ensure a coordinated national approach to this development, it will be asked to use existing networks to ensure that major stakeholders contribute to policy formulation. Its Terms of Reference are particularly relevant to the implementation of this Strategic Framework:

***That the Workforce Issues Sub-Committee, based on existing workplace experience and expertise, advise the Aboriginal and Torres Strait Islander Health Council on:***

- *mechanisms that would facilitate cooperation, and coordinate the diverse input to policy development;*
- *strategies to develop a workforce of health professionals, including Aboriginal and Torres Strait Islander Health Workers, who will be able to provide a high standard of care and more culturally appropriate services to Aboriginal and Torres Strait Islander clients; and*
- *to look at specific issues such as standards development, recruitment and retention of health professionals, including research/data on recruitment and retention rates, workforce development, as well as the urgent need for more GP and specialist services in rural and remote areas.'*

### 6.3.2 Commonwealth/State/Territory Framework Agreements

Agreements have been negotiated between the Commonwealth and each State/Territory, aimed at improving coordination in the delivery of health services to Aboriginal and Torres Strait Islander peoples. They were negotiated in consultation with community controlled health organisations and ATSIC and involve coordinated planning and consultation, additional effort from the States/Territories, and clearer two-way reporting.

Framework Agreements, outlining broad principles and commitments are currently being signed in each State/Territory, and forums are being established representing the community controlled sector, ATSIC, State/Territory Health and the Commonwealth. Forums have a key role in overseeing implementation of commitments made within each Agreement and in achieving better coordination between all levels of government. They are responsible to oversee and implement the Agreements' planning requirements.

Key areas for the work of the Forums (from the Framework Agreements) include:

- regional, community and state health planning processes;
- identifying priorities for the allocation of new funds on the basis of need;
- improving access to mainstream health services (including the promotion of culturally appropriate health care and improved community participation);
- improving linkages between service providers;
- promoting intersectoral collaboration,
- collecting and improving the quality of data; and
- developing and trialling outcome focused service contracts with communities.

Key areas which focus on the health workforce are:

- strategies to assist General Practitioners to work in rural and remote areas; and
- programs and strategies to improve the status of Aboriginal and Torres Strait Islander Health Workers consistent with national core curriculum and course accreditation.

All levels of government have agreed to report on progress in implementation, with reports intended to be forwarded to AHMAC, usually on a six monthly basis.

### 6.3.3 Feasibility studies

In 1994-95 the JHPC commissioned 23 studies nationwide to assess the feasibility of providing new health services to Aboriginal and Torres Strait Islander communities. In 1996, another three projects were added. These studies will result in additional services, either through establishing new community controlled services, expanding existing services or forming innovative partnerships with States/Territories. It is likely that these developments will increase the demand for all categories of health professionals and, therefore, increase employment opportunities for Aboriginal and Torres Strait Islander Health Workers. Some of these workers may be generalists. Some may focus on areas like social/mental health or substance misuse. Some studies have also recommended ways of providing training for additional health workers within local communities.

## 6.4 Recruitment of health professionals

### 6.4.1 Recruitment Services Project

State/Territory Recruitment and Promotion Services are being set up to assist community and government sectors to improve supply, within the area of Aboriginal and Torres Strait Islander health, of a range of primary care professionals in fields such as medicine, nursing and allied health. This will provide the basis for developing a register of interest of all categories of health professionals.

The Commonwealth and NACCHO are facilitating the establishment phase and a Project Officer is assisting host organisations to develop and launch the Services.

The Recruitment Services will provide a computer linked network with access to a national medical officer vacancy information system, and a community project will develop a cross-cultural information kit for use in recruitment and in higher education institutions to stimulate interest in Aboriginal and Torres Strait Islander health careers.

#### **6.4.2 Specialist services**

An Australian Medical Association (AMA) proposal regarding pilot projects for the provision of specialist services is linked to the proposed network of Recruitment Services (with the assistance of the AMA and the professional colleges). A number of issues are being investigated in relation to this linkage and to the further development of the proposal with all key stakeholders.

#### **6.4.3 General Practice Rural Incentive Program**

This Program commenced in 1992, as part of the General Practice Strategy, with the aim of attracting GPs to rural and remote communities. Its objectives are to:

- improve access by people in rural and remote communities to GP services;
- assist in the delivery of quality GP services by supporting appropriate training; and
- foster recruitment and retention of rural and remote GPs by the provision of grants.

Grants are made for relocation, remote areas, training, continuing education, locums and rural undergraduate support. Other specific purpose grants are sometimes made.

#### **6.4.4 Aboriginal Employment Development Policy (AEDP)**

The AEDP was established in 1987 in response to high levels of unemployment among Aboriginal and Torres Strait Islander peoples and the economic consequences of dispossession, including lack of access to economic resources and opportunities.

Programs developed under the AEDP have been delivered by DEET, ATSIC, the Australian Nature Conservation Agency and the Bureau of Resource Sciences. These programs have included:

- training and labour market assistance;
- assistance with community controlled community development activities;
- assistance with the development of community controlled enterprises; and
- enhancement of community control and involvement in policy decisions and program delivery.

The Review of the AEDP makes recommendations relevant to the implementation of this Strategic Framework. These recommendations are directed at increasing the quantity and quality of employment outcomes for indigenous people.<sup>25</sup>

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<sup>25</sup> ATSIC. Review of the AEDP: Aboriginal Employment Development Policy. 1994, p xiii-xxvi.

## 7. Strategic issues and action areas

### 7.1 Health workforce planning

Workforce planning is a method of determining the workforce required to meet needs. Workforce data should indicate the number and mix of workers in the existing workforce and project the number and mix needed to enter it each year to maintain, expand, contract or alter the mix of occupational groups. It is usually done on a large scale at a state or industry level and generates a formula to apply as a guide to local or regional need.

For workforce planning to be successful it needs to be part of an overall planning framework and be applied at state/territory, regional and local levels. It should be developed in consultation with key stakeholders and contain projections for the next decade with revisions every three years. Revisions will inform national and state/territory training programs and result in adjustments to the number of training and employment places required.

Table 1 in the Appendix outlines the number and type of health professionals employed in community controlled services.<sup>26</sup> To determine the future number and skill mix of workers needed to impact on the health status of Aboriginal and Torres Strait Islander peoples, a formula needs to be developed which is both robust (allowing for national, state/territory and regional planning) and flexible (accounting for local variation). It should act as a community guide in determining the health workforce they need.

There have been several attempts to determine the number and skill mix for Aboriginal and Torres Strait Islander communities. An RACGP study (1995) suggests that communities of 400-500 require a resident doctor, two registered nurses and three Aboriginal and Torres Strait Islander Health Workers.<sup>27</sup> Tregenza and Abbott (1995) suggest that one health worker is needed for every 100 people. There is little research to support the ratios in these studies, they do not appear to be based on community need nor take into account community or location factors. For instance, access to a doctor is one factor influencing the number of other health workers needed. A different mix of skills may be required where there is a resident doctor than where a doctor visits or is on call. Any limits on the availability of a doctor should see an appropriate increase in nurses and health workers.

It has been estimated that there are approximately 1,300 Aboriginal and Torres Strait Islander Health Workers employed across Australia. As indicated earlier, they work in numerous settings, with various roles and have undertaken a variety of courses. Implementation of the national competencies will necessitate skill upgrading for some workers, especially those who may, for a variety of reasons including the absence of good in-service training and other support mechanisms, have become deskilled.

The ABS estimated that the Aboriginal and Torres Strait Islander population was 319,003 in 1996<sup>28</sup>. If the ratio of Aboriginal and Torres Strait Islander Health Workers to population (1:100) recommended in the study by Tregenza and Abbott is applied, just over 3,000 workers are needed. This means that there is a current shortfall of over 1,700 Aboriginal and Torres Strait Islander Health Workers. Table Four in the Appendix indicates that approximately 300 Aboriginal and Torres Strait Islander people graduate from Health Worker courses annually. Only a fraction of these training places produce additional, fully qualified Health Workers. This is because some of the courses are continuing education which upgrade the skills of existing Health Workers and others are introductory courses which do not result in fully qualified Health Workers. On current trends, existing training places for Aboriginal and Torres Strait Islander Health Workers are not adequate to achieve the optimal workforce of 3,000 in the short to medium term.

<sup>26</sup> Data on Allied Health professionals has not been obtained and should be addressed by Strategy 12.

<sup>27</sup> Appropriate numbers of Allied Health professionals should be investigated in Strategy 12.

<sup>28</sup> Projections of the populations of Australian States and Territories (Department of Health and Family Services special request from ABS)

## 7.2 Recruitment and retention of health workers

### 7.2.1 Aboriginal and Torres Strait Islander Health Workers

There is a high attrition rate for Aboriginal and Torres Strait Islander Health Workers. An examination of best practice in health services may suggest ways of improving retention rates.

A conservative estimate would require the annual recruitment of about 300 workers to meet an attrition rate of about 10%. In conjunction with various retention strategies including ongoing staff development, in-service training and a career structure, this may provide a viable Aboriginal and Torres Strait Islander Health Worker workforce.

An important factor in employment is worker satisfaction. Aboriginal and Torres Strait Health Workers must be recognised for their unique role, and they require conditions of work commensurate with that role. Aboriginal and Torres Strait Islander Health Workers should have access to award and condition entitlements that give them parity with other Australians.

Traditional western approaches have not generally been very successful in relation to the recruitment, retention and graduation rates of Aboriginal and Torres Strait Islander people, whose participation and completion rates in higher education are lower than for other Australians.<sup>28</sup> Competency based education programs can provide ways to integrate cultural and western practice effectively and may lead to an increase in the number of Aboriginal and Torres Strait Islander people completing training.

It is important that an appropriate RPL process for applicants to Aboriginal and Torres Strait Islander Health Worker training courses is developed in parallel with the validating process for the competency standards. A number of projects and studies are currently being undertaken into the most suitable way to implement RPL. Any best practice models need to be developed in line with the national competencies.

### 7.2.2 Medical, nursing and allied health workers

The NAHS (1989) states that: *'Until tertiary institutions recognise the need for and benefits of culturally appropriate, relevant academic content and clinical experience for all health professionals, there will continue to be difficulties in attracting and retaining health professionals to work amongst Aboriginal communities and a limited understanding of Aboriginal health issues'*.

## 7.3 Training and development

### 7.3.1 Aboriginal and Torres Strait Islander Health Workers

Improvements to Aboriginal and Torres Strait Islander Health Worker training need to be based on relevant Australian and overseas experience. This means identifying examples of best practice and strengthening existing programs.

Initially, Aboriginal and Torres Strait Islander Health Workers received 'on the job training'. Formal training evolved according to regional, community or departmental needs, resulting in programs which are often very dissimilar.

There are 33 education/training centres in Australia offering courses for Aboriginal and Torres Strait Islander Health Workers. Table Four in the Appendix illustrates their locations, number of graduates over the past three years, anticipated 1996 graduates and 1997 projections. Programs range from 13 week certificate courses to three year degree courses. Most are stand alone, competitive programs with minimal articulation, transferability of learned skills, or consistency in teaching practices and are not

<sup>28</sup> National Review of Education for Aboriginal and Torres Strait Islander Peoples – Statistical Annex, Commonwealth of Australia, 1994, and - Higher Education Strategies for Aboriginal and Torres Strait Islander Students, 1992-1995, – A Summary Report, DEET, 1993.

underpinned by national competency standards or benchmarks. Resource sharing is limited or non-existent and there are differing levels of cultural components within programs.

There is need for uniformity in Aboriginal and Torres Strait Islander Health Worker training to facilitate recognition by peers, colleagues, communities and government, as for other health occupations, whilst preserving local/regional flexibility to meet diverse community needs. A process of reform has begun, evidenced by initiatives and forums identifying the need for an integrated system, starting at the community level, with pathways to higher levels in the vocational and higher education sectors.

For instance, a national project has developed a core set of competency standards for Aboriginal and Torres Strait Islander Health Workers, in consultation with those workers and their employers. Accredited courses will be based on these standards and will have been developed within a framework of commitment to:

- recognising and valuing the existing training and skills of workers;
- a primary health care approach to ensure that the community remains central;
- using a framework of Aboriginal Terms of Reference; re-empowerment and self-determination;
- a holistic Aboriginal view of health; and
- local diversity supported by a national Aboriginal health platform.<sup>29</sup>

### 7.3.2 Medical, nursing and allied health workers

The report to AHMAC on the health workforce in rural and remote Australia states that for Aboriginal and Torres Strait Islander Health Workers, doctors and nurses in rural and remote areas: '*... the capacity to readily take advantage of higher education opportunities is limited. Not only are the limitations imposed because of the remote locations of practice but also by the difficulties of organising relief. Strategies to enhance access to higher education will improve quality of care in remote Australia and will encourage retention of skilled practitioners. It is proposed that national programs of scholarships, study grants and/or paid leave be introduced...*'<sup>30</sup>

Also of concern are the low numbers of Aboriginal and Torres Strait Islander people entering tertiary institutions to undertake medical, nursing and other health professional education. Aboriginal students have a higher attrition rate in these courses when compared to non Aboriginal and Torres Strait Islander students.

The University of Newcastle is currently employing successful recruitment and retention strategies for Aboriginal and Torres Strait Islander medical students. Since 1991, 11 Aboriginal medical students have graduated. This is a retention rate of 98%.

The RACGP has a National Training Program for Rural Practice and the RACGP Taskforce on Indigenous Health has recently developed an Aboriginal Health Curriculum. The Australian Nursing Federation has established an Aboriginal and Torres Strait Islander nurses network to address the issue of low graduation rates from nursing.

<sup>29</sup> Grogan, G. Discussion paper on Workforce Issues for the Aboriginal Health Standing Committee of the National Health & Medical Research Council: Development of National Consistency in Training, Standards and Employment of Aboriginal Health Professionals. 1994.

<sup>30</sup> Report to the AHMAC Working Party on the Health Services Workforce in Rural and Remote Australia, May 1994, p 50. National Training & Employment Strategy - November 1996 Page 16

## 7.4 Professional development and support

### 7.4.1 Aboriginal and Torres Strait Islander Health Workers

There are markedly different approaches between states/territories to the occupational development of Aboriginal and Torres Strait Islander Health Workers. Unlike other health occupations they have no national forum through which they can effectively advance professional, occupational and educational concerns and contribute to debate on important health matters. The feasibility of establishing such a forum is in progress.

### 7.4.2 Medical, nursing and allied health workers

Many non-Aboriginal and Torres Strait Islander health workers are ill-prepared to provide culturally appropriate health services to Aboriginal and Torres Strait Islander peoples because they lack understanding of underlying cultural beliefs and social structures and/or of the roles of Aboriginal and Torres Strait Islander Health Workers.

Education programs for all health professionals need to cover competencies which ensure that graduates are adequately prepared educationally, culturally and socially to provide care that is acceptable to Aboriginal and Torres Strait Islander peoples. Their expectations also need to be realistic. Employers must provide them with accurate information on the relevant historical, social and political aspects of the community.

Encouragement and support to maintain professional networks and participation in research and professional development activities need to be an ongoing part of any educational and training supports.

The RACGP requires that all trainees spend six months of their general practice training in a remote community of disadvantage. However, this does not necessarily mean training in an Aboriginal or Torres Strait Islander community.

## 7.5 Regulation of practice

### 7.5.1 Aboriginal and Torres Strait Islander Health Workers

At present, legislation covering the practice of Aboriginal and Torres Strait Islander Health Workers exists only in the NT. The potential benefits of introducing legislation in all States/Territories include:

- an increase in professional recognition for Aboriginal and Torres Strait Islander Health Workers;
- consistency and thus portability of skills across states/territories; and
- the maintenance of standards of practice and, thus, protection of the community.

The potential negative aspects of legislation include:

- a decrease in flexibility as workers would be restricted to practise within the scope of the legislation;
- a decrease in community control of standards or ways of practising as community values may change over time at a different rate to legislation; and/or
- an increase in the cost of implementing and monitoring occupational practice.

It is important that the strengths and weaknesses of introducing legislation covering Aboriginal and Torres Strait Islander Health workers in all States/Territories are identified by:

- consulting with workers regarding the feasibility of developing legislation; and
- reviewing existing legislation and that covering other health occupations.

If legislation covering all Aboriginal and Torres Strait Islander Health Workers is recommended then it is important that:

- legislation is developed which is consistent across all States/Territories; and
- that all relevant stakeholders are involved and informed.

## 7.6 Monitoring and evaluation

Both monitoring and evaluation have an important place in planning and implementing a national training strategy because they provide valuable information for:

- assessing whether the training needs of the community have been met;
- determining the effectiveness of the various training methods; and
- making better decisions on future priorities and programs.

*Monitoring* means finding out where a program is at a point in time. For example: training staff are requested to report regularly on the number of courses offered and number of trainees and staff. It is a process of determining whether the outcomes that have been set for a program or process are being achieved within agreed timeframes.

For this to occur, performance indicators need to be set from which outcomes can be measured. These must reflect community aims and feedback to the community must be built into the process, consistent with the principles of primary health care and ATR.

*Evaluation* is the process of finding out the effectiveness of a training program in achieving its stated objectives. It is called:

- *progress evaluation* when it occurs at some stage during training;
- *final evaluation* when it occurs at the end of training; and
- *follow-up evaluation* when it occurs some time after training.

When monitoring and evaluation are built into the program plan from the beginning, important baseline data can be collected. If trainers, trainees and community understand their roles in monitoring and evaluation, it is more likely that useful data is obtained and that any subsequent change to the program is better accepted.

Some questions that should be considered in monitoring and evaluation are:

- what is the minimal data set for monitoring purposes and the steps that need to be taken to ensure that the data collected are useful for comparison purposes?
- will progress evaluation be built into the program so that appropriate changes to contents or methods can be made in order to meet program objectives?
- will final and follow-up evaluations be built into the program?
- what emphasis is given to trainee and community participation in the process?
- is there a role in the process for people outside the community (for example, consultants sensitive to the needs of trainees)?
- who will process, analyse and report on data collected, and who will get reports?
- will funding for monitoring and evaluation costs be made available?

## 7.7 Funding

The issue of resources cannot be separated from development of programs. This is of particular importance to community controlled training initiatives, which sit outside the education and training funding agencies. At present ongoing funding for community controlled training initiatives are lacking or difficult to negotiate. Community based training initiatives which provide the core competencies for Aboriginal and Torres Strait Islander Health Workers should be provided with recurrent funding in accordance with their ability to meet the need requirements of the industry.

The provision of adequate ongoing funding for the development and implementation of training courses will provide for core training and further enable Aboriginal and Torres Strait Islander Health Workers to develop the range of skills required by the community to meet their health needs and to facilitate improved health outcomes.

Critical to the success of training and employment strategies is the availability of appropriate infrastructure. Commitments to training will need to be linked to the adequacy and improvement of physical facilities, working conditions, equipment and educators.

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# Appendix

## Tables relating to the employment and education of the health workforce in Aboriginal and Torres Strait Islander health

Table 1: Aboriginal and Torres Strait Islander Health Workers, Registered Nurses, Doctors and Dentists employed by Community Controlled Health Services across Australia<sup>1</sup>

State	Health Worker	Registered Nurse	Doctor	Dentist	Service population
NSW	66	16	11	16	83,512
QLD	64	26	11	11	83,857
NT	97	23	21	2	48,683
SA	95	32	8	1	19,537
VIC	72	8	5	3	20,434
TAS	3	2	1	1	10,664
WA	90	47	23	1	50,268
ACT	?	?	?	?	2,048
<b>Total</b>	<b>487</b>	<b>154</b>	<b>80</b>	<b>35</b>	<b>319,003</b>

Table 2: State/Territory Employed Aboriginal and Torres Strait Islander Health Workers<sup>2</sup>

State	NSW	QLD	NT	SA	VIC	TAS	WA	ACT	Total
<b>HW</b>	90	500	149	48	10	5	74	3	879

<sup>1</sup>Health personnel data from Commonwealth Department of Health and Family Services (DHFS), Office for Aboriginal and Torres Strait Islander Health Services (Rebasing Data, 1996). Service population from ABS — special request from DHFS for 1996 figures

<sup>2</sup>Figures are approximate and do not include Hospital Liaison Officers. QLD total includes nursing assistants. VIC figures refer to drug and alcohol workers

Table 3: Relationships between the National Competency Standards, the Australian Standards Framework and the Australian Qualifications Framework<sup>1</sup>

National Competency Standards	Australian Standards Framework	Australian Qualifications Framework
	8	Advanced Diploma
<b>D</b>	<b>7</b>	
<b>C</b>	<b>6</b>	
<b>B</b>	<b>5</b>	Diploma
<b>A</b>	<b>4</b>	Certificate IV
	<b>3</b>	Certificate III
	<b>2</b>	Certificate II
	<b>1</b>	Certificate I
Units of competency packaged into groups by industry, based on workplace requirements	Benchmark levels – groups of units given a level that gives the best fit	Qualification level flows directly from ASF level standards

<sup>1</sup> Draft only – the relationship between competency standards and ASF levels is currently under review.

**Table 4: Location of centres educating/training Aboriginal and Torres Strait Islander Health Workers**

State	Centre	Funder	Course	Time in months	Graduates				
					93	94	95	96	97
<b>VIC</b>	Victorian AHS	DHFS	In-training						
<b>SA</b>	Aboriginal Study Centre	ATSIC	Certificate	12-18	–	–	12	20	44-60
	Adelaide Institute of TAFE	SA	Certif. level 3	480 hrs			16	23	
		DHFS	Certif. level 4	480 hrs	Just accredited to begin in 1997				
			Diploma	480 hrs	Just accredited to begin in 1997				
			Introductory	6	Just accredited to begin in 1997				
<b>WA</b>	Marr Mooditj	Mixed	Adv. certificate	12	16	55	17	20	35
			Assoc. Dip.	420 hrs	–	6	11	22	15
	Curtin University of Technology	DEETYA	Certificate	24					
			Assoc. Dip.	24	20	32	18	25	45
			BAS	36	–	3	4	6	17
	Kimberley AMS	DEETYA	Certificate	13 weeks	–	–	13	18	
			Adv. Certif.	12	3	7	7	17	
			Post Adv. Cert.	6 weeks			1		
	Ngaanyatjarra Health Serv.	WA	Adv. Cert.	12		1	3	6	
			Certificate				6		
	Kalgoorlie AMS (Bega Garn Birringu)	DEETYA	Adv. Cert.	12	–	–	–	–	12
	<b>NSW</b>	Yooroang Garang Sydney University	DEETYA	Diploma	24	3	14	11	4
BHS				36	–	–	–	–	1
Redfern AMS		DEETYA	AHW	12	8	7	7		
Wollongong University		DEETYA	BIHS	36	12	12	12	–	
Gungil Jindibah Centre — Southern Cross University		DEETYA	Assoc. Dip.	24	1	15	9	1	
Charles Sturt University		Mixed	Assoc. Dip.	24	Started in 1996				12
Macquarie University		DEETYA	Diploma	36	–	–	8	11	10
Booroongen Djugun Aboriginal Corp	DEETYA	Certif. Level 3	6						

State	Centre	Funder	Course	Time in months	Graduates					
					93	94	95	96	97	
NT	Batchelor College	ANTA	Certificate	12	52	80	50	51		
		DEETYA	Assoc. Dip.	24	-	8	10	7		
			Diploma	36	-	4	-	6		
	Central Australian Aboriginal Congress		Certificate				4	5		
	Danila Dilba	DHFS, ANTA	Assoc. Certif.	24				10	10	
	Anyinginyi Congress Aboriginal Corporation		Certif. Level 2	12					11	
			Certif. Level 3	24						2
	Nganampa Health Council	DHFS ANTA	Certif. Level 2	24		8			9	10
Certif. Level 3			36-48							
Central Australian Aboriginal Alcohol Programme Unit	DEETYA	Aboriginal alcohol counsellor training	?		10-13			9	15	
QLD	Rockhampton College	DEETYA-QLD	Certificate	6	-	-	22	-		
	Far North Qld Institute of TAFE	DEETYA-QLD	Certificate	12	36	23	-	25		
	Queensland University	DEETYA	BAHS	36	-	14	17	12	12	
	Cairns Health Training Unit	QLD DHFS	AHW	Short	Data not available					
	Aboriginal and Torres Strait Islander Corporation for Health	QLD	Certificate	12	-	-	18	20	20-25	
	Education and Training (St. East Queensland)		Assoc. Dip.	?	-	-	-	-	10-15	
	Townsville Rural Health Training Unit	DEETYA	Certificate	Varied	4	4	-	1		
			Assoc Dip.	Varied	-	1	5	3		
	Southbank College of TAFE (welfare)	Mixed	Certif. Level 4	?				9		
	Cunningham Centre (RHTU)		Certif. Level 2	?	-	-	10	10		
	Toowoomba		Assoc. Dip.	24	-	-	-	8		
	Hervey Bay Regional Health									
	Central QLD TAFE and Yangulla Centre		Certificate		-	13	14	-		
Assoc. Dip.			24	-	-	8	17			